



Schedule of Benefits

Physician Services Under the Health Insurance Act

(December 22, 2015 (effective March 1, 2016))

Ministry of Health and Long Term Care

[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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NOT ALLOCATED

GENERAL PREAMBLE

INTRODUCTION

[Commentary:

The *Health Insurance Act* and, to a lesser extent, the *Independent Health Facilities Act* and the *Commitment to the Future of Medicare Act*, 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** (GP6) 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** (GP9). Next is the section which lists the **Specific Elements of Assessments** (GP11). The next section provides information on **Consultations and Assessments** (GP12) followed by the section regarding services provided only in **Hospitals and Other Institutions** (GP26).

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
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)
Bariatric Regional Assessment and Treatment Centre (RATC)	a facility that is approved and funded by the Ministry of Health and Long-Term Care for the assessment and treatment of morbid obesity for persons who have been referred to the facility for that purpose.
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
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 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 <i>Public Hospitals Act</i>

GENERAL PREAMBLE

DEFINITIONS

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.]

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
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 consultant	a designated MOHLTC physician
MOHLTC	Ministry of Health and Long-Term Care
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 " <i>not eligible for payment</i> " as they remain insured services.]	
nurse practitioner	a Registered Nurse who holds an extended certificate of registration under the <i>Nursing Act</i> , 1991 and who also holds a certificate in a specialty set out in O. Regulation 275/94 made under the <i>Nursing Act</i> , 1991 and who has been issued an OHIP registration number.
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association

GENERAL PREAMBLE

DEFINITIONS

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.
[Commentary:	Patients cannot be charged for services described as “ <i>only eligible for payment</i> ” 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 <i>professional component</i> is found in the individual preambles to the applicable sections of the Schedule.]
referral	written request by a physician or nurse practitioner for the provision of expert services by another physician to the patient of the referring physician or nurse practitioner.
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
Schedule	Schedule of Benefits for Physician Services
specialist	a physician who holds one of the following: <ol style="list-style-type: none">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 <i>specialist</i> issued by the CPSO to a physician employed:<ul style="list-style-type: none">– 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; or4. 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.
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 <i>technical component</i> is found in the individual preambles to the applicable sections of the schedule.]
transferral	permanent or temporary complete transfer of the responsibility for the care of the patient from one physician to another
[Commentary:	A <i>transferral</i> occurs, for example, where the first physician is leaving temporarily on <i>holidays</i> 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 services* 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 MOHLTC and the OMA, additions, deletions, fee changes, or other modifications to the Schedule, are made by the MOHLTC following consultation with the OMA. Physicians who wish to have modifications to the Schedule considered should submit any proposals to the Physician Services Payment Committee (PSPC) 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 PSPC for consideration, with documentation supporting the introduction of this item into the Schedule. The PSPC will advise OHIP whether or not this new therapy is experimental. If the PSPC and the MOHLTC 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 MOHLTC, on the advice of the PSPC, 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:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900552_e.htm.

Claims must be submitted within six *months* 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. weekend 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 MOHLTC 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-requested emergency and special emergency assessments, *home care* application, or *home care* supervision.

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 components* listed under one fee schedule code, the technical and *professional components* 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*.

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 MOHLTC.
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 GP44 to GP52 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.

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*.

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 components* 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 Independent Health Facility, the premises, equipment, supplies, and personnel are funded under the facility fee set out in the *Independent Health Facilities Act*.

Patients cannot be charged for the premises, equipment, supplies and personnel for services denoted with the prefix "#" rendered outside of a hospital or Independent Health Facility 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 *Independent Health Facilities Act*.]

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 (GP42) 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.]

- 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.

GENERAL PREAMBLE

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

- 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 MOHLTC.
- 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 components* 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 physician or *nurse practitioner* 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 or *nurse practitioner* 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 or *nurse practitioner* 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.]

A consultation includes the services necessary to enable the consultant to prepare a written report (including findings, opinions, and recommendations) to the referring physician or *nurse practitioner*. 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 or *nurse practitioner* 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, the referring physician or *nurse practitioner* 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.

[Commentary:

The request would ordinarily also include the appointment date and 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. Where a consultant is requested by a resident or intern to perform a consultation, the amount payable for the service will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant.
2. Consultations, except for repeat consultations (as described immediately below), are limited to one per *12 month period* unless the same patient is referred to the same consultant a second time within the same *12 month period* with a clearly defined unrelated diagnosis in which case the limit is increased to two per *12 month period*. The amount payable for consultations in excess of these limits will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant.

Note:

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.

1. cataract surgery;
2. colonoscopy;
3. cystoscopy;
4. carpal tunnel surgery; or
5. 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 or *nurse practitioner*.

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 ROOM (ER) PHYSICIAN CONSULTATION

Payment rules:

1. The amount payable for a consultation by an ER Physician will be adjusted to a lesser assessment fee under either of the following circumstances:
 - a. the patient is referred by another ER 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. ER 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 ER 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 ER 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 is required to devote at least fifty minutes exclusively to the consultation with the patient.

[Commentary:

The calculation of the 50 minute minimum excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

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 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

Family Practice & Practice in General	Paediatrics
K017 - child	K269 - 12 to 17 years
K130 - adolescent	K267 - 2 to 11 years
K131 - adult age 18 to 64 inclusive	
K132 - adult 65 years of age and older	

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.

GENERAL PREAMBLE

ASSESSMENTS

PRE-DENTAL/PRE-OPERATIVE ASSESSMENTS

[Commentary:

For Definition and terms and conditions see page A4.]

SPECIFIC ASSESSMENT AND MEDICAL SPECIFIC ASSESSMENT

Definition/Required elements of service:

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

[Commentary:

As outlined on page GP26, 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.

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.

GENERAL PREAMBLE

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.

GENERAL PREAMBLE

ASSESSMENTS

Payment rules:

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

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)
287	Purpura, thrombocytopenia, other haemorrhagic conditions
290	Senile dementia, presenile dementia
299	<i>Child</i> psychoses or autism
313	Behavioural disorders of <i>childhood</i> 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 <i>infant</i>
902	Educational problems

[Commentary:

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

GENERAL PREAMBLE

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 A3 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.

GENERAL PREAMBLE

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 the first claim is or has been submitted for a service rendered by an optometrist or physician. 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 25.00

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 weeks 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 Homes, Homes 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, A901, A903, K004–K008, K013, K014, K022, K023, K028–K030, K032, K033, K037, K623, P003, P004, P008.

GENERAL PREAMBLE

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 full 15-minute time units. The *specific elements* are those for assessments.

K001 Detention – per full quarter hour.....

21.10

Payment rules:

1. Detention is payable under the following circumstances:

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 neuromuscular assessment, complex psychiatry assessment, complex respiratory assessment, enhanced 18 month well baby visit, midwife-requested anaesthesia assessment, midwife-requested assessment, midwife-requested genetic assessment or optometrist-requested assessment	60 minutes
initial assessment-substance abuse, special community medicine consultation, special family and general practice consultation, special optometrist-requested assessment, special <i>palliative care</i> consultation, special surgical consultation or midwife-requested special assessment	90 minutes
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 midwife-requested genetic assessment, comprehensive nephrology consultation, comprehensive respiratory disease consultation, comprehensive physical medicine and rehabilitation consultation, comprehensive rheumatology consultation, special paediatric consultation, special genetic consultation or special neurology consultation	120 minutes
extended comprehensive geriatric consultation, extended midwife-requested genetic assessment, extended special genetic consultation, extended special paediatric consultation, or paediatric neurodevelopmental 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.

GENERAL PREAMBLE

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 quarter hour or part thereof.....	42.10
K111	Air ambulance transfer with patient per quarter hour or part thereof	126.40
K112	Return trip without patient to place of origin following air or ground ambulance transfer, per half hour or major part thereof	25.05

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 quarter hour or part thereof (not eligible for payment with K001).....	20.20
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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.

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 GP44), 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.

LOW BIRTH WEIGHT BABY CARE

Definition:

Low birth weight baby care is any assessment of a well *newborn/infant* weighing less than 2.5 kilograms at birth.

GENERAL PREAMBLE

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 *months* 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 *children* 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 *children* 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.]

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.

GENERAL PREAMBLE

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*.

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*.

GENERAL PREAMBLE

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 room (ER) 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 ER 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 pre-operative visit” (i.e., the consultation or assessment which may be claimed when the decision to operate is made and the operation is scheduled).]

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency room (ER) 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 ER 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 room 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.

GENERAL PREAMBLE

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

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

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 weekly 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 paragraph 2, 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 weeks after admission, 3 visits per week from 6 to 13 weeks after admission, and 6 visits per month after 13 weeks. Services in excess of the limit are *not eligible for payment*.
2. After 5 weeks of hospitalization, any assessment in hospital required as a result of an acute intercurrent illness in excess of the weekly or monthly limits set out above constitutes C121 – “additional visit due to intercurrent illness”. The weekly or monthly limits set out above do not apply to additional visits due to intercurrent illness.
3. 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.]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

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 (Subsequent visit by the *MRP* - day of discharge);
 - b. for a patient admitted for obstetrical delivery or *newborn* care; or
 - c. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.
3. C122, C123 are not payable for a subsequent visit rendered by a surgeon to a hospital in-patient following non-Z prefix surgery.

[Commentary:

The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

4. 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.
5. 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.
6. 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 GP31.]

GENERAL PREAMBLE

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.]

GENERAL PREAMBLE

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 GP29.]

4. C142, C143 are *not eligible for payment*:

- a. when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* – day of discharge), or
- b. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

5. C142, C143 are not payable for visits rendered by a surgeon to a hospital in-patient in the first two weeks following non-Z prefix surgery.

[Commentary:

The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

6. 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.

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

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

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

Payment rules:

1. E083 is *only eligible for payment* once per patient per day.
2. E083 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. E083 is *not eligible for payment* for *palliative care* visits to patients in designated *palliative care* beds in Long-Term Care Institutions.
4. E083 is not applicable to any other service or premium.

[Commentary:

1. E083 is *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.
3. E083 is *not eligible for payment* with C121 additional visits for intercurrent illness.]

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*.

GENERAL PREAMBLE

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 *homes*, *homes* 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 *monthly* 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 A11, A12 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.]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

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

Definition/Required Elements of Service:

Monthly 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 pre-dental/pre-operative assessments (e.g. W903).
- F. Services described by periodic health visit or general re-assessments (e.g. W109, W004).
- G. 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.
- H. Service described by anticoagulation supervision (G271).
- I. Completion of CCAC application and *home* care supervision (K070, K071, K072).
- J. Services described by the following diagnostic and therapeutic procedures – venipuncture (G489), injection (G372, G373), immunization (G538, G590), Pap smear (G365, G394, E430, E431), intravenous (G379), and laboratory test codes (G001, G002, G481, G004, G005, G009, G010, G011, G012, G014).
- K. All medication reviews.
- L. All discussions with the staff of the institution related to the patient's care.
- M. 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 *holidays*).
- N. 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.

[Commentary:

Examples of services not included in the *Monthly 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*.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Psychotherapy, Hypnotherapy and all forms of Counselling, Primary Mental Health, and Psychiatric Care rendered by telephone, other electronic communications or in the physical absence of the patient (or patient's relative or *patient representative* as the case may be) are not insured services unless otherwise specifically listed in the Schedule.

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 inquiries (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 is as follows:

# 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:

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.]

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.

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 12% 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.]

GENERAL PREAMBLE

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 GP20 for further information.]

Payment rules:

1. With the exception of the codes listed in the table 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	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.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

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.

GENERAL PREAMBLE

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 services*.

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.

COMMON PROCEDURAL DESCRIPTION	APPLICABLE FEE CODES	CURRENT PAGE #
Venipuncture	G480, G482, G489	J7
Injections and immunizations	G372, G373, G538, G590, G840, G841, G842, G843, G844, G845, G846, G847, G848	J43, J43
Ultraviolet light therapy	G470	J29
Administration of oral polio vaccine	G462	J43
Simple office laboratory procedures	G001, G002, G004, G005, G009, G010, G011, G012, G014, G481	J52
Ear syringing, curetting or debridement	G420	J77
B.C.G. inoculation	G369	J42
Simple Spirometry and Flow Volume Loop	J301, J324, J304, J327	H3
Casts	Z198-Z209, Z211, Z213, Z216, Z873	N5

[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.]

GENERAL PREAMBLE

AGE-BASED FEE PREMIUMS

1. Despite any other provision in this Schedule, the amount payable for the following services rendered on or after October 1, 2009 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.

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 rendered on or after October 1, 2009 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, A903, C003, C903, W102, W109 or W903).
 - b. A general re-assessment (A004, C004, W004)
 - c. An intermediate assessment (A007).
 - d. A house call assessment (A901)
 - e. A focused practice assessment (A917, A927, A937, A947, A957 or A967).
 - f. A periodic health visit (K132)

GENERAL PREAMBLE

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 weekends or *holidays*.
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 weekends, submit claim(s) using fee codes found under the column titled "Elective *Home* Visit" of Special Visit Premium Table VI listed on page GP50.]

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.

GENERAL PREAMBLE

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 *Holidays*; 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.]

GENERAL PREAMBLE

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 MOHLTC.

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 room 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 GP45, to make a special visit to the hospital emergency department.
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 (GP48). 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.

GENERAL PREAMBLE

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.

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE I

Emergency Department					
	Weekdays	Weekdays	Evenings	Sat., Sun.	Nights
	Daytime (07:00-17:00)	Daytime (07:00 - 17:00) with Sacrifice of Office Hours	(17:00-24:00) Monday through Friday	and Holidays (07:00-24:00)	(00:00-07:00)
Travel Premium	\$36.40 K960	\$36.40 K961	\$36.40 K962	\$36.40 K963	\$36.40 K964
First Person Seen	\$20.00 K990	\$40.00 K992	\$60.00 K994	\$75.00 K998	\$100.00 K996
Additional Person(s) seen	\$20.00 K991	\$40.00 K993	\$60.00 K995	\$75.00 K999	\$100.00 K997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

SPECIAL VISIT PREMIUM TABLE II

Hospital Out-Patient Department					
	Weekdays	Weekdays	Evenings	Sat., Sun.	Nights
	Daytime (07:00-17:00)	Daytime (07:00 - 17:00) with Sacrifice of Office Hours	(17:00-24:00) Monday through Friday	and Holidays (07:00-24:00)	(00:00-07:00)
Travel Premium	\$36.40 U960	\$36.40 U961	\$36.40 U962	\$36.40 U963	\$36.40 U964
First person seen	\$20.00 U990	\$40.00 U992	\$60.00 U994	\$75.00 U998	\$100.00 U996
Additional person(s) seen	\$20.00 U991	\$40.00 U993	\$60.00 U995	\$75.00 U999	\$100.00 U997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE III

Hospital In-Patient		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	\$36.40 C960	\$36.40 C961	\$36.40 C962	\$36.40 C963	\$36.40 C964	
First person seen	\$20.00 C990	\$40.00 C992	\$60.00 C994	\$75.00 C986	\$100.00 C996	
Additional person(s) seen	\$20.00 C991	\$40.00 C993	\$60.00 C995	\$75.00 C987	\$100.00 C997	
Maximums (per time period)						
Travel premiums	2	2	2	6	unlimited	
Persons seen (first person and additional person(s))	10	10	10	20	unlimited	

SPECIAL VISIT PREMIUM TABLE IV

Long-Term Care Institution		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	\$36.40 W960	\$36.40 W961	\$36.40 W962	\$36.40 W963	\$36.40 W964	
First person seen	\$20.00 W990	\$40.00 W992	\$60.00 W994	\$75.00 W998	\$100.00 W996	
Additional person(s) seen	\$20.00 W991	\$40.00 W993	\$60.00 W995	\$75.00 W999	\$100.00 W997	
Maximums (per time period)						
Travel premiums	2	2	2	6	unlimited	
Persons seen (first person and additional person(s))	10	10	10	20	unlimited	

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE V

Emergency Department by Emergency Department Physician (as defined on GP46)				
	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	\$36.40 H960	\$36.40 H962	\$36.40 H963	\$36.40 H964
First person seen	\$20.00 H980	\$60.00 H984	\$75.00 H988	\$100.00 H986
Additional person(s) seen	\$20.00 H981	\$60.00 H985	\$75.00 H989	\$100.00 H987
Maximums (per time period)				
Travel premiums	2	2	4	unlimited
Persons seen (first person and additional person(s))	5	5	10	unlimited

SPECIAL VISIT PREMIUM TABLE VI

Special Visits to Patient's Home (other than Long-Term Care Institution)						
	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) Non- elective	Elective home visit
Travel Premium	\$36.40 B960	\$36.40 B961	\$36.40 B962	\$36.40 B963	\$36.40 B964	\$36.40 B960
First person seen	\$27.50 B990	\$44.00 B992	\$66.00 B994	\$82.50 B993	\$110.00 B996	\$27.50 B990
Maximums (per time period)						
Travel premiums	2	2	2	6	unlimited	2
First person seen	10	10	10	20	unlimited	10

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*.

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE VII

Palliative Care Home Visit		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	\$36.40 B966	\$36.40 B966	\$36.40 B966	\$36.40 B966	\$36.40 B966	\$36.40 B966
First person seen	\$82.50 B998	\$82.50 B998	\$82.50 B998	\$82.50 B998	\$82.50 B998	\$110.00 B997
Maximums (per time period)						
Travel premiums	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
First person seen	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited

SPECIAL VISIT PREMIUM TABLE VIII

Physician Office		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	\$36.40 A960	\$36.40 A962	\$36.40 A963	\$36.40 A964	\$36.40 A964
First person seen	\$20.00 A990	\$60.00 A994	\$75.00 A998	\$100.00 A996	\$100.00 A996
Maximums (per time period)					
Travel premiums	1	1	1	unlimited	
First person seen	1	1	1	unlimited	

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE IX

Other (non-professional setting not listed)					
	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	\$36.40 Q960	\$36.40 Q961	\$36.40 Q962	\$36.40 Q963	\$36.40 Q964
First person seen	\$20.00 Q990	\$40.00 Q992	\$60.00 Q994	\$75.00 Q998	\$100.00 Q996
Maximums (per time period)					
Travel premiums	1	1	1	1	unlimited
First person seen	1	1	1	1	unlimited

SPECIAL VISIT PREMIUM TABLE X

Geriatric Home Visit					
	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	\$36.40 B986	\$36.40 B986	\$36.40 B986	\$36.40 B986	\$36.40 B986
First person seen	\$82.50 B988	\$82.50 B988	\$82.50 B988	\$82.50 B988	\$110.00 B987
Maximums (per time period)					
Travel premiums	unlimited	unlimited	unlimited	unlimited	unlimited
First person seen	unlimited	unlimited	unlimited	unlimited	unlimited

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	\$76.40 C989	\$0.00	\$0.00	\$0.00
Maximums (per time period)					
First person seen	0	1	0	0	0

GENERAL PREAMBLE

TEAM CARE IN TEACHING UNITS

[Commentary:

Joint recommendations made by the CPSO and the OMA governing the charging of fees for services rendered by interns and residents in clinical teaching units were accepted by the MOHLTC on the understanding that the CPSO and medical schools ensure adherence to the rules governing these billing procedures. These recommendations were that the staff physician may make a claim to OHIP for services rendered by his/her intern or resident if the following requirements are met:

1. the responsible staff physician must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient at the earliest possible moment;
2. no fees are to be charged for services given by the intern or resident prior to his identification taking place;
3. when patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the physician responsible must be personally identified to the patient. The physician's relationship to the team must be defined by the clinical teaching unit director and his/her role must be known to the patient and other members of the team.]

Payment rules:

Where a service is rendered by an intern or resident in a clinical teaching unit or setting ("teaching service"), there is no amount payable to the intern or resident for the service. A service rendered by an intern or resident may be payable to the responsible staff physician where that physician assumes full responsibility for the appropriateness and the quality of the teaching service and the teaching service is rendered under the following circumstances:

1. Where the teaching service is a physical procedure, the responsible staff physician is, at the time of the procedure, physically located in the clinical teaching unit, and immediately available to intervene.
2. Where the teaching service is psychotherapy (and the presence of the responsible staff physician would distort the psychotherapy milieu) and that physician carefully reviews the record of the session with the intern or resident and thus supervises the psychotherapy. The number of time units payable is calculated as the lesser of:
 - a. the time spent by the responsible staff physician in discussion with the intern or resident; or
 - b. the time spent by the staff physician directly supervising the interview between the intern or resident and the patient.

The maximum number of time units payable to the responsible staff physician for such psychotherapy is the number of time units spent by the intern or resident with the patient.

[Commentary:

The service date to be used is the date the intern or resident saw the patient.]

3. In other circumstances, an amount may be payable to the responsible staff physician for services provided by interns or residents on those days when the responsible staff physician actually supervises the patient's care as evidenced by the presence of that physician in the clinical teaching unit on that day. This involves a physical visit to the patient and/or a chart review and detailed discussion between the responsible staff physician and the other member(s) of the health team.
4. In those situations where the responsible staff physician may supervise concurrently multiple procedures or services through the use of other members of the team, the total claims submitted by the responsible staff physician must not exceed the amount that staff physician might claim in the absence of the other members of the team.

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	\$12.04
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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*.

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	2 units
After 2.5 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.]

GENERAL PREAMBLE

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.

GENERAL PREAMBLE

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 GP44.]

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

C988B is *not eligible for payment* in respect of any special visits to assist at surgery in a calendar *month* if the amount payable for all surgical assistant's fees (including special visit premiums associated with performing surgical assistant services) rendered by the physician in that *month* is greater than 20% of the total amount payable for all insured services rendered by the physician in that *month*.

Evenings, Weekend/Holiday and Nights

C998B	Evenings (17:00h - 24:00h) Monday to Friday, first patient seen.....	60.00
C983B	Saturdays, Sundays or Holidays, daytime and evenings (07:00h -24:00h), first patient seen.....	75.00
C999B	Nights (00:00h - 07:00h), first patient seen.....	100.00

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 GP45.

[Commentary:

1. The specific requirements for special visits are found on pages GP44 to GP52.
2. These premiums are eligible for payment in addition to the E400 and E401 premiums.]

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	\$60.00 C998B	\$75.00 C983B	\$100.00 C999B
Maximums (per time period)						
First person seen	0	1		2	6	unlimited

GENERAL PREAMBLE

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:

E645	M111	M117	M134	M142	P042	P051	P052	P056	P059
R008	R009	R013	R014	R015	R016	R055	R056	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	R733	R734	R735	R737
R738	R742	R743	R746	R747	R749	R764	R770	R771	R772
R785	R786	R799	R800	R801	R802	R803	R804	R811	R815
R817	R818	R830	R832	R858	R863	R870	R872	R874	R876
R877	R927	R929	R920	R930	S005	S007	S090	S091	S092
S096	S098	S099	S120	S125	S189	S213	S214	S267	S270
S271	S274	S275	S294	S295	S298	S300	S321	S416	S429
S440	S441	S453	S454	S462	S484	S750	S758	S759	S816

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.

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.

[Commentary:

E101B is payable with after hours premiums.]

GENERAL PREAMBLE

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 GP11);
- 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 GP2), *general anaesthesia*, for the purposes of this Schedule, includes all forms of anaesthesia except 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	\$15.01
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Basic Units: The number of basic units is the number of basic units listed opposite the service in the column headed with "Anae" except,

- 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.]

GENERAL PREAMBLE

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 GP45, 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 GP44 to GP52.
2. These premiums are payable in addition to the E400 and E401 premiums.]

SPECIAL VISIT PREMIUM TABLE - ANAESTHESIA SERVICES

Anaesthesia Services					
Weekdays	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)	
\$0.00	\$60.00 C998C	\$60.00 C998C	\$75.00 C985C	\$100.00 C999C	
Maximums (per time period)					
First person seen	0	2	2	6	unlimited

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

CANCELLED SURGERY - ANAESTHESIA SERVICES

Payment rules:

1. If an anaesthetist 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 anaesthetist are necessary in the interest of the patient, the service provided by the second anaesthetist constitutes E001C with the actual number of time units (based on the actual time assisting the first anaesthetist) added to 6 basic units.

REPLACEMENT ANAESTHESIOLOGIST

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

- a. the amount payable to the first anaesthetist is calculated by adding the listed procedural basic units plus time units for the time the first anaesthetist is in attendance;
- b. except in the case of continuous conduction anaesthesia, the service provided by the replacement anaesthetist 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 GP59).

[Commentary:

1. Each anaesthetist must indicate, as part of the medical record, his/her starting and finishing times.
2. For continuous conduction anaesthesia, the replacement anaesthetist 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, has a value of 6 basic units.

E111A Combined spinal-epidural for labour, to P014C add 50.00

P016C time units for maintenance of obstetrical epidural anaesthesia are calculated on the basis of 1 unit for each $\frac{1}{2}$ hour of time to a maximum of 12 units.

E100C time units for attendance at delivery are calculated on the basis of 1 unit for each $\frac{1}{4}$ hour

[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 K8 of the Schedule.]

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

EXTRA UNITS

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

Fee code	Criteria	Number of extra units
E021C	premature <i>newborn</i> less than 37 weeks gestational age	9 units
E014C	<i>newborn</i> to 28 days	5 units
E009C	<i>infant</i> from 29 days to 1 year of age	4 units
E019C	<i>infant or child</i> from 1 year to 8 years of age inclusive	2 units
E007C	<i>adult</i> aged from 70 to 79 years, inclusive	1 unit
E018C	<i>adult</i> aged 80 years and older	3 units
E010C	patient with <i>body mass index (BMI)</i> > 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 <i>with or without</i> 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

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 anaesthetist 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.

GENERAL PREAMBLE

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
E650C	when a pump (<i>with or without</i> an oxygenator and <i>with or without</i> hypothermia) is used in conjunction with an anaesthetic	28 units
E645C	off pump coronary artery bypass grafting, to R742 or R743	40 units
E002C	when hypothermia is used by the anaesthetist in procedures not specifically identified as requiring hypothermia	25 units
E013C	when anaesthetic management is required for the emergency relief of acute upper airway (above the carina) obstruction (excluding choanal atresia)	10 units

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 GP61 are not payable with E030C.

E031C General anaesthesia or deep sedation 4 basic units

Note:

Extra units listed on GP61 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, anaesthesia means an anaesthesia service other than local infiltration, topical anaesthesia or procedural sedation rendered in support of the listed procedures. E023C replaces the listed basic units and time units for anaesthesia for these procedures.

E023C Anaesthesia service for E137, E138, E139, E140, E141, E143, E144, E145, E146, E147, E149, Z432, Z606, Z607, Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z555 or Z580 6 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.
2. Anaesthesia extra units listed on GP61 are eligible for payment with E023C.
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*.
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 anaesthetist 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

Note:

1. For E003B, the assistants' premiums apply as for assistants' services.
2. Anaesthesia extra units listed on GP61 are *not eligible for payment* with E003C.

GENERAL PREAMBLE

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 (e.g. post-operative care by surgeon).]

AFTER HOURS PROCEDURE PREMIUMS

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

- a. the service provided is one of the following:

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:

E111A	G060	G061	G062	G065	G066	G067	G068	G082	G083	G085	G090
G091	G092	G099	G117	G118	G119	G125	G176	G177	G178	G179	G211
G222	G224	G246	G248	G249	G260	G261	G262	G263	G268	G269	G275
G277	G279	G280	G282	G287	G288	G290	G294	G295	G297	G298	G303
G309	G322	G323	G324	G330	G331	G336	G347	G348	G349	G356	G376
G379	G380	G509	J001 to J068								

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 GP34 for definitions and conditions for Emergency Department Physician.]

GENERAL PREAMBLE

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 specialists 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 GP44) 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 GP44 to GP52.]

SPECIAL VISIT PREMIUM TABLE - NON ELECTIVE DIAGNOSTIC SERVICES

Non-elective Diagnostic Services			
	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and <i>Holidays</i> (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 C102	\$36.40 C103	\$36.40 C104
First person seen	\$60.00 C109	\$75.00 C108	\$100.00 C110
Additional person(s) seen	\$60.00 C105	\$75.00 C106	\$100.00 C107
Maximums (per time period)			
Travel premiums	2	6	unlimited
Persons seen (first and additional persons)	2	6	unlimited

[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.]

GENERAL PREAMBLE

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 physician 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.
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.

GENERAL PREAMBLE

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 <i>Holidays</i> (07:00- 24:00)	Nights (00:00- 07:00)
	\$60.00 E406	\$75.00 E407	\$100.00 E408
Maximums (per time period)	2	6	Unlimited

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.]

GENERAL PREAMBLE

EMERGENCY DEPARTMENT SESSIONAL FEES

Definition:

For the purposes of this part,

“eligible hospital” means a hospital, designated by the MOHLTC as eligible for Emergency Department sessional fees which provides 24 hour Emergency Department coverage on a continuing basis.

“sessional unit” means each one hour period, commencing on the hour, on any day (including weekends or *holidays*) between 20:00 and 08:00h.

“sessional period” refers to the four hour block for each of the sessional unit codes below.

“sessional physician” means the physician to whom payment is made in respect of a sessional unit.

Payment rules:

1. The amount payable for a sessional unit for all insured services rendered during that hour and for being on call to provide such insured services is \$72.80.
2. Claims for sessional units shall be submitted in accordance with the following codes:

Sessions – Monday to Friday (other than *holidays*)

H400	20:00h – 24:00h.....	72.80
H401	00:00h – 04:00h.....	72.80
H402	04:00h – 08:00h.....	72.80

Sessions – Saturdays, Sundays, *Holidays*

H403	00:00h – 04:00h.....	72.80
H404	04:00h – 08:00h.....	72.80
H405	08:00h – 12:00h.....	72.80
H406	12:00h – 16:00h.....	72.80
H407	16:00h – 20:00h.....	72.80
H408	20:00h – 24:00h.....	72.80

3. Services rendered to any person present in the Emergency Department of the hospital on or before 08:00h of any non-*holiday* weekday, and not assessed by the sessional physician before that time, are eligible for payment in addition to the sessional fee.
4. Services rendered to any person present in the Emergency Department of the eligible hospital before 20:00h and not assessed by the sessional physician on or before that time shall be deemed to have been rendered during the sessional unit.
5. Claims for sessional units are eligible for payment only if the following conditions are met:
 - a. the claim for the sessional unit is submitted using the OHIP identification number assigned by the MOHLTC for physicians claiming such services at each eligible hospital;
 - b. in addition to the claim submitted for the sessional unit, claims are submitted at \$0.00 for each and every other insured service rendered during the sessional period to which the sessional unit applies, using the appropriate codes listed in the Schedule; and
 - c. all physicians providing insured services in that eligible hospital during any sessional unit submit claims for those services on a sessional unit basis only, except as specifically outlined below.

GENERAL PREAMBLE

EMERGENCY DEPARTMENT SESSIONAL FEES

6. With the exceptions noted in section 7, where a fee is paid in respect of a sessional unit,
 - a. services rendered in the hospital during the sessional unit by any physician are *not eligible for payment*; and
 - b. services rendered anywhere by the sessional physician during that sessional unit are *not eligible for payment*.
7. Section 6 does not apply to the following:
 - a. services which comprise the daily, routine scheduled care of in-patients;
 - b. services rendered during a sessional unit by a physician other than the sessional physician who is
 - i. a *specialist*; or
 - ii. a general practice physician if the services comprise an obstetrical delivery, immediate post-delivery care of a *newborn*, anaesthesia (other than local anaesthesia), or surgery that requires the services of an anaesthesiologist;
 - c. services, other than assessments, consultations, counselling or psychotherapy, rendered during a sessional unit by:
 - i. a *specialist* who is the sessional physician, if the services are procedures that would normally require the services of a *specialist*; or
 - ii. a general practice physician who is the sessional physician if the services comprise an obstetrical delivery, immediate post-delivery care of a *newborn*, anaesthesia (other than local anaesthesia) or surgery that requires the services of an anaesthesiologist;
 - d. services rendered during a sessional unit by a supplementary physician where, in extraordinary or catastrophic circumstances, the sessional physician requires the assistance of a supplementary physician due to a high volume of patients and/or the serious nature of illness and/or injury of one or more patients; or
 - e. services rendered during a sessional unit by the sessional physician to a resident of a nursing *home* or other chronic care institution, at such nursing *home* or other institution.

GENERAL PREAMBLE

EMERGENCY DEPARTMENT ALTERNATIVE FUNDING AGREEMENTS

When one or more physicians have contracted with the MOHLTC 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.

GENERAL PREAMBLE

NOT ALLOCATED

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OHIP LISTED SPECIALTIES

NOT ALLOCATED

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

GENERAL LISTINGS

A005 Consultation 77.20

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 fifty (50) minutes of 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 144.75

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 seventy-five (75) minutes of 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 217.15

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 GP12).
2. The calculation of the 50 minute and 75 minute minimum for special and comprehensive consultations respectively excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

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 with the patient and/or patient's representative/family in consultation (majority of time must be spent in consultation with 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 144.75

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).

A905 Limited consultation 65.90

A006 Repeat consultation 45.90

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

A003 General assessment.....	77.20
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Note:

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

[Commentary:

Electrocardiography (i.e. G310, G313) and pulmonary function test services (i.e. J301, J304, J324, J327) are not payable 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.]

A004 General re-assessment	38.35
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Note:

The papanicolaou smear 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 a papanicolaou smear is performed outside hospital.

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.....	33.70
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[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*.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

House call assessment

A house call assessment is a primary care service rendered in a patient's *home* that satisfies, at a minimum, all of the requirements of an intermediate assessment.

A901 House call assessment..... 45.15

Payment rules:

A house call assessment is *only eligible for payment* for the first person seen during a single visit to the same location.

[Commentary:

Services rendered to additional patients seen during the same visit are payable at a lesser fee from the General Listings.]

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 45.15

Payment rules:

A complex house call assessment is *only eligible for payment* for the first person seen during a single visit to the same location.

[Commentary:

1. A frail elderly patient is defined as:

- a. 65 years or older with one or more of the following age-related illness(es), condition(s) or presentation(s):
 - i. Complex medical management needs;
 - ii. Polypharmacy;
 - iii. Cognitive impairment (e.g. dementia or delirium);
 - iv. Age-related reduced mobility or falls; and/or
 - v. Unexplained functional decline not otherwise specified.

and

- b. resides in a *home* that includes:
 - i. The patient's *home*; or
 - ii. Assisted living or retirement residence (but does not include a long-term care *home*).

2. A housebound patient is defined as:

- a. A person will be considered *homebound* where all the following criteria are met:
 - i. The person has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
 - ii. 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
 - iii. The person's care and support requirements can be effectively and appropriately delivered at *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..... 45.15

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 GP44 to GP52 of the General Preamble.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Pre-dental/Pre-operative assessments

Pre-dental/Pre-operative Assessments are services required to provide history and physical exam information to the peri-operative team that will be assessing suitability for surgery and anaesthesia. Pre-dental/Pre-operative assessments rendered by primary care physicians (General Family Practice/Paediatrics/Emergency Medicine) and **Specialists** are separately listed.

Pre-dental/Pre-operative assessments - General/Family Practice/Paediatrics/Emergency Medicine

A903	Pre-dental/pre-operative general assessment.....	65.05
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Pre-dental/Pre-operative assessments - Specialists

A904	Pre-dental/pre-operative assessment.....	33.70
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Payment rules:

1. A903 must include the required elements of a general assessment (see page GP14) or the amount payable will be adjusted to a lesser assessment fee.
2. A903 is limited to a maximum of two (2) services per patient per physician per *12 month period*.
3. A903 is *only eligible for payment* to the following specialties: General and Family practice (00), Paediatrics (26) and Emergency Medicine (12).

[Commentary:

Pre-operative and pre-dental general assessments constitute “general assessments” for the purpose of calculating general assessment limits set out on GP14. See page GP34 for the definition of an “Emergency Department Physician”.]

4. A904 is *not eligible for payment*:

- a. where the service is rendered on the *day* of surgery;
 - b. to a physician practising in the following specialties: General and Family Practice (00) Paediatrics (26), and Emergency Medicine (12); or
 - c. unless it includes as a minimum the elements of a partial assessment.
5. An admission general assessment (C003) or general re-assessment (C004) is *not eligible for payment* for an elective surgery patient for whom a pre-dental/pre-operative assessment has already been claimed, within 30 days of this pre-dental/pre-operative assessment.
 6. Only one of A904/C904/W904 or A903/C903/W903 is eligible for payment for the same patient for the same surgical procedure.

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.....	79.90
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CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (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	76.90
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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 GP26 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.....	20.60
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP18)	33.70
A002	Enhanced 18 month well baby visit (see General Preamble GP22).....	62.20
A007	Intermediate assessment or well baby care	33.70
A001	Minor assessment.....	21.70

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Focused practice assessment (FPA)

FPA is an assessment rendered by a GP/FP physician 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.....	33.70
A927	Allergy FPA.....	33.70
A937	Pain management FPA.....	33.70
A947	Sleep medicine FPA	33.70
A957	Addiction medicine FPA.....	33.70
A967	Care of the elderly FPA.....	33.70

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.

[Commentary:

Physicians should be prepared to provide to the ministry documentation demonstrating training and/or experience on request.]

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.....	13.05
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[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	43.60
K130	adolescent	77.20
K131	adult age 18 to 64 inclusive	50.00
K132	adult 65 years of age and older	77.20

Note:

For definitions and payment rules - see General Preamble GP14.

[Commentary:

Electrocardiography (i.e. G310, G313) and pulmonary function test services (i.e.J301, J304, J324, J327) are not payable when rendered to a patient who does not have symptoms, signs or an indication supported by generally accepted clinical practice guidelines relevant to the individual patient's circumstances.]

Periodic oculo-visual assessment

see General Preamble GP19 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
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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 an optometrist or general practitioner 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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 by a registered nurse holding an extended certificate of registration (RN(EC)) if requested
- g. any other medically necessary components of the examination (including eye-related procedures) not specifically listed above.

A115 Major eye examination..... 51.10

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 registered nurse holding an extended certificate of registration (RN(EC)).
2. This service is limited to one per patient per consecutive *12 month period* regardless of whether the first claim is or has been submitted for a major eye examination rendered by an optometrist or physician. 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.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Midwife-Requested Anaesthesia Assessment (MRAA)

Midwife-Requested Anaesthesia Assessment (MRAA) is an assessment of a mother or *newborn* provided by an anaesthesiologist upon the written request of a 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 general or specific assessment and the physician must submit his/her findings, opinions and recommendations verbally to the midwife and in writing to both the midwife and the patient's primary care physician, if applicable. Maximum one MRAA per patient per anaesthesiologist per pregnancy.

A816 Midwife-Requested Anaesthesia Assessment (MRAA)..... 106.80

Midwife-Requested Assessment (MRA)

Midwife-Requested Assessment (MRA) is an assessment of a mother or *newborn* provided by a physician upon the written request of a 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 general or specific assessment and the physician must submit his/her findings, opinions and recommendations verbally to the midwife and in writing to both the midwife and the patient's primary care physician, if applicable. Maximum one per patient per physician per pregnancy.

A813 Midwife-Requested Assessment (MRA)..... 101.70

Midwife-Requested Special Assessment (MRSA)

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 at least 50 minutes in direct patient contact, exclusive of tests. 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-Requested Special Assessment (MRSA)..... 186.95

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C005	Consultation.....	77.20
C911	Special family and general practice consultation - subject to the same conditions as A911.....	144.75
C912	Comprehensive family and general practice consultation - subject to the same conditions as A912.....	217.15
C945	Special palliative care consultation - subject to the same conditions as A945	144.75
C905	Limited consultation	65.90
C006	Repeat consultation	45.90
C003	General assessment.....	77.20
C004	General re-assessment	38.35
C816	Midwife-Requested Anaesthetist Assessment (MRAA) - subject to the same conditions as A816.....	106.80
C813	Midwife-Requested Assessment - subject to the same conditions as A813.....	101.70
C815	Midwife-Requested Special Assessment - subject to the same conditions as A815.....	186.95
C903	Pre-dental/pre-operative general assessment (maximum of 2 per 12 month period)	65.05
C904	Pre-dental/pre-operative assessment.....	33.70
C933	On-call admission assessment - subject to the same conditions as A933	79.90
C777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777.....	33.70
C771	Certification of death - subject to the same conditions as A771	20.60

Subsequent visits

C002	- first five weeks	per visit	31.00
C007	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C009	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28). per visit	31.00
C008	Concurrent care.....per visit	31.00
C010	Supportive care.....per visit	18.85
C882	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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
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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	52.20
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Low birth weight baby care (uncomplicated)

H002	- initial visit (per baby)	32.75
H003	- subsequent visit	16.25 per visit

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

EMERGENCY DEPARTMENT PHYSICIAN

Note:

See General Preamble GP34 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 GP3).

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*.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

H065	Consultation in Emergency Medicine	74.25
H105	In-patient interim admission orders.....	26.25

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	37.20
H103	Multiple systems assessment.....	35.65
H101	Minor assessment.....	15.00
H104	Re-assessment.....	15.00

Monday to Friday - Evenings (17:00h to 24:00h)

H132	Comprehensive assessment and care	46.30
H133	Multiple systems assessment.....	42.40
H131	Minor assessment.....	18.70
H134	Re-assessment.....	18.70

Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)

H152	Comprehensive assessment and care	63.30
H153	Multiple systems assessment.....	56.95
H151	Minor assessment.....	25.50
H154	Re-assessment.....	25.50

Nights (00:00h to 08:00h)

H122	Comprehensive assessment and care	73.90
H123	Multiple systems assessment.....	65.95
H121	Minor assessment.....	29.80
H124	Re-assessment.....	29.80

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)	34.20
H113	- daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays	19.80

CONSULTATIONS AND VISITS

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 components* 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 GP34 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 internet link: <http://www.ceus.ca>.]

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W105	Consultation	77.20
W911	Special family and general practice consultation - subject to the same conditions as A911	144.75
W912	Comprehensive family and general practice consultation - subject to the same conditions as A912	217.15
W106	Repeat consultation	45.90

Admission assessment

W102	- Type 1.....	69.35
W104	- Type 2.....	20.60
W107	- Type 3.....	30.70
W109	Periodic health visit	70.50
W777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	33.70
W771	Certification of death - subject to same conditions as A771	20.60
W004	General re-assessment of patient in nursing home (per the Nursing Homes Act)...	38.35

Note:

W004 may be claimed 6 months after Periodic health visit (per the *Nursing Homes Act*).

W903	Pre-dental/pre-operative general assessment (maximum of 2 per 12 month period)	65.05
W904	Pre-dental/pre-operative assessment	33.70

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W002	- first 4 subsequent visits per patient per month.....	per visit	32.20
W001	- additional subsequent visits (maximum 4 per patient per month)	per visit	21.20
W882	- palliative care (see General Preamble GP34).....	per visit	32.20

Nursing home or home for the aged

W003	- first 2 subsequent visits per patient per month.....	per visit	32.20
W008	- additional subsequent visits (maximum 2 per patient per month)	per visit	21.20
W872	- palliative care (see General Preamble GP34).....	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33). per visit		31.00

Monthly Management of a Nursing Home or Home for the Aged Patient

W010	Monthly management fee (per patient per month) (see General Preamble GP35 to GP36).....	108.85
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CONSULTATIONS AND VISITS

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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

K005	Individual care.....	per unit	62.75
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Counselling

Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 to GP41 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	62.75
K033	- additional units per patient per provider per 12 month period.....	per unit	38.15

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	62.75
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	38.80
K014	Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons.....	per unit	62.75
K015	Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons.....	per unit	62.75

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (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	31.40
K141	- 3 patients	per unit	20.90
K142	- 4 patients	per unit	15.80
K143	- 5 patients	per unit	13.00
K144	- 6 to 12 patients	per unit	11.05

[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 GP6, GP45 to GP50 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.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Psychotherapy

Includes narcoanalysis or psychoanalysis or treatment of sexual dysfunction - see General Preamble GP37.

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 GP5, GP37 to GP41 for definitions and time-keeping requirements.

K007	Individual care.....	per unit	62.75
Group - per member - first 12 units per day			
K019	- 2 people	per unit	31.40
K020	- 3 people	per unit	20.90
K012	- 4 people	per unit	15.80
K024	- 5 people	per unit	13.00
K025	- 6 to 12 people	per unit	11.05
K010	- additional units per member (maximum 6 units per patient per day)	per unit	10.00

Family

K004	- 2 or more family members in attendance at the same time	per unit	68.10
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Hypnotherapy

Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

K006	Individual care*	per unit	62.75
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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 GP22 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	104.80
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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	129.05
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K629	All other re-certification(s) of involuntary admission including completion of appropriate forms.....	38.25
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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).

CONSULTATIONS AND VISITS

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.

Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 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 MOHLTC 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	84.70
K888	CTO supervision including all associated CTO services except those related to initiation or renewal	per unit	84.70
K889	CTO renewal including completion of the CTO form and all preceding CTO services directly related to CTO renewal	per unit	84.70

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.

CONSULTATIONS AND VISITS

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 GP5, GP37 to GP41 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	62.75
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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 behalf of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent	per unit	62.75
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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	62.75
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Note:

K008 is claimed using the *child's* health number. Psychological testing is not an insured service.

CONSULTATIONS AND VISITS

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 Cancer Care Ontario.

K708	MCC Participant, per patient.....	31.35
K709	MCC Chairperson, per patient.....	40.45
K710	MCC Radiologist Participant, per patient.....	31.35

Payment rules:

1. K708, K709 and K710 are *only eligible for payment* in circumstances where:
 - a. the MCC meets the minimum standards, including attendance requirements, established by Cancer Care Ontario; and
 - b. the MCC is pre-scheduled.
2. K708, K709 and K710 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 and K710 are payable will be adjusted to correspond to the overall time of discussion.
3. K708 and K710 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 and K710 are each limited to a maximum of 5 services per patient per day, any physician.
5. K708 and K710 are each limited to a maximum of 8 services, per physician, per day.
6. Only K708 or K709 or K710 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 and K710 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).

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 Cancer Care Ontario website at the following internet link: <http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=14318>.
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.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[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

CONSULTATIONS AND VISITS

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]

CONSULTATIONS AND VISITS

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 J32).
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.]

CONSULTATIONS AND VISITS

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	31.35
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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 team care in teaching units 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	31.35
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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.]

CONSULTATIONS AND VISITS

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 *Children's Mental Health Ontario*, regarding an out-patient less than 18 years of age.

K704 Paediatric out-patient case conference per unit 31.35

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 *specialists* 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 *Children's Mental Health Ontario*, see the following link: http://www.kidsmentalhealth.ca/about_us/memberslist.php.]

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 and Long-Term Care, regarding an *adult* out-patient.

K701 Mental health out-patient case conference per unit 31.35

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.
3. K701 is eligible for payment to physicians other than those who are *specialists* 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.]

CONSULTATIONS AND VISITS

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 Regional Assessment and Treatment Centre (RATC)* and include physicians, regulated social workers and/or regulated health professionals regarding an out-patient registered with 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	31.35
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Payment rules:

1. K702 is *only eligible for payment* when rendered for a patient registered in a Bariatric RATC.
2. K702 is *only eligible for payment* for physicians identified to the ministry as working in 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 definition of 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	31.35
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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 MOHLTC.

[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	31.35
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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 months*.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Long-term care/community care access centre (CCAC) case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a long-term care/community care access centre (CCAC) 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 CCAC and/or regulated health professionals regarding a long-term care institution inpatient.

K124	Long-term care/CCAC case conference	per unit	31.35
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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 team care in teaching units 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 a CCAC, 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	31.35
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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 team care in teaching units 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*.

[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 *Homes* can be found at the following internet link: https://www.cms.gov/NursingHomeQualityInits/20_NHQIMDS20.asp]

CONSULTATIONS AND VISITS

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 MOHLTC.

K706 Convalescent care program case conference 31.35

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 team care in teaching units 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.]

CONSULTATIONS AND VISITS

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	31.35
K731	Physician to physician telephone consultation - Consultant physician.....	40.45

Physician on duty in an emergency department or a hospital urgent care clinic

K734	Physician to physician telephone consultation - Referring physician	31.35
K735	Physician to physician telephone consultation - Consultant physician.....	40.45

[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.

CONSULTATIONS AND VISITS

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.]

CONSULTATIONS AND VISITS

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	31.35
K733	CritiCall telephone consultation - Consultant physician	40.45

Physician on duty in an emergency department or a hospital urgent care clinic

K736	CritiCall telephone consultation - Referring physician	31.35
K737	CritiCall telephone consultation - Consultant physician	40.45

[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 3 K733 or K737 services (any combination) are eligible for payment per patient, per day.
4. This service is *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.
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.

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 and consultant physician(s);
4. the reason for the consultation; and
5. the opinion and recommendations of the consultant physician(s).

CONSULTATIONS AND VISITS

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's billing 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.]

CONSULTATIONS AND VISITS

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	16.00
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 specialists 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 GP24). 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 or *nurse practitioner* and consultant physicians;
3. reason for the consultation; and
4. the opinion and recommendations of the consultant physician.

CONSULTATIONS AND VISITS

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 GP39. 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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K022	HIV primary care	per unit	62.75
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Fibromyalgia/chronic fatigue syndrome care

Fibromyalgia/chronic fatigue syndrome care is the provision of care to patients with fibromyalgia or chronic fatigue syndrome. 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/chronic fatigue syndrome care	per unit	62.75
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Payment rules:

1. K037 is a time based service with time calculated based on units. Unit means $\frac{1}{2}$ hour or major part thereof – see General Preamble GP5, GP37 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.

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	62.75
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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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Genetic assessment

A genetic assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K016 Genetic assessment per unit 74.05

Payment rules:

This service is limited to 4 units per patient per day.

Sexually transmitted disease (STD) or potential blood-borne pathogen management

Sexually transmitted disease (STD) 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 STD 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 $\frac{1}{2}$ hour or major part thereof - see the General Preamble GP5, GP37 for definitions and time keeping requirements.

K028 STD management per unit 62.75

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 GP39. 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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements. Maximum 6 units per patient, per physician, per year.

K029 Insulin therapy support (ITS) per unit 62.75

[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.]

CONSULTATIONS AND VISITS

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 39.20

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 60.00

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 guidelines is available at www.oma.org.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

MANAGEMENT OF A BARIATRIC SURGERY PATIENT IN A BARIATRIC REGIONAL ASSESSMENT AND TREATMENT CENTRE (RATC)

Pre-operative medical management of a bariatric surgery patient in a 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 Bariatric RATC. The applicable service is payable only to the physician at the 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 Bariatric RATC	100.00
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Payment rules:

1. K090 is *only eligible for payment* if the pre-operative period is a minimum of four weeks.
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 Bariatric RATC.
3. K090 is *only eligible for payment* to a physician previously registered with the ministry as providing services in a 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 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.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Post-operative monthly management of a bariatric surgery patient in a Bariatric RATC

Definition/Required elements of service:

Post-operative *monthly* 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 Bariatric RATC. The service is payable to the physician at the 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 Bariatric RATC	25.00
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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 weeks 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 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 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.]

CONSULTATIONS AND VISITS

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 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	15.40
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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, A903, A905, K005, K007, K013, K017, K130, K131, K132, 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]:

A copy of a flow sheet meeting the medical record requirements and guidelines of the CTI program is available at www.oma.org or www.omacti.org. Physicians may complete the flow sheet or alternatively document that an initial discussion consistent with the 5A's model of the CTI program has taken place.]

Smoking cessation follow-up visit

Smoking cessation follow-up visit is the service rendered by a primary care physician in the *12 months* following E079 that is dedicated to a discussion of smoking cessation, in accordance with the guidelines and subject to the conditions below.

K039	Smoking cessation follow-up visit.....	33.45
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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 months* 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]:

A copy of a flow sheet meeting the medical record requirements and guidelines of the CTI program is available at www.oma.org or www.omacti.org. Physicians may complete the flow sheet or alternatively document that an initial discussion consistent with the 5A's model of the CTI program has taken place.]

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.

K018	- female	308.70
K021	- male	243.50

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	102.50
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CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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.....	62.75
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[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.]

Home care application

The service rendered by the *most responsible physician* for completion and submission of an application for *home care* to a Community Care Access Centre (CCAC) 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 application for *home care* if completed in whole or in part by a person other than the physician or the physician's employee is nil.

K070	Application	31.75
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Note:

1. K070 is limited to one per *home care* admission per patient.
2. K070 is *not eligible for payment* if the patient is currently receiving *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 Community Care Access Centre (CCAC) or CCAC 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 home care program)	21.40
K072	Chronic home care supervision (after the 8th week following admission to the home care program)	21.40

Payment rules:

1. K071 is limited to a maximum of one service per patient per physician per week for 8 weeks following admission to the *home care* program.
2. K071 is limited to a maximum of two services per patient per week for 8 weeks.
3. K072 is limited to a maximum of 2 services per month per patient per physician after the 8th week following admission to the *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
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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.

CONSULTATIONS AND VISITS

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 application

The service rendered for completion and submission of a health report form to a Community Care Access Centre (CCAC) on behalf of a patient who is applying for admission to a Long-Term Care facility.

K038 Completion of Long-Term Care health report form 45.15

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, cryptosporidiosis, cyclosporiasis, diphtheria, primary viral encephalitis, food poisoning (all causes), symptomatic giardiasis, invasive haemophilus influenzae b disease, hantavirus pulmonary syndrome, hemorrhagic fevers (e.g. ebola, marburg and other viral causes), hepatitis A, lassa fever, legionellosis, listeriosis, measles, acute bacterial meningitis, invasive meningococcal disease, paratyphoid fever, plague, acute poliomyelitis, Q fever, rabies, rubella, Severe Acute Respiratory Syndrome (SARS), shigellosis, smallpox, invasive group A streptococcal infections, tularemia, typhoid fever, verotoxin-producing E. coli infection indicator conditions (e.g. haemolytic-uremic syndrome), west Nile virus illness, and yellow fever.

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 under the regulation.

2. The diseases specified in association with K034 represent a subset of the reportable diseases listed in Regulation 559/91 under the *Health Protection and Promotion Act*. For payment purposes, the specified list of diseases has been identified as requiring an immediate telephone report.]

ALLERGY

Since the Royal College of Physicians and Surgeons of Canada has not set a standard for "Allergy Specialist", fees for consultations and visits shall be payable to an allergist according to his or her own General or Specialty listings, except as follows:

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.

CONSULTATIONS AND VISITS

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 of personal contact 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 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 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 144.75

Payment rules:

1. If A680 is not pre-booked at least one day before the service is rendered, the service is *not eligible for payment*.
2. A680 is limited to one per patient per physician except in circumstances where a *12 month period* has elapsed since the most recent insured service rendered to the patient by the same physician.
3. A680 is limited to a maximum of two per patient per *12 month period*.
4. A680 is *not eligible for payment* for the assessment of substance abuse related to smoking cessation.
5. Any insured service rendered to the patient before October 1, 2010 by the physician submitting a claim for A680/C680 for the same patient and paid as an insured service under the *Health Insurance Act* constitutes an "Initial Assessment - Substance abuse" service and is deemed to have been rendered on October 1, 2010.

[Commentary:

For assessment services related to smoking cessation, see general listings, A957, K039 and E079 services, as applicable.]

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 the all elements of the service must be recorded in the medical record or the amount payable for the service will be adjusted to lesser assessment fee.

C680 Initial assessment – substance abuse – subject to the same conditions as A680 .. 144.75

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 62.75

Payment rules:

1. K680 is a time based service with time calculated based on units. Unit means $\frac{1}{2}$ hour or major part thereof – see General Preamble GP5, GP37 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:

Monthly 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. The *monthly* management of a patient in an OAMP is *only eligible for payment* to a physician who has an active general exemption for methadone maintenance treatment for opioid dependence pursuant to Section 56 of the *Controlled Drugs and Substances Act* 1996.

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, fax or e-mail 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*.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

- 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. For the purposes of K682 and K683 the required services may be rendered by direct patient encounter or telemedicine.

[Commentary:

Telemedicine services are considered eligible as required services. See CPSO Standards and Guidelines for Methadone Maintenance Treatment related to telemedicine.]

- f. 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.
5. In circumstances where the administration of an opioid agonist is delegated to another qualified health professional, K682 and K683 are *only eligible for payment* if the physician can demonstrate that he/she has received a delegation exemption from the CPSO.

[Commentary:

OAMP *monthly* 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.
2. The CPSO Methadone Maintenance Treatment Program Standards and Clinical Guidelines may be found at the following internet link: <http://www.cpso.on.ca>.
3. K683, K682, and K684 will be subject to a joint review by the MOHLTC and the Ontario Medical Association on or before December 31, 2012.]

CONSULTATIONS AND VISITS

ANAESTHESIA (01)

GENERAL LISTINGS

Consultation

A015 Consultation..... 106.80

Payment rules:

The routine pre-anaesthetic evaluation of the patient required by the *Public Hospitals Act* does not constitute a consultation, regardless of where and when this evaluation is performed.

A016 Repeat consultation 52.15

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..... 47.50

Note:

This service is *not eligible for payment*:

1. with P014C - introduction of catheter for epidural labour analgesia;
2. for management of routine post-operative pain; or
3. for *referrals* from another anaesthesiologist.

[Commentary:

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 an assessment.]

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 47.50

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C015 Consultation - subject to the same conditions as A015 106.80

C016 Repeat consultation 52.15

C215 Limited consultation for acute pain management - subject to the same conditions as A215..... 47.50

C013 Specific assessment 47.50

C014 Specific re-assessment..... 28.00

CONSULTATIONS AND VISITS

ANAESTHESIA (01)

Subsequent visits

C012	- first five weeks	per visit	31.00
C017	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C019	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C018	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine section

GENERAL LISTINGS

A605	Consultation.....	157.00
A765	Consultation, patient 16 years of age and under	165.50

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 seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A600	Comprehensive cardiology consultation	300.70
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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 GP12).
2. The calculation of the 75 minute minimum time for comprehensive cardiology consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A675	Limited consultation	105.25
A606	Repeat consultation.....	105.25
A603	Medical specific assessment	79.85
A604	Medical specific re-assessment.....	61.25
A601	Complex medical specific re-assessment.....	70.90
A608	Partial assessment	38.05

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.

CONSULTATIONS AND VISITS

CARDIOLOGY (60)

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C605	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C600	Comprehensive cardiology consultation - subject to the same conditions as A600	300.70
C675	Limited consultation	105.25
C606	Repeat consultation	105.25
C603	Medical specific assessment	79.85
C604	Medical specific re-assessment.....	61.25
C601	Complex medical specific re-assessment.....	70.90

Subsequent visits

C602	- first five weeks	per visit	31.00
C607	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C609	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28).per visit	31.00
C608	Concurrent care.....	31.00
C982	Palliative care (see General Preamble GP34).....	31.00

CONSULTATIONS AND VISITS

CARDIAC SURGERY (09)

GENERAL LISTINGS

A095	Consultation	90.30
A935	Special surgical consultation (see General Preamble GP13)	160.00
A096	Repeat consultation	60.00
A093	Specific assessment	44.40
A094	Partial assessment	24.10

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C095	Consultation	90.30
C935	Special surgical consultation (see General Preamble GP13)	160.00
C096	Repeat consultation	60.00
C093	Specific assessment	44.40
C094	Specific re-assessment.....	25.95

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C098	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52.

W095	Consultation.....	90.30
W096	Repeat consultation	60.00

CONSULTATIONS AND VISITS

CLINICAL IMMUNOLOGY (62)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A625	Consultation.....	157.00
A765	Consultation, patient 16 years of age and under	165.50
A525	Limited consultation	105.25
A626	Repeat consultation	105.25
A623	Medical specific assessment	79.85
A624	Medical specific re-assessment.....	61.25
A621	Complex medical specific re-assessment.....	70.90
A628	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16)	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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C625	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C525	Limited consultation	105.25
C626	Repeat consultation	105.25
C623	Medical specific assessment	79.85
C624	Medical specific re-assessment.....	61.25
C621	Complex medical specific re-assessment.....	70.90

Subsequent visits

C622	- first five weeks	per visit	31.00
C627	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C629	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C628	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

General Listings

A055	Consultation.....	125.60
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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 fifty (50) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A050	Special community medicine consultation	144.75
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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 seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A400	Comprehensive community medicine consultation	240.55
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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 GP12).
2. The calculation of the 50 and 75 minute minimum time for special and comprehensive community medicine consultations respectively excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A405	Limited consultation.....	84.20
A056	Repeat consultation.....	84.20
A053	Medical specific assessment.....	79.85
A054	Medical specific re-assessment.....	61.25
A051	Complex medical specific re-assessment	70.90
A058	Partial assessment	38.05

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C055	Consultation.....	125.60
C050	Special community medicine consultation – subject to the same conditions as A050	144.75
C400	Comprehensive community medicine consultation – subject to the same conditions as A400.....	240.55
C405	Limited consultation.....	84.20
C056	Repeat consultation.....	84.20
C053	Medical specific assessment.....	79.85
C054	Medical specific re-assessment.....	61.25
C051	Complex medical specific re-assessment	70.90

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

Subsequent visits

C052	- first five weeks	per visit	31.00
C057	- sixth to thirteenth week (maximum 3 per patient per week)	per visit	31.00
C059	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment.....	58.80
C124	- day of discharge	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28). per visit	31.00
C058	Concurrent care.....per visit	31.00
C982	Palliative care (see General Preamble GP34)	31.00

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 GP44 to GP52.

W055	Consultation	125.60
W050	Special community medicine consultation – subject to the same conditions as A050	144.75
W400	Comprehensive community medicine consultation – subject to the same conditions as A400	240.55
W405	Limited consultation.....	84.20
W056	Repeat consultation.....	84.20

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 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W052	- first 4 subsequent visits per patient per month	per visit	32.20
W051	- additional subsequent visits (maximum 6 per patient per month).....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W053	- first 2 subsequent visits per patient per month	per visit	32.20
W058	- additional subsequent visits (maximum 3 per patient per month)	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33). per visit		31.00

CONSULTATIONS AND VISITS

DERMATOLOGY (02)

GENERAL LISTINGS

A025	Consultation	72.15
A027	Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient	147.30

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	44.45
A023	Specific assessment	38.70
A024	Partial assessment	21.90
U025	Initial e-assessment.....	44.45
U023	Repeat e-assessment.....	29.00
U026	Follow-up e-assessment.....	21.90
U021	Minor e-assessment	11.00

CONSULTATIONS AND VISITS

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 related diseases (i.e. pyoderma gangrenosum, Sweet's syndrome, 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. Chronic pruritus *with or without* skin manifestations (i.e. 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.

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 of direct patient encounter time.

A020 Complex dermatology assessment..... 49.95

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.

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C025	Consultation.....	147.30
C026	Repeat consultation	44.45
C023	Specific assessment	38.70
C024	Specific re-assessment.....	25.40
C020	Complex dermatology assessment - subject to same conditions as A020.....	49.95

Subsequent visits

C022	- first five weeksper visit	31.00
C027	- sixth to thirteenth week (maximum 3 per patient per week).....per visit	31.00
C029	- after thirteenth week (maximum 6 per patient per month) per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C028	Concurrent care.....per visit	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52

W025	Consultation.....	147.30
W026	Repeat consultation	44.45

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W022	- first 4 subsequent visits per patient per month.....per visit	32.20
W021	- additional subsequent visits (maximum 6 per patient per month)per visit	21.20
W982	- palliative care (see General Preamble GP34)per visit	32.20

Nursing home or home for the aged

W023	- first 2 subsequent visits per patient per month.....per visit	32.20
W028	- additional subsequent visits (maximum 3 per patient per month)per visit	21.20
W972	- palliative care (see General Preamble GP34)per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33) .per visit	31.00

CONSULTATIONS AND VISITS

EMERGENCY MEDICINE (12)

EMERGENCY DEPARTMENT - PHYSICIAN ON DUTY

H055	Consultation (see General Preamble GP13)	97.60
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Note:

1. See General Preamble GP34 for definitions and conditions for physicians on duty.
2. All other consultations and visits - use the listings for Family Practice & Practice In General.

CONSULTATIONS AND VISITS

ENDOCRINOLOGY & METABOLISM (15)

GENERAL LISTINGS

A155	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50

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 of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A150	Comprehensive endocrinology consultation	300.70
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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 GP12).
2. The calculation of the 75 minute minimum time for comprehensive endocrinology consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A255	Limited consultation	105.25
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A156	Repeat consultation	105.25
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A153	Medical specific assessment	79.85
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A154	Medical specific re-assessment.....	61.25
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A151	Complex medical specific re-assessment.....	70.90
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A158	Partial assessment	38.05
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E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%
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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	89.85
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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 months. 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.]

CONSULTATIONS AND VISITS

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	75.00
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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 www.oma.org or www.diabetes.ca/for-professionals/resources/2008-cpg]

CONSULTATIONS AND VISITS

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.....	115.00
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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, Independent Health Facilities (IHF), 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*.

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C155	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C150	Comprehensive endocrinology consultation - subject to the same conditions as A150.....	300.70
C255	Limited consultation.....	105.25
C156	Repeat consultation	105.25
C153	Medical specific assessment	79.85
C154	Medical specific re-assessment.....	61.25
C151	Complex medical specific re-assessment.....	70.90
C760	Complex endocrine neoplastic disease assessment - subject to the same conditions as A760.....	89.85

Subsequent visits

C152	- first five weeks	per visit	31.00
C157	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C159	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28)	31.00
C158	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W155	Consultation.....	157.00
W765	Consultation, patient 16 years of age and under.....	167.00
W150	Comprehensive endocrinology consultation - subject to the same conditions as A150	300.70
W255	Limited consultation.....	105.25
W156	Repeat consultation.....	105.25
W760	Complex endocrine neoplastic disease assessment - subject to the same conditions as A760.....	89.85

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 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W152	- first 4 subsequent visits per patient per month	per visit	32.20
W151	- additional subsequent visits (maximum of 6 per patient per month)....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W153	- first 2 subsequent visits per patient per month	per visit	32.20
W158	- subsequent visits per month (maximum of 3 per patient per month)....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33).per visit		31.00

CONSULTATIONS AND VISITS

GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine section.

GENERAL LISTINGS

A415	Consultation.....	157.00
A765	Consultation, patient 16 years of age and under	165.50
A545	Limited consultation	105.25
A416	Repeat consultation	105.25
A413	Medical specific assessment	79.85
A414	Medical specific re-assessment.....	61.25
A411	Complex medical specific re-assessment.....	70.90
A418	Partial assessment	38.05
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 A4.]

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C415	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C545	Limited consultation	105.25
C416	Repeat consultation	105.25
C413	Medical specific assessment	79.85
C414	Medical specific re-assessment.....	61.25
C411	Complex medical specific re-assessment.....	70.90

CONSULTATIONS AND VISITS

GASTROENTEROLOGY (41)

Subsequent visits

C412	- first five weeks	per visit	31.00
C417	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ...	per visit	31.00
C419	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28)	per visit 31.00
C418	Concurrent care	per visit 31.00
C982	Palliative care (see General Preamble GP34).....	per visit 31.00

CONSULTATIONS AND VISITS

GENERAL SURGERY (03)

GENERAL LISTINGS

A035	Consultation	90.30
A935	Special surgical consultation (see General Preamble GP13)	160.00
A036	Repeat consultation	60.00
A033	Specific assessment	44.40
A034	Partial assessment	24.10

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C035	Consultation	90.30
C935	Special surgical consultation (see General Preamble GP13)	160.00
C036	Repeat consultation	60.00
C033	Specific assessment	44.40
C034	Specific re-assessment.....	25.95

Subsequent visits

C032	- first five weeks	per visit	31.00
C037	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C039	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C038	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W035	Consultation	90.30
W036	Repeat consultation	60.00

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W032	- first 4 subsequent visits per patient per month.....	per visit	32.20
W031	- additional subsequent visits (maximum of 6 per patient per month).....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W033	- first 2 subsequent visits per patient per month.....	per visit	32.20
W038	- subsequent visits per month (maximum of 3 per patient per month).....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33)	per visit	31.00

CONSULTATIONS AND VISITS

GENERAL THORACIC SURGERY (64)

GENERAL LISTINGS

A645	Consultation	90.30
A935	Special surgical consultation (see General Preamble GP13)	160.00
A646	Repeat consultation	60.00
A643	Specific assessment	44.40
A644	Partial assessment	24.10

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C645	Consultation	90.30
C935	Special surgical consultation (see General Preamble GP13)	160.00
C646	Repeat consultation	60.00
C643	Specific assessment	44.40
C644	Specific re-assessment	25.95

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28)	31.00
C648	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34)	31.00

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 GP44 to GP52.

W645	Consultation	90.30
W646	Repeat consultation	60.00

CONSULTATIONS AND VISITS

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*	165.00
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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 of direct contact with the patient *with or without* family.

A220	Special genetic consultation*	300.70
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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 of direct contact with the patient *with or without* family.

A223	Extended special genetic consultation*	395.65
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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.

A325	Limited consultation	105.25
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A226	Repeat consultation	105.25
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A221	Genetic minor assessment	38.05
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Genetic assessment

A Genetic Assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K016	Genetic assessment, patient or family	per unit	74.05
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Payment rules:

This service is limited to 4 units per patient per day.

CONSULTATIONS AND VISITS

GENETICS (22)

Midwife-requested genetic assessment

This service is the assessment of a patient provided by a geneticist upon the written request of a midwife because of the complex, obscure or serious nature of the patient's problem. The midwife-requested genetic assessment includes the common and *specific elements* of an assessment.

A800	Midwife-requested genetic assessment.....	165.00
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Payment rules:

1. This service is limited to one per patient, per physician, per *12 month period*.
2. The geneticist must submit his/her findings, opinions and recommendations in writing to both the midwife and the patient's primary care physician, 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 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-requested genetic assessment

This service is an assessment provided by a geneticist upon the written request of a 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 of direct contact with the patient.

A801	Comprehensive midwife-requested genetic assessment	300.70
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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 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-requested genetic assessment

This service is the assessment provided by a geneticist upon the written request of a 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 of direct contact with the patient.

A802	Extended midwife-requested genetic assessment	395.65
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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 must be retained on the patient's permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

CONSULTATIONS AND VISITS

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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K222	Genetic care, patient or family	per unit	74.70
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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	37.65
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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

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 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 and the patient's primary care physician, if applicable, or the amount payable for the service will be reduced to a lesser fee.

K224	Clinical interpretation requested by a midwife	37.65
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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
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Note:

Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time keeping requirements.

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C225	Consultation*	165.00
C220	Special genetic consultation* - subject to the same conditions as A220	300.70
C223	Extended special genetic consultation* - subject to the same conditions as A223	395.65
C325	Limited consultation	105.25
C226	Repeat consultation	105.25
C800	Midwife-requested genetic assessment – subject to the same conditions as A800	165.00
C801	Comprehensive midwife-requested genetic assessment – subject to the same conditions as A801	300.70
C802	Extended midwife-requested genetic assessment – subject to the same conditions as A802	395.65

Subsequent visits

C222	- first five weeks	per visit	31.00
C227	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C229	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

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 GP44 to GP52.

W225	Consultation*	165.00
W220	Special genetic consultation* - subject to the same conditions as A220	300.70
W223	Extended special genetic consultation* - subject to the same conditions as A223	395.65
W325	Limited consultation	105.25
W226	Repeat consultation	105.25

Note:

*A consultation is payable at nil if a genetic assessment (K016) or genetic care (K222) has previously been claimed by the same physician.

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W222	- first 4 subsequent visits per patient per month	per visit	32.20
W221	- additional subsequent visits (maximum of 6 per patient per month).....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W224	- first 2 subsequent visits per patient per month	per visit	32.20
W228	- subsequent visits per month (maximum of 3 per patient per month).....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33). per visit		31.00

CONSULTATIONS AND VISITS

GERIATRICS (07)

GENERAL LISTINGS

A075	Consultation.....	175.00
A070	Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient	185.00

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 at least 75 minutes with the patient exclusive of time spent rendering any other service to the patient.

A775	Comprehensive geriatric consultation.....	300.70
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[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:

1. The consultation must be *scheduled* at least one day before the service is rendered.
2. 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 at least 90 minutes with the patient exclusive of time spent rendering any other service to the patient.

A770	Extended comprehensive geriatric consultation	395.65
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[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.

CONSULTATIONS AND VISITS

GERIATRICS (07)

A375	Limited consultation	105.25
A076	Repeat consultation	105.25
A073	Medical specific assessment	79.85
A074	Medical specific re-assessment.....	61.25
A071	Complex medical specific re-assessment.....	70.90
A078	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%

Geriatic 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	Geriatic telephone support	per unit	35.45
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Payment rules:

1. A maximum of two (2) units of K077 are eligible for payment per patient per day.
2. A maximum of eight (8) 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 MOHLTC.
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.

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C075	Consultation.....	185.00
C775	Comprehensive geriatric consultation - subject to the same conditions as A775....	300.70
C770	Extended comprehensive geriatric consultation - subject to the same conditions as A770.....	395.65
C375	Limited consultation	105.25
C076	Repeat consultation	105.25
C073	Medical specific assessment	79.85
C074	Medical specific re-assessment.....	61.25
C071	Complex medical specific re-assessment.....	70.90

Subsequent visits

C072	- first five weeks	per visit	31.00
C077	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C079	- after thirteenth week (maximum 6 per patient per month).....	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C078	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W075	Consultation	185.00
W775	Comprehensive geriatric consultation - subject to the same conditions as A775	300.70
W770	Extended comprehensive geriatric consultation - subject to the same conditions as A770	395.65
W375	Limited consultation	105.25
W076	Repeat consultation	105.25

Admission assessment

W272	- Type 1.....	69.35
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 months after Periodic health visit (as per the *Nursing Homes Act*)

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W072	- first 4 subsequent visits per patient per month	per visit	32.20
W071	- additional subsequent visits (maximum of 6 per patient per month)	per visit	21.20
W982	- palliative care (see General Preamble GP34).....	per visit	32.20

Nursing home or home for the aged

W073	- first 2 subsequent visits per patient per month.....	per visit	32.20
W078	- subsequent visits per month (maximum of 3 per patient per month)	per visit	21.20
W972	- palliative care (see General Preamble GP34).....	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33). per visit		31.00

Monthly Management of a Nursing Home or Home for the Aged Patient

W010	Monthly management fee (per patient per month) (see General Preamble GP35 to GP36).....	108.85
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CONSULTATIONS AND VISITS

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A615	Consultation.....	157.00
A765	Consultation, patient 16 years of age and under	165.50
A655	Limited consultation	105.25
A616	Repeat consultation	105.25
A613	Medical specific assessment	79.85
A614	Medical specific re-assessment.....	61.25
A611	Complex medical specific re-assessment.....	70.90
A618	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16)	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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C615	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C655	Limited consultation	105.25
C616	Repeat consultation	105.25
C613	Medical specific assessment	79.85
C614	Medical specific re-assessment.....	61.25
C611	Complex medical specific re-assessment.....	70.90

Subsequent visits

C612	- first five weeks	per visit	31.00
C617	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C619	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C618	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

INFECTIOUS DISEASE (46)

GENERAL LISTINGS

A465	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50

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 seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A460	Comprehensive infectious disease consultation	300.70
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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 GP12).
2. The calculation of the 75 minute minimum time for comprehensive infectious disease consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A275	Limited consultation	105.25
A466	Repeat consultation	105.25
A463	Medical specific assessment	79.85
A464	Medical specific re-assessment.....	61.25
A461	Complex medical specific re-assessment.....	70.90
A468	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16)	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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C465	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C460	Comprehensive infectious disease consultation - subject to the same conditions as A460.....	300.70
C275	Limited consultation	105.25
C466	Repeat consultation	105.25
C463	Medical specific assessment	79.85
C464	Medical specific re-assessment.....	61.25
C461	Complex medical specific re-assessment.....	70.90

CONSULTATIONS AND VISITS

INFECTIOUS DISEASE (46)

Subsequent visits

C462	- first five weeks	per visit	31.00
C467	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C469	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C468	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52.

W465	Consultation.....	157.00
W765	Consultation, patient 16 years of age and under	167.00
W460	Comprehensive infectious disease consultation - subject to the same conditions as A460.....	300.70
W275	Limited consultation	105.25
W466	Repeat consultation	105.25

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

Note:

*May only be claimed 6 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W462	- first 4 subsequent visits per patient per month.....per visit	32.20
W461	- additional subsequent visits (maximum of 6 per patient per month)per visit	21.20
W982	- palliative care (see General Preamble GP34).....per visit	32.20

Nursing home or home for the aged

W463	- first 2 subsequent visits per patient per month.....per visit	32.20
W468	- subsequent visits per month (maximum of 3 per patient per month)per visit	21.20
W972	- palliative care (see General Preamble GP34).....per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33) .per visit	31.00

CONSULTATIONS AND VISITS

INTERNAL AND OCCUPATIONAL MEDICINE (13)

GENERAL LISTINGS

A135	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50

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	300.70
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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 GP12).
2. The calculation of the 75 minute minimum time for comprehensive internal medicine consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A435	Limited consultation	105.25
A136	Repeat consultation	105.25
A133	Medical specific assessment	79.85
A134	Medical specific re-assessment.....	61.25
A131	Complex medical specific re-assessment.....	70.90
A138	Partial assessment	38.05
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 A4.]

K045	Diabetes management by a specialist	75.00
K046	Diabetes team management.....	115.00

[Commentary:

For K045 and K046 definition/required elements, payment rules and record keeping requirements see Endocrinology and Metabolism section.]

CONSULTATIONS AND VISITS

INTERNAL AND OCCUPATIONAL 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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C135	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C130	Comprehensive internal medicine consultation - subject to the same conditions as A130.....	300.70
C435	Limited consultation	105.25
C136	Repeat consultation	105.25
C133	Medical specific assessment	79.85
C134	Medical specific re-assessment.....	61.25
C131	Complex medical specific re-assessment.....	70.90

Subsequent visits

C132	- first five weeks	per visit	31.00
C137	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C139	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C138	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

INTERNAL AND OCCUPATIONAL 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 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 GP44 to GP52.

W235	Consultation	157.00
W765	Consultation, patient 16 years of age and under.....	167.00
W130	Comprehensive internal medicine consultation - subject to the same conditions as A130	300.70
W435	Limited consultation.....	105.25
W236	Repeat consultation.....	105.25

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 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W132	- first 4 subsequent visits per patient per month	per visit	32.20
W131	- additional subsequent visits (maximum of 6 per patient per month)	per visit	21.20
W982	- palliative care (see General Preamble GP34).....	per visit	32.20

Nursing home or home for the aged

W133	- first 2 subsequent visits per patient per month	per visit	32.20
W138	- subsequent visits per month (maximum of 3 per patient per month)....	per visit	21.20
W972	- palliative care (see General Preamble GP34).....	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33). per visit		31.00

CONSULTATIONS AND VISITS

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	102.00
A286	Limited consultation	71.20
A586	Repeat consultation	71.20
A283	Medical specific assessment	55.55
A284	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%

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 J47 to J48).

A585	Diagnostic consultation	64.70
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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*.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C285	Consultation	102.00
C286	Limited consultation	71.20
C586	Repeat consultation	71.20
C283	Medical specific assessment	55.55
C585	Diagnostic consultation - subject to the same conditions as A585	64.70
C288	Concurrent care	30.10 per visit

CONSULTATIONS AND VISITS

MEDICAL ONCOLOGY (44)

GENERAL LISTINGS

A445	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50
A845	Limited consultation	105.25
A446	Repeat consultation	105.25
A443	Medical specific assessment	79.85
A444	Medical specific re-assessment.....	61.25
A441	Complex medical specific re-assessment.....	70.90
A448	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16)	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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C445	Consultation	157.00
C765	Consultation, patient 16 years of age and under	165.50
C845	Limited consultation	105.25
C446	Repeat consultation	105.25
C443	Medical specific assessment	79.85
C444	Medical specific re-assessment.....	61.25
C441	Complex medical specific re-assessment.....	70.90

Subsequent visits

C442	- first five weeks	per visit	31.00
C447	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C449	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

CONSULTATIONS AND VISITS

MEDICAL ONCOLOGY (44)

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area.....	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C448	Concurrent careper visit	31.00
C982	Palliative care (see General Preamble GP34)per visit	31.00

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 GP44 to GP52.

W445	Consultation	157.00
W765	Consultation, patient 16 years of age and under.....	167.00
W845	Limited consultation	105.25
W446	Repeat consultation	105.25

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 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W442	- first 4 subsequent visits per patient per month..... per visit	32.20
W441	- additional subsequent visits (maximum of 6 per patient per month) per visit	21.20
W982	- palliative care (see General Preamble GP34)..... per visit	32.20

Nursing home or home for the aged

W443	- first 2 subsequent visits per patient per month	32.20
W448	- subsequent visits per month (maximum of 3 per patient per month).... per visit	21.20
W972	- palliative care (see General Preamble GP34)..... per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33). per visit	31.00

CONSULTATIONS AND VISITS

NEPHROLOGY (16)

GENERAL LISTINGS

A165	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50

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.....	300.70
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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 GP12).
2. The calculation of the 75 minute minimum time for comprehensive nephrology consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A865	Limited consultation	105.25
A166	Repeat consultation	105.25
A163	Medical specific assessment	79.85
A164	Medical specific re-assessment.....	61.25
A161	Complex medical specific re-assessment.....	70.90
A168	Partial assessment	38.05

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C165	Consultation	157.00
C765	Consultation, patient 16 years of age and under	165.50
C160	Comprehensive nephrology consultation - subject to the same conditions as A160	300.70
C865	Limited consultation	105.25
C166	Repeat consultation	105.25
C163	Medical specific assessment	79.85
C164	Medical specific re-assessment.....	61.25
C161	Complex medical specific re-assessment.....	70.90

CONSULTATIONS AND VISITS

NEPHROLOGY (16)

Subsequent visits

C162	- first five weeks	per visit	31.00
C167	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C169	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment.....	58.80
C124	- day of discharge	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C168	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34)	31.00

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 GP44 to GP52.

W165	Consultation	157.00
W765	Consultation, patient 16 years of age and under.....	167.00
W160	Comprehensive nephrology consultation - subject to the same conditions as A160	300.70
W865	Limited consultation.....	105.25
W166	Repeat consultation.....	105.25

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

Note:

*May only be claimed 6 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W162	- first 4 subsequent visits per patient per month	per visit	32.20
W161	- additional subsequent visits (maximum of 6 per patient per month)....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W163	- first 2 subsequent visits per patient per month	per visit	32.20
W168	- subsequent visits per month (maximum of 3 per patient per month)....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33).per visit		31.00

CONSULTATIONS AND VISITS

NEUROLOGY (18)

GENERAL LISTINGS

A185	Consultation.....	176.35
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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 of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A180	Special neurology consultation	300.70
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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.

A385	Limited consultation	84.95
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A186	Repeat consultation	84.95
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A183	Medical specific assessment	78.80
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A184	Medical specific re-assessment.....	62.10
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A181	Complex medical specific re-assessment.....	71.90
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A188	Partial assessment	37.65
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E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%
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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 neurologist:

- a. generalized peripheral neuropathies;
- b. myopathies;
- c. diseases of the neuromuscular junction; or
- d. diseases of the motor neurone.

A113	Complex neuromuscular assessment.....	89.85
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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 A113.

[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 neurologist. 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.]

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C185	Consultation.....	176.35
C180	Special neurology consultation - subject to the same conditions as A180	300.70
C385	Limited consultation.....	84.95
C186	Repeat consultation	84.95
C183	Medical specific assessment	78.80
C184	Medical specific re-assessment.....	62.10
C181	Complex medical specific re-assessment.....	71.90
C113	Complex neuromuscular assessment - subject to the same conditions as A113	89.85

Subsequent visits

C182	- first five weeks	per visit	31.00
C187	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C189	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C188	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W185	Consultation.....	176.35
W180	Special neurology consultation - subject to the same conditions as A180	300.70
W385	Limited consultation	84.95
W186	Repeat consultation.....	84.95
W113	Complex neuromuscular assessment - subject to the same conditions as A113....	89.85
W184	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:

*May only be claimed 6 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W182	- first 4 subsequent visits per patient per month	per visit	32.20
W181	- additional subsequent visits (maximum of 6 per patient per month).....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W183	- first 2 subsequent visits per patient per month	per visit	32.20
W188	- subsequent visits per month (maximum of 3 per patient per month).....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33).per visit		31.00

CONSULTATIONS AND VISITS

NEUROSURGERY (04)

GENERAL LISTINGS

A045	Consultation	121.10
A935	Special surgical consultation (see General Preamble GP13)	160.00
A046	Repeat consultation	58.25
A043	Specific assessment	58.25
A044	Partial assessment	30.00

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C045	Consultation	121.10
C935	Special surgical consultation (see General Preamble GP13)	160.00
C046	Repeat consultation	58.25
C043	Specific assessment	58.25
C044	Specific re-assessment	30.00

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80	
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80	
C121	Additional visits due to intercurrent illness (see General Preamble GP28)	per visit	31.00
C048	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP34)	per visit	31.00

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 GP44 to GP52.

W045	Consultation	107.00
W046	Repeat consultation	51.45

CONSULTATIONS AND VISITS

NUCLEAR MEDICINE (63)

GENERAL LISTINGS

A635	Consultation.....	82.40
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Special nuclear medicine consultation

A special nuclear medicine consultation is payable when all components of a regular nuclear medicine consultation are met but, because of the very complex, obscure or serious nature of the problem, the physician is required to spend a minimum of 50 minutes with the patient in consultation.

A835	Special nuclear medicine consultation.....	180.00
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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.

A735	Diagnostic consultation.....	33.70
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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	57.25
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A638	Partial assessment	35.35
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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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C635	Consultation.....	82.40
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C835	Special nuclear medicine - subject to the same conditions of A835	180.00
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C735	Diagnostic consultation - subject to the same conditions as A735	33.70
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C636	Repeat consultation	57.25
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CONSULTATIONS AND VISITS

OBSTETRICS AND GYNAECOLOGY (20)

GENERAL LISTINGS

A205	Consultation*	101.70
A935	Special surgical consultation (see General Preamble GP13).....	160.00
A206	Repeat consultation*.....	54.10
A203	Specific assessment*.....	47.45
A204	Partial assessment	26.35

Note:

The Papanicolaou smear 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 a papanicolaou smear is performed outside hospital.

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C205	Consultation*	101.70
C935	Special surgical consultation (see General Preamble GP13).....	160.00
C206	Repeat consultation*.....	54.10
C203	Specific assessment*.....	47.45
C204	Specific re-assessment*	29.65

Subsequent visits

C202	- first five weeksper 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)	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment.....	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C208	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52.

W305	Consultation*	101.70
W306	Repeat consultation*.....	54.10

Note:

*Includes (where indicated) biopsy of cervix, papanicolaou smear, examination of trichomonas suspension.

CONSULTATIONS AND VISITS

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.....	82.30
A935	Special surgical consultation (see General Preamble GP13).....	160.00
A236	Repeat consultation	45.85
A231	Neuro-ophthalmology consultation	120.00

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.]

A233	Specific assessment	57.70
A234	Partial assessment	28.95

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
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Payment rules:

E423 is limited to a maximum of two services per *12 month period* per patient per physician.

U235	Initial e-assessment.....	45.85
U233	Repeat e-assessment.....	43.30
U236	Follow-up e-assessment.....	28.95
U231	Minor e-assessment	15.00

Periodic oculo-visual assessment

A237	- aged 19 years and below.....	56.60
A239	- aged 65 years and above	56.60

Note:

See General Preamble GP19 for definitions and conditions.

CONSULTATIONS AND VISITS

OPHTHALMOLOGY (23)

Major eye examination

A115 Major eye examination (see page A7) 51.10

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 25.00

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 J74).]

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 months of age or younger; or
- b. aged 10 months to 16 years with minimum stage 3 ROP disease.

A250 Retinopathy of prematurity assessment 120.00

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.

CONSULTATIONS AND VISITS

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.....	240.00
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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	120.00
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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.
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.]

CONSULTATIONS AND VISITS

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).....	82.30
Payment rules:		
1. This service is limited to one per patient, per physician, per <i>12 month period</i> .		
2. The ophthalmologist must submit his/her findings, opinions and recommendations in writing to both the optometrist and the patient's primary care physician, 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 of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A256	Special optometrist-requested assessment.....	144.75
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Payment rules:

This service is limited to one per patient, per physician, per *12 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.

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.

In addition to the assessment, this service requires all of the following:

- a. the development of a continuing comprehensive vision care plan;
- 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.....	120.00
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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:

Examples of medical conditions that may qualify for this service include certain chromosomal abnormalities, autism, cerebral palsy etc. or evaluation of *children/infants* with low vision associated with or resulting in developmental delay.]

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to n-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C235	Consultation.....	82.30
C935	Special surgical consultation (see General Preamble GP13)	160.00
C236	Repeat consultation	45.85
C231	Neuro-Ophthalmology Consultation – subject to the same conditions as A231	120.00
C233	Specific assessment	57.70
C234	Specific re-assessment.....	29.35
C250	Retinopathy of prematurity assessment - subject to the same conditions as A250.	120.00

Subsequent visits

C232	- first five weeksper 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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment.....	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C238	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52.

W535	Consultation.....	82.30
W536	Repeat consultation	45.85
W231	Neuro-Ophthalmology Consultation – subject to the same conditions as A231	120.00

CONSULTATIONS AND VISITS

ORTHOPAEDIC SURGERY (06)

GENERAL LISTINGS

A065	Consultation	83.10
A935	Special surgical consultation (see General Preamble GP13)	160.00
A066	Repeat consultation	51.70
A063	Specific assessment	42.55
A064	Partial assessment	24.05

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C065	Consultation	83.10
C935	Special surgical consultation (see General Preamble GP13)	160.00
C066	Repeat consultation	51.70
C063	Specific assessment	42.55
C064	Specific re-assessment.....	25.50

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C068	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W065	Consultation.....	83.10
W066	Repeat consultation.....	51.70

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W062	- first 4 subsequent visits per patient per month	per visit	32.20
W061	- additional subsequent visits (maximum of 6 per patient per month).....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W063	- first 2 subsequent visits per patient per month	per visit	32.20
W068	- subsequent visits per month (maximum of 3 per patient per month).....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33)	per visit	31.00

CONSULTATIONS AND VISITS

OTOLARYNGOLOGY (24)

GENERAL LISTINGS

A245	Consultation	77.90
A935	Special surgical consultation (see General Preamble GP13)	160.00
A246	Repeat consultation	48.60
A243	Specific assessment	41.10
A244	Partial assessment	24.55

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C245	Consultation	77.90
C935	Special surgical consultation (see General Preamble GP13)	160.00
C246	Repeat consultation	48.60
C243	Specific assessment	41.10
C244	Specific re-assessment	27.50

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C248	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34)..... per visit	31.00

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 GP44 to GP52.

W345	Consultation	77.90
W346	Repeat consultation	48.85

CONSULTATIONS AND VISITS

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 *MOHLTC* by demonstrating that the continuation of treatment is generally accepted and necessary for the patient under the circumstances.

A265 Consultation 167.00

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 of direct contact with the patient.

A260 Special paediatric consultaton 300.70

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 of direct contact with the patient.

A662 Extended special paediatric consultation 395.65

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 of direct contact with the patient and caregiver.

A667 Neurodevelopmental consultation..... 395.65

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.

[Commentary:

Neurodevelopmental consultations for less complex conditions, e.g. attention deficit disorder, are payable at a lesser fee.]

CONSULTATIONS AND VISITS

PAEDIATRICS (26)

Prenatal consultation

A prenatal consultation is the service rendered by a paediatrician upon request of a physician who considers a fetus of greater than 20 weeks 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	91.35
A565	Limited consultation	91.35
A266	Repeat consultation	91.35
A263	Medical specific assessment	77.70
A264	Medical specific re-assessment.....	59.45
A661	Complex medical specific re-assessment.....	68.80
A268	Enhanced 18 month well baby visit (see General Preamble GP22).....	62.40
A261	Level 1 - Paediatric assessment.....	21.50
A262	Level 2 - Paediatric assessment.....	42.15
E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%
K045	Diabetes management by a specialist.....	75.00

[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	41.60
K269	- 12 - 17 years of age	77.20

Note:

1. For definitions and payment rules - see General Preamble GP14.
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	100.00
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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.
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*.

CONSULTATIONS AND VISITS

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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

K122	- individual developmental and/or behavioural care	per unit	80.30
K123	- family developmental and/or behavioural care	per unit	91.10

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).]

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C265	Consultation.....	167.00
C260	Special paediatric consultation - subject to the same conditions as A260.....	300.70
C662	Extended special paediatric consultation - subject to the same conditions as A662	395.65
C667	Neurodevelopmental consultation - subject to same conditions as A667	395.65
C665	Prenatal consultation - subject to the same conditions as A665	91.35
C565	Limited consultation	91.35
C266	Repeat consultation.....	91.35
C263	Medical specific assessment	77.70
C264	Medical specific re-assessment.....	59.45
C661	Complex medical specific re-assessment.....	68.80

Subsequent visits

C262	- first six weeks.....per visit	31.00
C267	- seventh to thirteenth week inclusive (maximum 3 per patient per week)	31.00
C269	- after thirteenth week (maximum 6 per patient per month)	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C268	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

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
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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	57.90
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Low birth weight newborn uncomplicated care

H262	- initial.....	per newborn	61.00
H263	- thereafter	per visit	17.75

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 GP44 to GP52.

W265	Consultation.....	167.00
W260	Special paediatric consultation - subject to the same conditions as A260.....	300.70
W662	Extended special paediatric consultation - subject to the same conditions as A662	395.65
W667	Neurodevelopmental consultation - subject to same conditions as A667.....	395.65
W565	Limited consultation.....	91.35
W266	Repeat consultation.....	82.90

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 GP33)

Chronic care or convalescent hospital

W262	- first 4 subsequent visits per patient per month	per visit	32.20
W261	- additional subsequent visits per month (maximum 6 per patient per month)	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

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 children who require medical supervision.

CONSULTATIONS AND VISITS

PHYSICAL MEDICINE & REHABILITATION (31)

GENERAL LISTINGS

A315	Consultation	172.85
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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.

A425	Comprehensive physical medicine and rehabilitation consultation	300.70
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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.

A515	Limited consultation	91.35
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A316	Repeat consultation	91.35
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A313	Medical specific assessment	74.00
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A310	Medical specific re-assessment	65.00
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A311	Complex medical specific re-assessment	70.90
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A318	Partial assessment	38.05
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E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%
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CONSULTATIONS AND VISITS

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.....	89.85
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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.....	89.85
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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.

[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.)]

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C315	Consultation.....	182.85
C425	Comprehensive physical medicine and rehabilitation consultation – subject to the same conditions as A425.....	300.70
C515	Limited consultation	91.35
C316	Repeat consultation	91.35
C313	Medical specific assessment	74.00
C314	Medical specific re-assessment.....	65.00
C311	Complex medical specific re-assessment.....	70.90
C510	Complex neuromuscular assessment - subject to the same conditions as A510....	89.85
C511	Complex physiatry assessment - subject to the same conditions as A511	89.85

Subsequent visits

C312	- first five weeks	per visit	31.00
C317	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C319	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C318	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W515	Consultation.....	182.85
W425	Comprehensive physical medicine and rehabilitation consultation - subject to the same conditions as A425.....	300.70
W310	Limited consultation.....	91.35
W516	Repeat consultation.....	91.35
W510	Complex neuromuscular assessment - subject to the same conditions as A510....	89.85
W511	Complex physiatry assessment - subject to the same conditions as A511	89.85

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 months after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W312	- first 4 subsequent visits per patient per month	per visit	32.20
W311	- additional subsequent visits (maximum of 6 per patient per month).....	per visit	21.20
W982	palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W313	- first 2 subsequent visits per patient per month	per visit	32.20
W318	- subsequent visits per month (maximum of 3 per patient per month)....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33).per visit		31.00

CONSULTATIONS AND VISITS

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 *weekly* and *monthly* 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	39.00
H317	- from thirteenth to twenty-sixth week (maximum 3 per patient per week)	per visit	39.00
H319	- twenty-seventh week onwards (maximum 6 per patient per month).....	per visit	39.00

Rehabilitation counselling

Rehabilitation counselling one or more persons. Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

H313	Rehabilitation counselling	per unit	76.95
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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
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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.]

CONSULTATIONS AND VISITS

PLASTIC SURGERY (08)

GENERAL LISTINGS

A085	Consultation	81.10
A935	Special surgical consultation (see General Preamble GP13)	160.00
A086	Repeat consultation	47.95
A083	Specific assessment	41.55
A084	Partial assessment	26.55

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C085	Consultation	81.10
C935	Special surgical consultation (see General Preamble GP13)	160.00
C086	Repeat consultation	47.95
C083	Specific assessment	41.55
C084	Specific re-assessment.....	27.80

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C088	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52.

W085	Consultation.....	81.10
W086	Repeat consultation	47.95

CONSULTATIONS AND VISITS

PSYCHIATRY (19)

GENERAL LISTINGS

A195	Consultation	199.40
A895	Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient	232.70

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 of direct contact with the patient.

A190	Special psychiatric consultation	300.70
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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 of direct contact with the patient exclusive of discussion with caregivers or any separately payable services. 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	300.70
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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 of direct contact with the patient and caregiver. 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	395.65
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Note:

Neurodevelopmental consultations for *children* or *adolescents* or for less complex conditions e.g. attention deficit disorder are payable at a lesser fee.

A395	Limited consultation	105.25
A196	Repeat consultation	105.25
A193	Specific assessment	79.85
A194	Partial assessment	38.05

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	212.65
A198	- consultative interview with patient less than age 22	212.65
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.....	212.65
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.....	212.65

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).

[Commentary:

For psychiatric consultation extension with parents or caregivers, see K630.]

CONSULTATIONS AND VISITS

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* with the patient and/or patient's relative(s), *patient's representative* or other caregivers.

Note:

The time unit measured excludes time spent on separately billable interventions.

K630 Psychiatric consultation extension per unit 105.10

Payment rules:

1. K630 is a time based service. Time is calculated based on units - Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5 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]

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to n-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C895	Consultation	232.70
C190	Special psychiatric consultation - subject to the same conditions as A190	300.70
C395	Limited consultation	105.25
C196	Repeat consultation	105.25
C795	Geriatric psychiatric consultation - subject to same conditions as A795	300.70
C695	Neurodevelopmental consultation - subject to same conditions as A695.....	395.65
C193	Specific assessment	79.85
C194	Specific re-assessment.....	61.25

Subsequent visits

C192	- first five weeks	per visit	31.00
C197	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ...	per visit	31.00
C199	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment.....	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C198	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34)..... per visit	31.00

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 GP44 to GP52.

W895	Consultation	232.70
W190	Special psychiatric consultation - subject to the same conditions as A190	300.70
W795	Geriatric psychiatric consultation - subject to same conditions as A795	300.70
W695	Neurodevelopmental consultation - subject to same conditions as A695.....	395.65
W395	Limited consultation	105.25
W196	Repeat consultation	105.25

CONSULTATIONS AND VISITS

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 K198add 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, A695 or A795add 200.00

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, 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) months as required.

2. K189 is limited to a maximum of one per physician per patient per 12 month period.

CONSULTATIONS AND VISITS

PSYCHIATRY (19)

Assessments under the Mental Health Act

See General Preamble GP22 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 GP5, GP37 for definitions and time-keeping requirements.

K620	Consultation for involuntary psychiatric treatment	per unit	85.00
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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.....	104.80
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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	129.05
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K629	All other re-certification(s) of involuntary admission including completion of appropriate forms.....	38.25
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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, Children'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.

CONSULTATIONS AND VISITS

PSYCHIATRY (19)

PSYCHOTHERAPY, FAMILY PSYCHOTHERAPY, HYPNOTHERAPY AND PSYCHIATRIC CARE

Note:

1. For conditions and definitions - see General Preamble GP37 to GP41.
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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

Psychiatric care

K198	- out-patient	per unit	80.30
K199	- in-patient	per unit	92.60

Family psychiatric care

K196	- out-patient	per unit	91.10
K191	- in-patient	per unit	105.10

Note:

Family psychotherapy is claimed against the patient's health number and diagnosis.

Psychotherapy

K197	Individual out-patient psychotherapy	per unit	80.30
K190	Individual in-patient psychotherapy	per unit	84.15
K195	Family psychotherapy - out-patients (two or more members).....	per unit	91.10
K193	Family psychotherapy - in-patients (two or more members).....	per unit	95.45

Group psychotherapy, out-patients - per member - first 12 units per day

K208	- 2 people	per unit	40.15
K209	- 3 people	per unit	26.75
K203	- 4 people	per unit	20.10
K204	- 5 people	per unit	16.05
K205	- 6 to 12 people	per unit	14.45
K206	- additional units - per member (maximum 6 per patient per day).....	per unit	12.85

Group psychotherapy, in-patients - per member - first 12 units per day

K210	- 2 people	per unit	42.10
K211	- 3 people	per unit	28.05
K200	- 4 people	per unit	21.00
K201	- 5 people	per unit	16.80
K202	- 6 to 12 people	per unit	15.15
K207	- additional units - per member (maximum 6 per patient per day).....	per unit	12.85

Hypnotherapy

K192	Individual.....	per unit	80.30
K194	Group - for induction and training for hypnosis - per member (maximum eight people).....	per unit	14.60

CONSULTATIONS AND VISITS

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 50.00

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 with the patient in consultation.

[Commentary:

The calculation of the 50 minute minimum excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A365 Special interventional radiological consultation 223.20

CONSULTATIONS AND VISITS

DIAGNOSTIC RADIOLOGY (33)

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.....	89.50
A332	Radiology second opinion of MRI study, per study.....	199.70

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.....	17.75
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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.....	17.75
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NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C335	Consultation - subject to the same conditions as A335	50.00
C365	Special interventional radiological consultation - subject to the same conditions as A365.....	223.20
C330	Radiology second opinion of CT study, per study - subject to the same conditions as A330.....	89.50
C332	Radiology second opinion of MRI study, per study - subject to the same conditions as A332	199.70

CONSULTATIONS AND VISITS

RADIATION ONCOLOGY (34)

GENERAL LISTINGS

A345	Consultation	152.40
A765	Consultation, patient 16 years of age and under	165.50
A745	Limited consultation	99.30
A346	Repeat consultation	99.30
A343	Medical specific assessment	77.55
A340	Medical specific re-assessment.....	59.55
A341	Complex medical specific re-assessment.....	68.90
A348	Partial assessment	37.05
E078	- chronic disease assessment premium (see General Preamble GP16)	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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C345	Consultation	152.40
C765	Consultation, patient 16 years of age and under	165.50
C745	Limited consultation	99.30
C346	Repeat consultation	99.30
C343	Medical specific assessment	77.55
C344	Medical specific re-assessment.....	59.55
C341	Complex medical specific re-assessment.....	68.90

Subsequent visits

C342	- first five weeks	per visit	31.00
C347	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C349	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C348	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

RESPIRATORY DISEASE (47)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A475	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50

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 seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A470	Comprehensive respiratory disease consultation	300.70
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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 GP12).

2. The calculation of the 75 minute minimum time for comprehensive respiratory diseases consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A575	Limited consultation	105.25
A476	Repeat consultation	105.25
A473	Medical specific assessment	79.85
A474	Medical specific re-assessment.....	61.25
A471	Complex medical specific re-assessment.....	70.90
A478	Partial assessment	38.05

E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%
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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 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	89.85
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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.
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).]

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C475	Consultation	157.00
C765	Consultation, patient 16 years of age and under	165.50
C470	Comprehensive respiratory disease consultation - subject to the same conditions as A470.....	300.70
C575	Limited consultation	105.25
C476	Repeat consultation	105.25
C473	Medical specific assessment	79.85
C474	Medical specific re-assessment.....	61.25
C471	Complex medical specific re-assessment.....	70.90
C570	Complex respiratory assessment – subject to the same conditions as A570	89.85

Subsequent visits

C472	- first five weeks	per visit	31.00
C477	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ...	per visit	31.00
C479	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment.....	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C478	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34)..... per visit	31.00

CONSULTATIONS AND VISITS

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A485	Consultation.....	157.00
A765	Consultation, patient 16 years of age and under	165.50

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.....	300.70
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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 GP12).
2. The calculation of the 75 minute minimum time for comprehensive rheumatology consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A595	Limited consultation	105.25
A486	Repeat consultation	105.25
A483	Medical specific assessment	79.85
A484	Medical specific re-assessment.....	61.25
A481	Complex medical specific re-assessment.....	70.90
A488	Partial assessment	38.05

E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%
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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; or
- c. Polymyalgia rheumatica.

A480	Complex rheumatology assessment.....	89.85
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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.

[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.]

CONSULTATIONS AND VISITS

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	75.00
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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.

CONSULTATIONS AND VISITS

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.

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.

CONSULTATIONS AND VISITS

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C485	Consultation.....	157.00
C765	Consultation, patient 16 years of age and under	165.50
C590	Comprehensive rheumatology consultation - subject to the same conditions as A590	300.70
C595	Limited consultation	105.25
C486	Repeat consultation	105.25
C483	Medical specific assessment	79.85
C484	Medical specific re-assessment.....	61.25
C481	Complex medical specific re-assessment.....	70.90
C480	Complex rheumatology assessment - subject to the same conditions as A480.....	89.85

Subsequent visits

C482	- first five weeks	per visit	31.00
C487	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....	per visit	31.00
C489	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C488	Concurrent care.....per visit	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

CONSULTATIONS AND VISITS

UROLOGY (35)

GENERAL LISTINGS

A355	Consultation*	80.00
A935	Special surgical consultation (see General Preamble GP13)	160.00
A356	Repeat consultation*	55.75
A353	Specific assessment*	45.00
A354	Partial assessment	26.00

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 HOSPITAL IN-PATIENT SERVICES

See General Preamble GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C355	Consultation*	80.00
C935	Special surgical consultation (see General Preamble GP13)	160.00
C356	Repeat consultation*	55.75
C353	Specific assessment*	45.00
C354	Specific re-assessment	26.00

Subsequent visits

C352	- first five weeks	per visit	31.00
C357	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C359	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C358	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....per visit	31.00

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 GP44 to GP52.

W355	Consultation*	80.00
W356	Repeat consultation*	55.75

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.

CONSULTATIONS AND VISITS

VASCULAR SURGERY (17)

GENERAL LISTINGS

A175	Consultation	90.30
A935	Special surgical consultation (see General Preamble GP13)	160.00
A176	Repeat consultation	60.00
A173	Specific assessment	44.40
A174	Partial assessment	24.10

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 GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

C175	Consultation	90.30
C935	Special surgical consultation (see General Preamble GP13)	160.00
C176	Repeat consultation	60.00
C173	Specific assessment	44.40
C174	Specific re-assessment.....	25.95

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 GP29 to GP30 for terms and conditions.

C122	- day following the hospital admission assessment	58.80
C123	- second day following the hospital assessment	58.80
C124	- day of discharge.....	58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C178	Concurrent care	31.00
C982	Palliative care (see General Preamble GP34).....	31.00

CONSULTATIONS AND VISITS

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 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 GP44 to GP52.

W175	Consultation.....	90.30
W176	Repeat consultation	60.00

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

W172	- first 4 subsequent visits per patient per month	per visit	32.20
W171	- additional subsequent visits (maximum of 6 per patient per month)....	per visit	21.20
W982	- palliative care (see General Preamble GP34)	per visit	32.20

Nursing home or home for the aged

W173	- first 2 subsequent visits per patient per month	per visit	32.20
W178	- subsequent visits per month (maximum of 3 per patient per month)....	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20
W121 Additional visits due to intercurrent illness (see General Preamble GP33) .per visit			31.00

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 GP8, 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 physician.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional components* 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 components* 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). Fees for the *technical component* of these services are only billable under the *Independent Health Facilities Act*.
3. With the exception of J818, J835, J821, 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. Fees for the *technical component* of services rendered in an Independent Health Facility are listed in the *Schedule of Facility Fees*.
8. Bone or labeled leukocyte scintigraphy ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department is insured when the bone or labeled leukocyte scintigraphy 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 bone or labeled leukocyte scintigraphy and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.
9. The technical and professional fee components for myocardial perfusion imaging /echocardiogram/exercise stress test/stress echocardiogram 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 myocardial perfusion imaging/exercise stress test/cardiac stress echo studies 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. 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 shown 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 be useful in patients undergoing low risk non cardiac surgery (class III)]

NUCLEAR MEDICINE - IN VIVO

CARDIOVASCULAR SYSTEM

		H	P
Venography			
J802	- peripheral and superior vena cava.....	96.35	38.70
First Transit			
J804	- without blood pool images	16.10	15.90
J867	- with blood pool images	57.30	22.30
Cardioangiography			
J806	- first pass for shunt detection, cardiac output and transit studies	95.10	41.70
Myocardial Perfusion Scintigraphy			
J807	- resting, immediate post stress	217.55	38.10
J866	- application of SPECT (maximum 1 per examination)..... add	43.50	23.65
J808	- delayed	80.10	20.90
J809	- application of SPECT (maximum 2 per examination)	43.50	23.65
Myocardial scintigraphy			
J810	- acute infarction, injury	88.25	37.90
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	38.70

NUCLEAR MEDICINE - IN VIVO

ENDOCRINE SYSTEM

H P

Adrenal scintigraphy

J816	- with iodocholesterol	385.90	38.70
J868	- with iodocholesterol and dexamethasone suppression	451.30	44.60
J869	- with MIBG	555.35	44.45

Thyroid scintigraphy

J818	- with Tc99m or I-131.....	64.15	38.70
J871	- with I-123	103.10	38.70

[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	17.50
J870	- repeat.....	14.65	10.30

Parathyroid scintigraphy

J820	- dual isotope technique with T1201 and Tc99m Iodine	234.70	53.10
J872	Metastatic survey with I-131	240.60	44.45

NUCLEAR MEDICINE - IN VIVO

GASTROINTESTINAL SYSTEM

	H	P
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Schilling test			
J821	- single isotope	44.65	11.40
J823	- dual isotope.....	48.15	9.70
Malabsorption test			
J824	- with C ¹⁴ substrate	57.30	9.95
J873	- with whole body counting.....	137.70	14.25
Gastrointestinal			
J825	- protein loss.....	82.45	9.75
J874	- blood loss using - Cr ⁵¹	61.90	9.70
J829	- transit	103.10	38.70
Calcium absorption			
J826	- Ca ⁴⁵	61.90	9.95
J875	- Calcium ⁴⁷ absorption/excretion	253.10	31.00
J827	- Oesophageal motility studies - one or more	118.90	38.70
Gastro-oesophageal			
J876	- reflux	56.70	38.70
J877	- aspiration	40.15	38.70
Abdominal scintigraphy - for gastrointestinal bleed			
J830	- Tc99m sulphur colloid or Tc ⁰⁴	87.00	38.70
J878	- labelled RBCs	143.20	38.70
J879	- LeVeen shunt patency	66.30	38.70
J831	Biliary scintigraphy.....	114.50	38.70
J832	Liver/spleen scintigraphy	80.10	38.70
J833	Salivary gland scintigraphy	96.25	38.70

NUCLEAR MEDICINE - IN VIVO

GENITOURINARY SYSTEM

		H	P
J834	Dynamic renal imaging	96.25	31.30
Computer assessed renal function			
J835	- includes first transit	131.70	55.50
J880	- repeat after pharmacological intervention	44.85	17.10
J836	Static renal scintigraphy	33.25	38.70
J837	ERPF by blood sample method	40.15	9.95
J838	GFR by blood sample method	40.15	9.95
J839	Cystography for vesicoureteric reflux	120.55	38.70
Testicular and scrotal scintigraphy			
J840	- includes first transit	82.45	38.70

NUCLEAR MEDICINE - IN VIVO

HAEMATOPOIETIC SYSTEM

		H	P
J841	Plasma volume	43.50	11.40
J843	Red cell volume	48.15	11.40
J847	Ferrokinetics - clearance, turnover, and utilization	400.95	26.50
J848	Red cell, white cell or platelet survival	102.60	21.25
J849	Red cell survival with serial surface counts	148.25	27.10
Bone marrow scintigraphy			
J881	- whole body.....	113.70	47.70
J882	- single site	84.85	38.70
In-111 leukocyte scintigraphy			
J883	- whole body.....	364.30	46.75
J884	- single site	320.80	38.70

NUCLEAR MEDICINE - IN VIVO

MUSCULOSKELETAL SYSTEM

		H	P
Bone scintigraphy			
J850	- general survey	103.70	47.70
J851	- single site	84.85	38.70
Gallium scintigraphy			
J852	- general survey	177.55	51.70
J853	- single survey	123.70	38.70
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	23.65

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 Tc99m or I-131 HSA	120.25	43.95
J885	- with In-111	308.20	43.95
J886	- via shunt puncture.....	88.55	42.70
J858	Brain scintigraphy	90.40	38.70

RESPIRATORY SYSTEM

J859	Perfusion lung scintigraphy.....	85.90	34.60
J887	Ventilation lung scintigraphy	107.70	34.60
J860	Perfusion and ventilation scintigraphy - same day	171.85	47.70

NUCLEAR MEDICINE - IN VIVO

MISCELLANEOUS

		H	I	P
J861	Radionuclide lymphangiogram	112.20		52.60
J862	Ocular tumour localization	75.60		54.90
J864	Tear duct scintigraphy.....	97.35		41.25
J865	Total body counting	187.95		38.70
Application of Tomography (SPECT), other than to J808 or J852				
J866	- maximum one per Nuclear Medicine examination.....add	43.50		23.65

NUCLEAR MEDICINE - IN VIVO

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	38.70
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Note:

For the purpose of this provision, "dense breast(s)" means (a) breast(s) occupied by over 75% fibroglandular tissue as noted on mammography.

NUCLEAR MEDICINE - IN VIVO

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 J42.
- b. Injection into CSF spaces or shunt apparatus - Z801 or Z821 on page X5.
- c. Arterial puncture - Z459 on pages H5 and J7.
- d. Paracentesis in conjunction with shunt patency study - Z590 on page S28.

NUCLEAR MEDICINE - IN VIVO

NOT ALLOCATED

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 for the investigation of the indications listed below.
2. PET scanning for all oncologic or suspected oncologic indications must be performed using a combined positron emission tomography-computed tomography scanner (PET/CT) in order to localize anatomically any areas of abnormality on the PET image.
3. Interpretation of a CT scan performed to identify the anatomical location of a PET scan abnormality or for attenuation correction is *not eligible for payment*.

[Commentary:

1. It is expected that the physician requesting a PET scan is making clinical decisions related to the treatment of the patient or is basing their request on the recommendation of the treating physician.
2. A PET scan may be available for indications other than those listed below through the Ontario Cancer PET Registry for patients meeting eligibility criteria. This registry is coordinated by Cancer Care Ontario. The contact number is 1-877-473-8411.]

Solitary pulmonary nodule (SPN)

Solitary pulmonary nodule for which a diagnosis could not be established by a needle biopsy due to:

- a. unsuccessful attempted needle biopsy;
- b. the SPN is inaccessible to needle biopsy; or
- c. the existence of a contra-indication to the use of needle biopsy.

J700 Solitary pulmonary nodule 237.50

Thyroid cancer

Thyroid cancer for which standard imaging studies, including I-131 scan and/or neck ultrasound, are negative or equivocal, and recurrent or persistent disease is suspected on the basis of an elevated and/or rising thyroglobulin level(s).

J701 Thyroid cancer 237.50

Germ cell tumour

Germ cell tumour for which recurrent or persistent disease is suspected on the basis of:

- a. elevated tumour marker(s) (beta human chorionic gonadotrophin (HCG) and/or alpha fetoprotein) in the presence of negative or equivocal standard imaging studies; or
- b. the presence of a residual mass after primary treatment for seminoma when curative surgical resection is being considered.

J702 Germ cell tumour 237.50

POSITRON EMISSION TOMOGRAPHY (PET)

P

Colorectal cancer

Colorectal cancer for which standard imaging studies are negative or equivocal and recurrent disease after surgical resection is suspected on the basis of an elevated and/or rising carcinoembryonic antigen (CEA) level(s).

J703	Colorectal cancer.....	237.50
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Lymphoma

For the evaluation of a residual mass(es) following chemotherapy in a patient with Hodgkin's or Non-Hodgkin's lymphoma when further potentially curative therapy (such as radiation or stem cell transplantation) is being considered.

J704	Lymphoma for the evaluation of a residual mass(es)	237.50
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For the assessment of response in early stage Hodgkin's lymphoma following 2 or 3 cycles of chemotherapy when chemotherapy is being considered as the definitive single modality therapy.

J705	Lymphoma for the assessment of response to treatment.....	237.50
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Non-small cell lung cancer (NSCLC):

- a. For which curative surgical resection is being considered based on negative standard imaging tests; or
- b. For clinical stage III NSCLC which is being considered for potentially curative combined modality therapy with radical radiotherapy and chemotherapy.

J706	Non-small cell lung cancer.....	237.50
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Limited disease small cell lung cancer

Limited disease small cell lung cancer for evaluation and staging where combined modality therapy with chemotherapy and radiotherapy is being considered.

J709	Limited disease small cell lung cancer	237.50
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Esophageal carcinoma

- a. Baseline staging assessment of those patients diagnosed with esophageal cancer being considered for curative therapy.
- b. Repeat PET/CT scan on completion of pre-operative/neoadjuvant therapy, prior to surgery.

J710	Esophageal carcinoma	237.50
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Metastatic squamous cell carcinoma – evaluation of neck nodes

J711	Metastatic squamous cell carcinoma – evaluation of neck nodes	237.50
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Note:

J711 is only insured when the primary disease site is unknown after radiologic and clinical investigation.

Liver metastasis from colorectal cancer

Prior to surgery for resection of metastatic lesions from colorectal cancer only when:

- a. The surgical procedure on the liver is high risk; or
- b. The patient is considered at high risk for surgery.

[Commentary:

Examples of high risk liver surgical procedures are multiple staged liver resection or where vascular reconstruction is required.]

J712	Liver metastasis from colorectal cancer.....	237.50
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Staging nasopharyngeal carcinoma

J713	Staging of nasopharyngeal carcinoma.....	237.50
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POSITRON EMISSION TOMOGRAPHY (PET)

P

Cardiac PET using fluorodeoxyglucose (FDG)

Cardiac PET using fluorodeoxyglucose (FDG) for myocardial viability assessment in a patient that:

- a. has moderate to severe ischemic left ventricular dysfunction (left ejection less than or equal to 40%) despite maximal medical therapy; and
- b. is a suitable candidate for a cardiac revascularization procedure or cardiac transplantation.

J707	- cardiac PET	237.50
J708	- cardiac PET with quantitative analysis, to J707.....	add 0%

Note:

PET is an insured service for the clarification of myocardial viability when:

- a. a previous myocardial imaging assessment has been rendered, using another modality (e.g. SPECT using thallium, MIBI or dobutamine stress echocardiography) and the result of the previous imaging assessment was equivocal or demonstrated insufficient viable myocardium; or
- b. a patient with a left ventricular ejection fraction less than 35% and known multi-vessel coronary disease determined by coronary angiography urgently needs an assessment of myocardial viability.

[Commentary:

Examples of other modalities for assessing viability include SPECT imaging using myocardial perfusion agents such as thallium, MIBI or tetrofosmin, or dobutamine stress echocardiography.]

Payment rules:

Only one of J700, J701, J702, J703, J704, J705, J706, J707, J709 or J710 is eligible for payment per patient per day.

Claims submission instructions:

Submit claims for the *professional component* of a PET scan using the "C" suffix.

POSITRON EMISSION TOMOGRAPHY (PET)

NOT ALLOCATED

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 a Cancer Care Ontario (CCO) Centre or Princess Margaret Hospital (PMH) 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, CCO Centre or PMH 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 *not eligible for payment*.
4. X302, X304 may not be claimed by the staff of Cancer Care Ontario or Princess Margaret Hospital.

RADIATION ONCOLOGY

RADIOThERAPY

Fee

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
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Level 2 - Intermediate Treatment Planning

- must include one or more of the following treatments and corresponding NHPIP codes

<u>Treatment</u>	<u>NHPIP Code</u>
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

RADIATION ONCOLOGY

RADIOTHERAPY

Fee

Level 3 - Complex Treatment Planning

- must include one or more of the following treatments and corresponding NHPIP codes

<u>Treatment</u>	<u>NHPIP Code</u>
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

RADIATION ONCOLOGY

RADIOTHERAPY

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

	<u>Treatment</u>	<u>NHPIP Code</u>
	Full 3D target definition (volumetric imaging), 3D dose computation, 3D plan evaluation	333
	Paediatric radiotherapy	342
	Stereotactic radiotherapy	
	Total skin electron treatment	
	Total body irradiation	
	Intensity Modulated Radiotherapy (IMRT)	
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

RADIATION ONCOLOGY

RADIUM AND RADIOISOTOPES (SEALED SOURCES)

		Fee
X322	Treatment planning, dosage calculation and preparation of any special treatment device.....	71.30
	Intracavitary application of radium or sealed sources including dilatation and curettage carried out at the same time as application	
X323	- first application	223.65
X334	- repeat application.....	111.90
X324	Interstitial application of radium or sealed radioisotope.....	223.65
# X325	Application of radium or radioisotope plaque or mould.....	69.80

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.....	85.30
# X327	Hyperthyroidism	77.80
# X335	Induction of hypothyroidism	75.90
# X336	Prostate malignancy	75.90
# X328	Polycythemia	45.35
# X329	Metastatic disease of bone	70.55
# X330	Ascites and/or pleural effusion(s) due to malignancy	54.00
# X332	Arthritis - single or multiple site.....	36.45

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 GP8, 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 physician.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional components* 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 components* 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). Fees for the *technical component* of these services are only claimed under the *Independent Health Facilities Act*. Fees for the *technical component* of services rendered in an Independent Health Facility are listed in the *Schedule of Facility Fees*.
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 physician 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 or accessory nasal sinuses 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 physician 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.
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.

DIAGNOSTIC RADIOLOGY

PREAMBLE

23. No extra fee should be claimed for rapid sequence IVP.
24. Nephrotomography is covered by the listings for intravenous pyelogram 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. Mammography or x-ray of the chest, ribs, arm, wrist, hand, leg, ankle or foot, rendered in an Independent Health Facility or a hospital in-patient or out-patient department is insured when referred by a registered nurse holding an extended certificate of registration (RN(EC)).
27. Plain x-rays of the head, neck, pelvis, tibia or chest, computed tomography of the head, examinations of fistulas or sinuses or sialograms ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department are insured when the plain x-rays of the head, neck, pelvis, tibia or chest, computed tomography of the head, examinations of fistulas or sinuses or sialograms are 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 plain x-rays of the head, neck, pelvis, tibia and chest, computed tomography of the head, examinations of fistulas or sinuses or sialograms and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.
28. 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.

[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
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Skull			
X001	- four views.....	29.90	13.25
X009	- five or more views	37.25	16.40
X003	Sella turcica (when skull not examined)	14.90	6.40
Facial bones			
X004	- three views.....	21.70	10.30
Nose			
X005	- two views	14.90	6.40
Mandible			
X006	- three views (unilateral or bilateral).....	21.70	10.35
X012	- four or more views	29.90	13.25
X007	Temporomandibular joints - four views including open and closed mouth views....	21.70	10.35
Sinuses			
X008	- three views.....	21.70	10.35
Mastoids			
	- bilateral		
X010	- six views	28.65	14.25
X011	- Internal auditory meati (when skull not examined).....	21.70	10.35
Note:			
Dental x-rays of the teeth are not an insured benefit.			
X016	Eye, for foreign body.....	14.85	9.05
X017	Eye, for localization, additional	15.30	20.40
X018	Optic foramina	16.85	9.05
X019	Salivary gland region	13.75	7.95
Neck for soft tissues			
X020	- two views	13.75	7.95

DIAGNOSTIC RADIOLOGY

SPINE AND PELVIS

	H	P
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Cervical spine			
X025	- two or three views	25.90	7.95
X202	- four or five views	33.40	10.75
X203	- six or more views	40.35	13.25
Thoracic spine			
X027	- two views	23.65	7.95
X204	- three or more	29.90	10.65
Lumbar or lumbosacral spine			
X028	- two or three views	25.90	7.95
X205	- four or five views	33.40	10.75
X206	- six or more views	40.35	13.35
Entire spine (scoliosis series)			
X032	- four views	53.55	20.75
Orthoroentgenogram (3 foot film)			
X033	- single view	21.70	10.15
X031	- two or more views	29.70	13.35
Sacrum and/or coccyx			
X034	- two views	23.95	6.40
X207	- three or more views	31.05	10.65
Sacro-iliac joints			
X035	- two or three views	21.70	10.35
X208	- four or more views	28.95	13.05
Pelvis and/or hip(s)			
X036	- one view	14.90	6.40
X037	- two views (e.g. AP and frog view, both hips, or AP both hips plus lateral one hip)	27.75	9.20
X038	- three or more views (e.g. pelvis and sacro-iliac joints, or AP both hips plus lateral each hip)	31.90	10.35

DIAGNOSTIC RADIOLOGY

UPPER EXTREMITIES

	H	P
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Clavicle			
X045 - two views	14.90	6.40	
X209 - three or more views	22.90	8.90	
Acromioclavicular joints (bilateral) with or without weighted distraction			
X046 - two views	21.70	10.35	
X210 - three or more views	29.60	13.05	
Sternoclavicular joints (bilateral)			
X047 - two or three views	17.95	7.95	
X211 - four or more views	25.60	10.90	
Shoulder			
X048 - two views	17.95	7.95	
X212 - three or more views	25.60	10.65	
Scapula			
X049 - two views	17.95	7.95	
X213 - three or more views	25.80	10.65	
Humerus including one joint			
X050 - two views	14.90	6.40	
X214 - three or more views	22.75	9.30	
Elbow			
X051 - two views	14.90	6.40	
X215 - three or four views	22.90	9.05	
X216 - five or more views	30.85	11.65	
Forearm including one joint			
X052 - two views	14.90	6.40	
X217 - three or more views	22.90	9.05	
Wrist			
X053 - two or three views	14.90	6.40	
X218 - four or more views	22.90	9.05	
Hand			
X054 - two or three views	14.90	6.40	
X219 - four or more views	22.90	9.05	
Wrist and hand			
X055 - two or three views	21.70	13.05	
X220 - four or more views	27.65	15.70	
Finger or thumb			
X056 - two views	11.50	4.70	
X221 - three or more views	14.90	6.40	

DIAGNOSTIC RADIOLOGY

LOWER EXTREMITIES

		H	P
Hip (unilateral)			
X060	- two or more views	23.75	7.65
Femur including one joint			
X063	- two views	14.90	6.40
X223	- three or more views	22.20	9.05
Knee including patella			
X065	- two views	14.90	6.40
X224	- three or four views	22.90	9.05
X225	- five or more views	30.85	11.65
Tibia and fibula including one joint			
X066	- two views	14.90	6.40
X226	- three or more views	22.90	9.05
Ankle			
X067	- two or three views	14.90	6.40
X227	- four or more views	22.90	9.05
Calcaneus			
X068	- two views	14.90	6.40
X228	- three or more views	22.90	9.05
Foot			
X069	- two or three views	14.90	6.40
X229	- four or more views	22.90	9.05
Toe			
X072	- two views	11.50	4.70
X230	- three or more views	14.90	9.05
X064	Leg length studies (orthoroentgenogram).....	21.70	10.35

DIAGNOSTIC RADIOLOGY

SKELETAL SURVEYS

H P

Skeletal survey for bone age		H	P
X057	- single film	14.90	6.40
X058	- two or more films or views	21.70	10.65

Other survey studies - e.g. rheumatoid, metabolic or metastatic		H	P
X080	- single view	7.45	3.30
X081	- each additional film or view	7.45	3.30

DIAGNOSTIC RADIOLOGY

CHEST AND ABDOMEN

		H	P
Chest			
X090	- single view	14.90	6.40
X091	- two views	21.90	10.75
X092	- three or more views	28.15	12.45
Note: Miniature chest film for survey purposes only is not an insured benefit.			
Ribs			
X039	- two or more views	17.95	7.85
Sternum			
X040	- two or more views	17.95	7.85
Thoracic inlet			
X096	- two or more views	14.90	6.40
Abdomen			
X100	- single view	14.90	6.40
X101	- two or more views	22.80	9.20

DIAGNOSTIC RADIOLOGY

GASTROINTESTINAL TRACT

		H	P
Palatopharyngeal analysis			
X105	- cine or videotape.....	29.50	36.90
Pharynx and oesophagus			
X106	- cine or videotape.....	29.50	36.90
X107	Oesophagus when X103, X104, X108 or X109 not claimed.....	26.70	21.40
Oesophagus, stomach and duodenum			
X108	- including survey film, if taken	46.30	38.15
X104	- double contrast, including survey film, if taken	48.50	46.40
X103	- double contrast, including survey film, if taken, and small bowel.....	60.95	58.40
X110	Hypotonic duodenogram.....	39.35	32.95
X109	Oesophagus, stomach and small bowel	59.10	49.80
Small bowel only			
X111	- when only examination performed during patient's visit.....	26.40	21.80
Colon			
X112	- barium enema including survey film, if taken	48.40	29.40
X113	- air contrast, primary or secondary, including survey films, if taken	61.30	49.80
Gallbladder			
X114	- one or multiple <i>day</i> examinations	29.95	11.60
X120	- one or multiple <i>day</i> examinations with preliminary plain film	39.80	11.60
X116	T-tube cholangiogram	21.70	9.90
X117	Operative cholangiogram.....	21.70	11.10
X123	Operative pancreatogram or ERCP	21.70	9.00

DIAGNOSTIC RADIOLOGY

GENITOURINARY TRACT

		H	P
X129	Retrograde pyelogram, unilateral or bilateral.....	21.70	9.00
X130	Intravenous pyelogram including preliminary film.....	49.65	22.75
X137	Cystogram (catheter).....	23.85	8.40
X135	Cystourethrogram, stress or voiding (catheter)	27.50	13.80
X131	Cystourethrogram (non-catheter)	5.75	4.75
X191	Intestinal conduit examination or nephrostogram	21.70	9.00
X138	Percutaneous antegrade pyelogram.....	21.70	9.00
X139	Percutaneous nephrostogram	21.70	11.10
X134	Retrograde urethrogram	17.95	6.80
X136	Vasogram.....	17.95	6.80
X141	Cavernosography	20.65	8.30

DIAGNOSTIC RADIOLOGY

OBSTETRICS AND GYNAECOLOGY

X147 Hysterosalpingogram..... H 29.80 P 11.35

DIAGNOSTIC RADIOLOGY

FLUOROSCOPY - BY PHYSICIAN WITH OR WITHOUT SPOT FILMS

		H	P
X195	Chest	9.25	14.20
X196	Skeleton.....	9.25	14.20
X197	Abdomen	9.25	14.20
X189	Fluoroscopic control of clinical procedures done by another physician per 1/4 hour.....	7.30	23.75

DIAGNOSTIC RADIOLOGY

SPECIAL EXAMINATIONS

H	P
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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	30.90
X182	- selective (per vessel, to a maximum of 4).....	79.30	37.45
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	15.50
X175	- bilateral	39.35	30.90
X198	Splenoportogram	59.10	22.60
X199	Translumbar aortogram	59.10	22.60
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	27.50
X200	- with fluoroscopy and complete positioning throughout by physician	36.70	45.55
Bronchogram			
X158	- unilateral	28.95	23.00
X159	- bilateral	38.40	34.60
X162	Cerebral stereotaxis.....	59.20	23.10
X122	Cholangiogram, percutaneous trans-hepatic.....	29.50	23.15
X121	Stereotactic core breast biopsy.....	-	83.15

DIAGNOSTIC RADIOLOGY

BONE MINERAL DENSITY (BMD) MEASUREMENT

H

P

Dual-energy X-ray Absorptiometry (DXA) - by axial technique only

Definition:

For the purpose of second and subsequent testing,

“**high risk patient**” means a patient:

1. at risk for accelerated bone loss (in the absence of other risk factors, patient age is deemed not to place a patient at high risk for accelerated bone loss);
2. with osteopenia or osteoporosis on any previous BMD testing; or
3. with bone loss in excess of 1% per year as demonstrated by previous BMD testing.

“**low risk patient**” means a patient who is not a high risk patient.

Definition/Required elements of service:

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

X145	- one site	42.85	40.15
X146	- two or more sites.....	55.20	48.00

Second test - low risk patient

X152	- one site	42.85	40.15
X153	- two or more sites.....	55.20	48.00

Subsequent test - low risk patient

X142	- one site	42.85	40.15
X148	- two or more sites.....	55.20	48.00

Subsequent test - high risk patient

X149	- one site	42.85	40.15
X155	- 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. Second test - low risk patient (X152/X153) is limited to a maximum of one test rendered not earlier than 36 months following the baseline test (X145/X146).
3. Subsequent test - low risk patient (X142/X148) is *not eligible for payment* when rendered earlier than 60 months following the second or any subsequent test.
4. Any combination of services described by X152 or X153 that were rendered to a patient between July 1, 2007 and April 1, 2008 for which claims were submitted and paid as insured services under the *Health Insurance Act* constitutes, a “second test – low risk patient” for the purpose of determining service maximums for a second or subsequent test - low risk patient, and is deemed to have been rendered on July 1, 2010.

DIAGNOSTIC RADIOLOGY

BONE MINERAL DENSITY (BMD) MEASUREMENT

H P

5. Any service described by X152 or X153 rendered between April 1, 2008 and July 1, 2010 for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes a subsequent test - low risk patient for the purpose of determining service maximums for second or subsequent test – low risk patient and is deemed to have been rendered on July 1, 2010.
6. Subsequent test - high risk patients (X149/X155) is limited to a maximum of one test every 12 months unless the ordering physician obtains written prior authorization from a *medical consultant*.

[Commentary:

Authorization will be dependent on the ordering physician demonstrating that the test is generally accepted as necessary for the patient under the circumstances.]

[Commentary:

1. Baseline, second test and subsequent tests should be ordered only in accordance with current practice guidelines. In those situations where testing is ordered on a particular patient for reasons that vary from the guidelines, the ordering physician should ensure that the patient's medical record sufficiently explains the justification for the test in this particular case.
2. In the event a patient with a previous normal baseline test (X145/X146) or second test (X152/X153) or normal subsequent test – low risk patient (X142/X148) meets any of the criteria listed for high risk patients as stated above, the patient would be eligible for subsequent test – high risk patient services (X149/X155) subject to the restriction stated in payment rule #6.
3. The 2002 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada (reviewed in 2006) can be found at http://www.cmaj.ca/cgi/reprint/167/10_suppl/s1.pdf.
4. Individuals under age 65 without one major or two minor risk factors typically do not benefit from BMD measurement.]

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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 without contrast material followed by contrast material(s).

X235 Cardio-thoracic - 147.50

Note:

1. The service described by X235 includes the supervision of oral beta blockers and/or IV injection where clinically indicated.
2. X235 is *only eligible for payment* when the service is performed using a minimum of a 64-detector CT scanner.
3. X235 is *only eligible for payment* when:
 - a. one or more of the following indications 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 in patients in whom cardiac function may not be assessed by magnetic resonance imaging or echocardiography; or
 - b. conventional coronary angiography is technically infeasible, or contraindicated for:
 - i. a clinically stable symptomatic patient with low to intermediate probability of obstructive coronary disease;
 - ii. a clinically stable symptomatic patient who has planned surgery for valvular or structural heart disease;
 - iii. a patient has low to intermediate probability of stent stenosis where the stent has a diameter > 3mm; or
 - iv. a patient with suspected clinically relevant congenital coronary artery anomalies.

Payment rules:

1. X417, X406, X407, and X125 are *not eligible for payment* with X235.
2. 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.

Medical record requirements:

X235 is *only eligible for payment* when the patient's permanent medical record includes all of the following:

1. An interpretation is provided by a physician who must meet the current American College of Radiology's minimum training standards for thorax and cardiac CT imaging.
2. A record of a detailed relevant patient history and demographics to determine the scan protocol is maintained.
3. A diagnosis of the entire detailed field of view is provided including the lymph nodes, pleura, lungs, mediastinum, airways, bony thorax, spine and heart, and veins, arteries and other related anatomical structure.
4. A quantitative evaluation of coronary calcium for risk stratification is documented when clinically appropriate.

DIAGNOSTIC RADIOLOGY

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. Examples where CT coronary angiography is not insured include:
 - a. for a patient with a high pre-test probability of obstructive coronary artery disease or ECG or cardiac enzyme evidence of an acute coronary syndrome;
 - b. for purposes of screening, risk stratification, or calcium scoring in asymptomatic patients.
3. The maintenance of radiation dose should be consistent with the As Low As Reasonably Achievable principle and current standards under the direction of the radiologist Radiation Protection Officer.]

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.]

1. when rendered for a patient for whom colonoscopy is technically infeasible, has been difficult in the past, or contraindicated;
2. 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;
3. when double contrast barium enema services are unavailable or regarded as inadequate for clinical or diagnostic reasons.]
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 Reasonably Achievable principle and current standards under the direction of the radiologist Radiation Protection Officer.]

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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	23.00
X167	Fistula or sinus.....	21.50	11.45
X169	Laminogram, planigram, tomogram.....	39.90	11.35
X170	Laryngogram.....	28.95	23.00
X171	Lymphangiogram	49.00	23.05
X192	Mammary ductography	25.05	10.65

Mammogram - Signs or Symptoms

[Commentary:

For individuals with identified signs or symptoms or follow-up of established disease.]

Dedicated equipment

X184	- unilateral	28.05	16.90
X185	- bilateral	37.15	27.00

Mammogram - No Signs or Symptoms

[Commentary:

Where the sole reason for the request for a mammogram is for an individual with identified risk factors in accordance with clinical practice guidelines.]

Dedicated equipment

X172	- unilateral	28.05	16.90
X178	- bilateral	37.15	27.00
X194	Additional coned views with or without magnification (limit of two per breast) per film	5.95	5.20
X201	Breast biopsy specimen x-ray, per specimen	5.95	5.20
X150	Mechanical evaluation of knee	25.45	15.85
X193	Microradioscopy of the hands.....	14.50	11.60
X173	Myelogram - spine and/or posterior fossa	34.95	27.30
X190	Pantomography	17.75	6.90
X154	Penis.....	15.95	4.70
X165	Photographic subtraction	-	11.35
X176	Sialogram.....	29.80	11.35
X177	Skin thickness measurement.....	15.60	9.20
X183	Ventriculogram.....	48.40	34.70
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 fee for X166 is listed in the Schedule of Facility Fees for Independent Health Facilities.

DIAGNOSTIC RADIOLOGY

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...	121.40	6
# J022	- selective catheterization - add to catheter insertion fee (per vessel, to maximum of 4)..... each	60.15	

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	38.05	
# J056	- transcatheter fibrinolytic therapy	582.45	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
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Note:

J058 claimed same patient same day as G298 is payable at nil.

# J066	Renal angioplasty	438.10	6
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Carotid angiogram

# J031	- direct puncture	89.90	6
# J025	Transluminal angioplasty including angiography (if anatomy is known), with or without pressure measurements - one or more site(s) or vessel(s)	398.15	6

Note:

1. If anatomy unknown at time of procedure, claim J021 and/or J022 at 50%. For simultaneous bilateral punctures and angioplasties, the amount payable for the second angioplasty 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	38.20	6
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# J048	Percutaneous trans-hepatic catheter portal venography	311.05	6
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Peripheral arteriogram

# J027	- direct puncture	76.55	6
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Peripheral venogram

# J026	- direct puncture	61.50	6
# J033	Splenoportogram	111.50	6
# J034	Trans-lumbar aortogram	89.90	6

Vertebral angiogram

# J032	- direct puncture or by retrograde brachial injection.....	111.50	6
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Embolization (e.g. for treatment of haemangioma or renal carcinoma)

# J040	- first vessel, claim appropriate angiographic procedural and radiological fees plus	105.30	
# J047	- each additional vessel catheterized and occluded per vessel	49.35	
# 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.....	29.55	
# J035	Pressure measurements during angiography	29.55	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES		Spec	Anae
# J001	Arthrogram, tenogram or bursogram	29.55	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	437.30	6
# J036	Fistula or sinus injection	26.95	
# J068	Hydrostatic/pneumatic reduction of intussusception.....	44.25	7
# J008	Hysterosalpingogram.....	56.70	6
# J004	Intramammary needling for localization under mammographic control	70.35	
# J009	Laryngogram.....	33.50	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
Lymphangiogram			
# J010	- per side	105.30	
# J037	Mammary ductography	70.35	
# J011	Myelogram	93.40	6
# J038	- with supine views requiring removal and re-introduction of spinal needle	21.75	
# J020	- with posterior fossa views	23.85	
# J012	Nephrotomogram	-	6
# J060	Nephrostogram	29.55	
# J045	Percutaneous antegrade pyelogram	122.10	6
# J055	Percutaneous gastrostomy	223.75	
# J061	Percutaneous cecostomy	223.75	
# J062	Percutaneous cholecystostomy	223.75	
# J063	Percutaneous jejunostomy	259.55	
# J064	Exchange of drainage tubes, including supervision, imaging and hard copy film interpretation if any	72.65	
# J046	Percutaneous nephrostomy	223.75	6
# J041	Percutaneous removal of intravascular and intraureteric foreign bodies	295.25	IC
# J065	Dilation of non-vascular structures	20.50	6
# J059	Non-vascular stenting	101.55	
# J069	Percutaneous radiofrequency ablation using CT or ultrasound guidance	515.70	
Note:			
CT or ultrasound guidance is <i>not eligible for payment</i> when performed in addition to J069.			
# J051	Percutaneous spinal cord puncture for syringogram	94.60	6
# J013	Percutaneous trans-hepatic cholangiogram	105.30	6
# J057	Transjugular intrahepatic portosystemic shunt (TIPS)	787.35	7
# J052	Positive contrast cisternogram	99.90	6
Z597	Intracavitary/intratumoural injections	90.10	7
# J039	Renal cyst puncture	121.95	6
# J018	Sialogram	45.40	6
# J007	Tomogram	-	7
# J028	Urethrogram and/or urethrocystogram and/or intestinal conduit examination, cystogram	29.55	
# J029	Vasogram	59.95	6

Note:

Intubation of small intestine (see Z540 listed in Digestive System - Intestines (except rectum)).

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.]

MAGNETIC RESONANCE IMAGING (MRI)

P

Head

X421	- multislice sequence.....	73.35
E875	- with magnetic resonance spectroscopy, 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, 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

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.

MAGNETIC RESONANCE IMAGING (MRI)

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.

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 usedadd	36.65
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 GP8, 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 physician.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional components* 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 components* 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). Fees for the *technical component* of these services are only billable under the *Independent Health Facilities Act* and are listed in the *Schedule of Facility Fees*.
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 physician 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*.
8. Ultrasound of the abdomen, pelvis or breast, rendered in an Independent Health Facility or a hospital in-patient or out-patient department, is insured when referred by a registered nurse holding an extended certificate of registration (RN(EC)).
9. Ultrasound for normal, complicated or high risk pregnancy (but not for the postpartum period) rendered in an Independent Health Facility or hospital is insured when referred by a midwife.
10. Ultrasound of the face ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department is insured when the ultrasound of the face 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 ultrasound of the face and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.

[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	23.70
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	24.55
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Note:

Heart - Echocardiography - see listings in Diagnostic and Therapeutic Procedures.

Abdomen and Retroperitoneum

Abdominal scan

J135	- complete	48.75	26.55
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 weeks gestation (maximum one per normal pregnancy).....	48.75	26.55
J160	- for high risk pregnancy or complications of pregnancy	48.75	26.55
J166	- multiple gestation, for each additional fetus, to J160..... add	41.45	22.10

Gestational age for Maternal Serum Screening Program

J157	- before 16 weeks gestation (maximum one per normal pregnancy)	32.10	17.55
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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

Note:

J167 is *only eligible for payment* when rendered by a physician for assessment of fetal anemia or intrauterine growth retardation measuring below the 10th percentile.

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 Intracavitory ultrasound* (e.g. transrectal, transvaginal) 48.75 26.55

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 intracavitory 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 J37 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
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Intracavitory ultrasound

J161	- limited - for other than pregnancy	32.10	16.25
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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 intracavitory ultrasound.

J164	Follicle monitoring studies	24.40	12.30
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[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

VASCULAR SYSTEM

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 weeks of J186 or J187 requiring at least 50 minutes...		22.90

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
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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	14.20
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DIAGNOSTIC ULTRASOUND

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 14.20

Note:

Not to be billed unless study specifically requested by referring physician.

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 physician.

DIAGNOSTIC ULTRASOUND

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
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Penile Doppler Evaluation

J199	- doppler scan	6.85	7.80
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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
	Breast		
J127	- scan B-mode (per breast)	23.70	13.10
	Scrotal		
J183	- scan	47.30	23.80

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	-	25.00
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Note:

E475 is payable on a per unit basis. Unit means $\frac{1}{4}$ hour or major part thereof - see General Preamble GP6, GP45 for definitions and time-keeping requirements.

J290	- Spinal sonography	-	30.60
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DIAGNOSTIC ULTRASOUND

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 or 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 components* 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	36.85
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	-	19.65

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 GP8, 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" on page GP8.

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 physician.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional components* 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 components* 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). Fees for *technical component* of services rendered in an Independent Health Facility are listed in the *Schedule of Facility Fees*.
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. Pulmonary function studies ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department are insured when the pulmonary function studies are 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 pulmonary function studies and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.
6. 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, anesthetic 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)	9.30	7.85
J324	- repeat after bronchodilator.....	2.81	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	18.55	10.75
J327	- repeat after bronchodilator.....	2.81	6.45

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 *technical component* of the study complies with the CPSO Clinical Practice Parameters and Facility Standards for Diagnostic Spirometry and Flow Volume Loop Studies; and
 - d. The physician claiming the *professional component* must be able to demonstrate appropriate training in pulmonary function testing interpretation.

[Commentary:

1. For J304 and J327, a computer or automated interpretation in the absence of a documented physician interpretation, are not sufficient for payment purposes.
2. The CPSO Clinical Practice Parameters and Facility Standards for Diagnostic Spirometry and Flow Volume Loop Studies may be found at the following internet link: http://www.cpso.on.ca/uploadedFiles/policies/guidelines/facilities/Diagnostic%20Spirometry_Apr08.pdf.
3. 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	17.55
J307	- by body plethysmography	17.50	17.85
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	16.05
J303	Extra pulmonary airways resistance by plethysmography.....	16.20	16.05
J340	Maximum inspiratory and expiratory pressures	2.81	3.43
J310	Carbon monoxide diffusing capacity by single breath method.....	21.40	18.00
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	50.75
E450	- J315 plus J301 or J304 before and/or after exercise..... add	13.30	8.05
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	18.10	25.05
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	65.40
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	24.50
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	10.80
J334	- J332 with at least two levels of supplemental O ₂	30.55	16.05
J336	- with single blind assessment of exercise on room air and with supplemental oxygen	30.55	16.05

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	34.70
J335	Antigen challenge test	51.85	30.95

Fee

Z459	Arterial puncture for blood gas analysis.....	10.20
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Note:

For *home/self-care ventilation listing* - see Diagnostic and Therapeutic Procedures page J40.

PULMONARY FUNCTION STUDIES

NOT ALLOCATED

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.

- A. Where the services are not identified with prefix #, the *specific elements* are those listed in the General Preamble GP11.
- B. Where the services are identified with prefix #, the *specific elements* are those listed in the General Preamble GP11 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 physician.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the *technical and professional components* 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 components*, 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 physician.
- 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(+).	5.10

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 GP11).

# 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 yearper test	1.60

Hyposensitisation

G202	- each injection	4.45
G212	- when sole reason for visit (including first injection).....	9.75

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
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Ophthalmic tests

+ G203	- direct, to maximum of 3 per year	1.60
+ G204	- quantitative.....	12.40

Patch test

G206	- maximum of 90 per patient, per year	2.39
G198	- for industrial or occupational dermatoses, to a maximum of 125 per patient, per year	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	15.00
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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.

[Commentary:

See General Preamble GP5 for definitions and time keeping requirements.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ALLERGY

		Fee
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
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Skin testing		
G209	- technical component, to a maximum of 50 per year	per test 0.69
G197	- professional component, to a maximum of 50 per year	per test 0.19

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
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 GP59, no anaesthesia service other than E023C is eligible for payment when rendered in support of Z432.

[Commentary:

Refer to E023C on GP63 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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

	Fee	Anae
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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).....	19.90
# Z438	Insertion of Swan-Ganz catheter (not included in anaesthetic, respiratory or critical care benefits)	162.50

Note:

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	168.00	6
# Z457	Surgical removal or repair of implanted central venous catheter	48.90	6
# Z446	Insertion of subcutaneous venous access reservoir	168.00	6
# Z447	- revision same site	74.05	6
# E684	- when performed in infant or child, to Z456 or Z446	add	214.10

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	12.75
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

	Fee	Anae
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BLOOD TRANSFUSIONS

# G275 Exchange transfusion	205.45
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Note:

Assistant at exchange transfusion (see General Preamble GP54).

# G280 Intra-uterine fetal transfusion - initial or subsequent.....	186.90
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G276 Donor cell pheresis (platelets or leukocytes).....	15.35
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Therapeutic plasma exchange

# G277 - initial and repeat, to a maximum of 5 per year	each	82.00
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# G278 - more than 5 per year	each	41.80
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# G272 Manual plasmapheresis (see General Preamble GP8)	I.C
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LDL apheresis

# G287 - initial and repeat, to a maximum of 5 per year	each	82.00
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# G290 - more than 5 per year	each	41.80
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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
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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
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Left heart

# Z440 - retrograde aortic	210.55	7
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# Z441 - transeptal	297.15	7
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# G296 Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab	110.95
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# G285 Dye dilution densitometry when rendered in a cardiac catheter lab using a Swan- Ganz catheter, to Z438	add	32.90
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# G286 Thermal dilution studies when rendered in a cardiac catheter lab using a Swan- Ganz catheter, to Z438	add	32.90
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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
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# G289 Fick determination	110.95
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# G300 Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations.....	110.95
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# G301 Exercise studies during catheterization	122.40
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# G306 Isotope studies during cardiac catheterization.....	110.95
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# G305 Intracardiac phonocardiography	122.40
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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.....	118.70
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Bypass graft angiogram

# G509	- maximum one per bypass graft.....	80.40
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Note:

Includes internal mammary artery implant.

Selective coronary catheterization

# Z442	- both arteries	289.55	6
# G263	- with other drug interventional studies	add	97.40

Note:

Includes injection of intracoronary nitroglycerin.

Transluminal coronary angioplasty

# Z434	- one or more sites on a single major vessel.....	471.60	6
G262	- each additional major vessel	add	212.45

Note:

If anatomy unknown at time of procedure, claim G297 at 50%.

# G298	Coronary angioplasty stent, per stent.....	78.95
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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 arteriosus with umbrella	377.55	20
# Z461	- mitral valvuloplasty for rheumatic stenosis	566.20	

Note:

Z448 to Z461 includes angiography *with or without* pressure measurements.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
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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:

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).]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

	Fee	Anae
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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
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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
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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
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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
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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
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Tilt table testing of vasomotor syncope

# G314	- to include arterial cannulation, provocative and blocking drugs, physician must be continually present	112.00
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

Fee

PREAMBLE

1. ECGs may be requested by a Registered Nurse in the Extended Class (RN(EC)) in non-urgent and non-acute circumstances. Physicians and hospitals should use Fee Codes G313 and G310 for requests by RN(EC)s.
2. An ECG ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department is insured when the ECG 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 ECG and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.
3. 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	6.60
G313	- professional component - must include written interpretation	4.45

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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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.....	43.50
G319	- professional component.....	62.65

Dobutamine stress test

G174	- technical component, when rendered outside of hospital	add	46.75
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Dipyramide Thallium stress test

G111	- technical component.....	50.75
G112	- professional component.....	75.00

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 services* 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).]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

T P

CONTINUOUS ECG MONITORING (E.G. HOLTER)

Level 1

Requires a recorder capable of recording or analyzing and recalling for subsequent analysis all beats and transmitting this information to a scanner which is capable of analyzing or printing every beat and also performing a trend analysis. Minimum 12 hours recording.

G651	- technical component - 12 to 35 hours recording.....	23.90
G652	- technical component - 12 to 35 hours scanning	32.70
G650	- professional component - 12 to 35 hours recording.....	47.90
G682	- technical component - 36 to 59 hours recording.....	47.80
G683	- technical component - 36 to 59 hours scanning	65.40
G658	- professional component - 36 to 59 hours recording.....	75.45
G684	- technical component - 60 hours to 13 days recording	71.65
G685	- technical component - 60 hours to 13 days scanning.....	98.10
G659	- professional component - 60 hours to 13 days recording	95.85
G647	- technical component - 14 or more days recording	112.65
G648	- technical component - 14 or more days scanning	164.00
G649	- professional component - 14 or more days recording.....	122.25

Level 2

All other monitoring devices which record only portions of the monitoring period or do not provide trend analysis. Minimum 12 hours monitoring.

G654	- technical component - 12 to 35 hours recording.....	22.80
G655	- technical component - 12 to 35 hours scanning	15.60
G653	- professional component - 12 to 35 hours recording.....	34.10
G686	- technical component - 36 to 59 hours recording.....	45.60
G687	- technical component - 36 to 59 hours scanning	31.20
G656	- professional component - 36 to 59 hours recording.....	51.15
G688	- technical component - 60 hours to 13 days recording	68.40
G689	- technical component - 60 hours to 13 days scanning.....	46.85
G657	- professional component - 60 hours to 13 days recording	68.20

Note:

1. Maximum one *professional component*, one technical recording component and one technical scanning component per patient, per recording.
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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

T P

Cardiac loop monitoring (per 14 day test)

Patient interactive technology continuously capable of capturing retrospective real-time ECG data and of transferring this data to a remote base station for analysis and interpretation.

G692	- technical component	168.45
G690	- professional component, interpretation	122.25

Event recorder

G661	- technical component	4.00
G660	- professional component	8.65

Interpretation of telephone transmitted ECG rhythm strip

G311	- technical component	1.92
G320	- professional component	4.30

Single chamber reprogramming including electrocardiography

G284	- technical component	8.80
G283	- professional component	11.30

Dual chamber reprogramming including electrocardiography

G181	- technical component	11.55
G180	- professional component	16.95

Pacemaker pulse wave analysis including electrocardiography

G308	- technical component	8.80
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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
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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.....	10.35
G518	- professional component	11.20

Impedance plethysmography

G121	- technical component.....	12.55
G120	- professional component.....	7.00

Digital photoplethysmography

G127	- technical component, per extremity	12.55
G126	- professional component, per extremity	7.00

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ECHOCARDIOGRAPHY

(EFFECTIVE APRIL 1, 2016)

[Commentary:

Paragraphs 1-4 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:

 - a. applied by April 1, 2016 to be accredited by an organization approved by the MOHLTC to grant echocardiography accreditation and whose application has not yet been denied; or
 - b. has been accredited by an organization approved by the MOHLTC to grant echocardiography accreditation.
2. Echocardiography services that are performed at a facility described in paragraph 1a above are *not eligible for payment* unless the organization approved by the MOHLTC to grant echocardiography accreditation is satisfied that the applicant is actively pursuing accreditation.

[Commentary:

1. Actively pursuing accreditation means that documentation is submitted and a site visit is confirmed to the satisfaction of the organization approved by the MOHLTC to grant echocardiography accreditation.
 2. The Cardiac Care Network has been approved by the MOHLTC to grant echocardiography accreditation.
 3. A list of accredited facilities can be found at <http://www.ccnecho.ca/Home/Home.aspx>
3. 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.
 4. 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 <http://www.ccnecho.ca/Standards/DownloadStandards.aspx> and that was in place on the date the service was rendered.

Note:

Documentation of requirements 3a-c must be made available to the MOHLTC on request.

5. Echocardiography services include cardiac monitoring and/or oximetry when rendered.
6. 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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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.....	112.60
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.....	127.85
G583	- professional component.....	110.15

Payment rules:

G570, G571, G574 or G575 are *not eligible for payment* with G582 or G583.

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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 weeks of a complete study to re-evaluate a specific finding or question.]

G574 - technical component 16.05

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 126.75

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 months prior to September 1, 2011; and
 - 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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 internet link:

http://www.ccs.ca/images/Guidelines/Guidelines_POS_Library/Echo_STDP_2004.pdf

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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)	110.55
G523	- second ¼ hour (or part thereof)	55.20
G522	- after first ½ hour, per ¼ hour (or part thereof).....	36.35
G391	Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof).....	28.35

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.

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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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)	56.80
G391	- after first ¼ hour per ¼ hour (or part thereof).....	28.35

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.

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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CRITICAL CARE

Fee

[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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 anaesthetist(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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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	146.45
# G402	- 31st day onwards	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	193.45
# G406	- 2nd to 30th day, inclusive	101.55
# G407	- 31st day onwards.....	67.60

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.

Physician-in-charge

# G557	- 1st day	325.40
# G558	- 2nd to 30th day, inclusive.....	213.50
# G559	- 31st day onwards.....	85.35

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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	358.00
# G601	- 2nd to 30th day, inclusive.....per diem	178.95
# G602	- 31st day onwards,.....per diem	89.40
# 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.....	536.95
# 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	245.65
# G611	- 2nd day onwards,.....per diem	122.80

Level C

Intermediate care including one or more of oxygen administration, non-invasive monitoring or gavage feeding

# G620	- 1st day	155.20
# G621	- 2nd day onwards,.....per diem	77.60

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/anaesthetists providing complete care. If *infant* has been transferred from one level to another in either direction, up or down, second day benefits apply.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CRITICAL CARE

Fee

HYPERBARIC OXYGEN THERAPY (HBOT)

Hyperbaric Oxygen Therapy is the service rendered when a physician administers and supervises HBOT. 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; and
 - b. The treatment is initiated within 14 days of a diagnosis of ISSHL is made or confirmed by an Otolaryngologist.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
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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 October 1, 2013, the following indications were approved by the ministry. For current information please contact a *medical consultant*.

- 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
- idiopathic sudden sensorineural hearing loss (ISSHL)]

Hypothermia induction

# G210	Hypothermia (therapeutic) induction and management	190.75
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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
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Payment rules:

G556 is payable once per patient per hospital admission.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 or physiotherapy clinic prescribed as a health facility under sub-section 35(10) under Regulation 552 of the *Health Insurance Act*.

+ G470 Ultraviolet light therapy	7.85
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[Commentary:

See General Preamble GP42 for conditions and limitations regarding delegation and supervision of G470.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DIALYSIS

Asst	Fee	Anae
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Note:

Team benefits to include listed items. This does not include preliminary investigation of the case.

Haemodialysis

# R849	Initial and acute (includes both medical and surgical components).....	621.35	6
# R850	Surgical component alone - insertion of Scribner shunt	313.25	7
G325	Medical component alone.....	317.25	
# G323	Acute, repeat - for the first 3 services	158.60	
# G083	Continuous venovenous haemodialysis - initial and acute (for the first 3 services).....	380.75	
# G091	Continuous arteriovenous haemodialysis - initial and acute (for the first 3 services).....	253.85	
# G085	Continuous venovenous haemofiltration - initial and acute (for the first 3 services).....	369.65	
# G295	Continuous arteriovenous haemofiltration - initial and acute (for the first 3 services).....	246.45	

Note:

Haemodialysis to include haemofiltration, haemoperfusion.

Continuous haemodiafiltration

# G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services).....	444.15	
# G092	Continuous arteriovenous haemodiafiltration - initial and acute (for the first 3 services).....	317.25	
# G094	Chronic, continuous haemodiafiltration.....	67.00	

Slow continuous ultrafiltration

# G090	Venovenous slow continuous ultrafiltration - initial and acute (for the first 3 services).....	317.25	
# G294	Arteriovenous slow continuous ultrafiltration - initial and acute (for the first 3 services).....	184.75	
# G096	Chronic, slow continuous ultrafiltration	67.00	

Revision of Scribner shunt

# Z450	- single.....	102.55	7
# Z451	- both	152.40	6
# Z452	De-clotting of Scribner shunt	93.60	
# R843	Removal of cannula or A.V. shunt.....	101.00	7
# R827	Creation of A.V. fistula	440.00	7
		6	

Note:

R827 - see also listing under Cardiovascular System, Veins - Repair.

Bypass graft for haemodialysis

# R851	- synthetic.....	444.70	7
# R840	- autogenous vein.....	424.10	7

Subclavian or external 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	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DIALYSIS

		Asst	Fee	Anae
Peritoneal dialysis				
# G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary).....	219.50		
# G331	Repeat acute (up to 48 hours) - for the first 3 services	197.55		
# R852	Insertion of peritoneal cannula by laparotomy or laparoscopy	256.10	6	
# R885	Removal of peritoneal cannula by laparotomy or laparoscopy	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	Declothing 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 weekly 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 *specialists* 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.

Chronic dialysis weekly team fee

# G860	Hospital haemodialysis	127.20
# G861	Hospital peritoneal dialysis	127.20
# G862	Hospital self-care haemodialysis or satellite haemodialysis	127.20
# G863	Independent health facility haemodialysis	127.20
# G864	Home peritoneal dialysis.....	127.20
# G865	Home haemodialysis	127.20
# G866	Intermittent haemodialysis - at an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above).....	68.80

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 weekly team fee paid at the full amount, regardless of the number of treatments rendered.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
+ G342	Implantation of hormone pellets.....	31.05
+ G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination.....	49.80

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, fax or e-mail 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.
- C. Discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), by telephone, fax or e-mail 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ENDOCRINOLOGY AND METABOLISM

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
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GASTROENTEROLOGY

P

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 - oesophageal motility study(ies) with manometry 76.05

G353 - oesophageal acid perfusion test and/or provocative drug testing 28.75

G251 - oesophageal pH study for reflux, with installation of acid 27.05

G351 - oesophageal pH study for reflux, with installation of acid, with 24 hour monitoring 31.85

G354 Anal-rectal manometry..... 38.50

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GASTROENTEROLOGY

		Fee
G254	Management of post liver, lung or pancreas transplant immunosuppression - in lieu of non-emergency hospital visits in-patient visits	per visit 34.70

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 weeks post liver, lung or pancreas transplant surgery.

G349	Oesophageal tamponade (Blakemore bag) - insertion	45.30
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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.....	6.60
G166	- professional component.....	10.45

P

# G332	Capsule endoscopy	122.25
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Payment rules:

G332 is only insured when rendered for the purpose of identifying gastrointestinal bleeding of obscure origin when all appropriate conventional techniques have failed to identify a source.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GYNÄCOLOGY

		Fee
G363	Cervical mucous penetration test	22.00
+ G364	Postcoital test of cervical mucous.....	17.60
G378	Insertion of intrauterine contraceptive device	25.50
E542	- when performed outside hospital.....add	11.15
+ G362	Insertion of laminaria tent	6.25
E870	- when laminaria tent supplied by the physicianadd	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.]

Papanicolaou smear

+ G365	- periodic	6.75
E430	- when papanicolaou smear is performed outside of hospital, to G365 add	11.55

[Commentary:

E430 is payable when the requirements for G365 are met.]

Payment rules:

1. G365 is limited to one per patient per 33 month period.
2. G365 is uninsured for patients less than 21 years of age.
3. G365 is uninsured for patients older than 70 years of age who have had three or more normal tests in the prior 10 years.
4. G365 is *not eligible for payment* when performed in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment or routine post-natal visit.

[Commentary:

1. Periodic Papanicolaou smears in excess of the limit are not insured.
2. Guidelines for cervical screening can be found at <https://www.cancercare.on.ca/>
3. Current guidelines recommend routine Pap smear screening once every 36 months. The schedule period of 33 months is in recognition that some patients may be seen just prior to the recommended time interval.]

+ G394	- additional for:	
	- follow-up of abnormal pap smear; or	
	- follow-up of inadequate pap smear; or	
	- annually in a patient who is immunocompromised, e.g. HIV-positive or taking long-term immunosuppressants; or	
	- a patient with a history of oncogenic HPV-typing; 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.....	6.75

Medical record requirements:

Physicians claiming G394 must have documentation of an abnormal or inadequate Pap result for which a follow-up is required or documentation of the cause of the immunocompromised status or documentation of difficulties in accessing the service within the specified time period otherwise G394 is *not eligible for payment*.

E431	- when papanicolaou smear is performed outside of hospital, to G394 add	11.55
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Note:

The papanicolaou smear is included in the 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. However, the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured papanicolaou smear is performed outside hospital.

[Commentary:

E431 is payable when the requirements for G394 are met.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GYNÄCOLOGY

	Fee
Z463 Removal of Norplant	65.30

Pessary

G398 Medical management of prolapse - initial pessary fitting or re-fitting as required. This service is eligible for payment in addition to any applicable consultation or assessment. Maximum one per patient per 12 month period	61.30
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[Commentary:

G398 is *not eligible for payment* for routine follow-up insertion of a pessary as that service is included as an element of the assessment or consultation.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

HAEMATOLOGY

Fee

HAEMOGLOBINOPATHIES AND CONGENITAL HAEMOLYTIC ANAEMIAS

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 Anaemia. 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

HOME AND SELF CARE SERVICES

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
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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
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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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

Fee

BOTULINUM TOXIN SERVICES	
G870	Botulinum toxin injection(s) of extraocular muscle(s), (unilateral)
G871	Botulinum toxin injection(s) for blepharospasm, (unilateral or bilateral)
G872	Botulinum toxin injection(s) for hemifacial spasm, (unilateral or bilateral)
G873	Botulinum toxin injection(s) for spasmodic dysphonia
G874	Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral)
	120.00
	120.00
	120.00
	120.00
	50.00

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	- with EMG guidance (when required to determine the injection site), for one injection, to G870, G873, G874, or G875	add 18.85
G878	- with EMG guidance (when required to determine the 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
G879	- with ultrasound guidance (when required to determine the injection site), for one injection, to G870, G873, G874 or G875	add 18.85
G880	- with ultrasound guidance (when required to determine the injection site), for two or more injections, to G870, G873, G874 or G876	add 28.10

Payment rules:

1. When used to determine the injection site, EMG or ultrasound services other than G877, G878, G879 or G880 are *not eligible for payment* with Botulinum toxin services.
2. All Botulinum toxin services are limited to one treatment per condition, per patient every 10 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.

[Commentary:

Botulinum toxin injection(s) for indications other than those listed above are not insured services.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 G370add	11.15	
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 G328add	11.15	
E446	- peripheral joint injection using image guidance following a failed blind attempt, to G370 or G371	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 services* 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 <http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/ohtas-reports-and-ohtac-recommendations/intra-articular-viscosupplementation-with-hylan-g-f-20-to-treat-osteoarthritis-of-the-knee>
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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

Fee Anae

INTRAMUSCULAR, SUBCUTANEOUS OR INTRADERMAL

G372	- with visit (each injection)	3.89
G373	- sole reason (first injection)	6.75
G372	- each additional injection	3.89

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	4.50
+ G841	Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric	4.50
+ G842	Hepatitis B (HB)	4.50
+ G843	Human Papillomavirus (HPV)	4.50
+ G844	Meningococcal C Conjugate (Men-C).....	4.50
+ G845	Measles, Mumps, Rubella (MMR)	4.50
+ G846	Pneumococcal Conjugate.....	4.50
+ G847	Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult.....	4.50
+ G848	Varicella (VAR).....	4.50
+ G538	Other immunizing agents not listed above.....	4.50
+ G590	Influenza agent	4.50

INTRALESIONAL INFILTRATION

+ G375	- one or two lesions	8.85
+ G377	- 3 or more lesions	13.30
G383	- extensive (see General Preamble GP8)	I.C

Note:

Intralesional injection of acne lesions with corticosteroids is not an insured service.

G462	Administration of oral polio vaccine	1.65
+ 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)	4.55

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 or G281, injections into established I.V. apparatus may not be claimed.

G389	Infusion of gamma globulin, initiated by physician, including preparation 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.
3. For Intravenous drug test for pain, see Z811 p. X1.]

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.

SPECIFIC ELEMENTS

For Management of parenteral alimentation

In addition to the *common elements*, this service includes the *specific elements* of assessments (see General Preamble GP11). Not to be claimed in addition to hospital visits.

G510	Management of parenteral alimentation - physician in charge per visit.....	21.00
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

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, G281, 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, G281, 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	54.25
G281	- each additional standard chemotherapy agent, other than initial agent.....	7.70

[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
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[Commentary:

Examples of complex single agents include rituximab, 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
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[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 cytosine, 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.]

G075	Test dose (bleomycin and l-asparaginase) once per patient per drug	30.50
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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)	262.40
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Monthly telephone supervision

G382	Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, monthly	13.30
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 chemotherapy for a period of twenty-one (21) days following initiation of the agent(s).

G388 Management of special oral chemotherapy, for malignant disease..... 20.50

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 every twenty-one (21) days to a maximum of six (6) services per patient per *12 month period*.

[Commentary:

Examples of special oral chemotherapy include fludarabine, imatinib, dasatanib, nilotinib, erlotinib, capecitabine, sunitinib, sorafenib, thalidomide, temazolamide and lenalidomide.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 physician, 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 (lipoma, debridement); spermatocele; tendon or tendon sheath; testicular appendage; thrombus or embolus; uterine contents (induced abortion); varicocele; vas deferens (other than sterilization).

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*).

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

LABORATORY MEDICINE

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.

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 components* 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).

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

LABORATORY MEDICINE

Fee

INTERPRETATION OF ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY

Anatomic Pathology - Surgical Pathology

L861	Surgical Pathology, Level 1	5.20
L862	Surgical Pathology, Level 2	8.45
L863	Surgical Pathology, Level 3	14.30
L864	Surgical Pathology, Level 4	48.65
L865	Surgical Pathology, Level 5	103.20
L866	Surgical Pathology, Level 6	181.65
L867	Surgical Pathology, Unlisted specimens	46.65
L822	Operative consultation, with or without frozen section.....	77.20
L823	- each subsequent frozen section or direct smear and/or selection of tissue for biochemical assay e.g. estrogen receptors	add 38.25
L801	Metabolic bone studies	95.30
L833	Nerve teasing.....	140.75

Anatomic Pathology - Cytopathology

L812	Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation	4.60
L805	Aspiration biopsy e.g. lung, breast, thyroid, prostate	79.00
L806	Bronchial, oesophageal, gastric, endometrial or other brushings and washings....	35.45
L808	Imprint, touch preparation and/or direct smear.....	36.35
L815	Sputum per specimen for general and/or specific assessment e.g. cellular abnormalities, asbestos bodies, lipids, haemosiderin.....	36.35
L804	Smear, specific assessment e.g. eosinophils, asbestos bodies, amniotic fluid cells for estimation of fetal maturation.....	14.30
L810	Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	22.05
L824	Synovial fluid analysis, including description, viscosity, mucin clot, cell count, and compensated polarized light microscopy for crystals.....	24.70
L825	Compensated polarized light microscopy for synovial fluid crystals	12.80
L819	Seminal fluid analysis for infertility, including count, motility and morphology	13.60
L848	Seminal fluid analysis - quantitative kinetic studies, including velocity linearity and lateral head amplitude.....	29.65
L820	Smear for spermatozoa	6.05

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

LABORATORY MEDICINE

		Fee
Cytogenetics		
L807	Smear for sex chromatin (Barr Body) or Neutrophil drumsticks	4.95
L811	Y chromosome.....	6.05
L803	Karyotype.....	73.95
Special Procedures and Interpretation - Histology or Cytology		
L834	Histochemistry of muscle - 1 to 3 enzymes	11.85
L835	- each additional enzymeadd	11.85
L841	Enzyme histochemistry and interpretation - per enzyme	11.85
L837	Immunohistochemistry and interpretation - per marker	15.60
L868	Special histochemistry for identification of microorganisms.....	35.05
L869	Special histochemistry for identification of elements other than microorganisms....	15.55
L817	Anti-tissue antibodies and interpretation - per case.....	6.05
L842	- anti-tissue antibodies, screening dilution, titration and interpretationadd	8.45
L849	Interpretation and handling of decalcified tissue	12.80
L843	Special microscopy of tissues including polarization, interference phase contrast, dark field, autofluorescence or other microscopy and interpretation.....	19.80
L844	Special microscopy of fluids (polarization, interference, phase contrast, dark field, autofluorescence or other microscopy and interpretation).....	12.80
L845	Specimen radiography or microradiography and interpretation	10.40
L832	X-ray diffraction analysis and interpretation.....	23.70
L816	Electron microscopy by TEM, STEM or SEM technique	97.95
L831	- analytical electron microscopy, elemental detection or mapping, electron diffraction, per caseadd	49.35
L836	Morphometry per parameter	24.70
L846	Flow cell cytometry and interpretation - per marker.....	11.85
L847	Caffeine - halothane contracture test and other confirmatory tests for malignant hyperthermia	65.15
Biochemistry and Immunology		
L827	Interpretation of carcinoembryonic antigen (CEA).....	5.30
L828	Interpretation of hormone receptors for carcinoma to include estrogen and/or progesterone assays.....	7.95
Haematopathology		
L800	Blood film interpretation (Romanowsky stain).....	20.85
L826	Blood film interpretation (special stain).....	11.85
L802	Bone marrow interpretation (Romanowsky stain).....	44.45
Z403	Bone marrow aspiration.....	33.90
L830	Terminal transferase by immunofluorescence	11.85
L838	Leukocyte phenotyping by monoclonal antibody technique	19.80
L829	Haemoglobinopathy interpretation (payable for abnormal results only).....	12.90

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Laboratory Medicine

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).....	11.37
G016	TSH (thyroid stimulating hormone).....	9.82
G017	Prolactin.....	14.48
G018	Estradiol.....	28.44
G019	LH (luteinizing hormone).....	9.31
G020	Progesterone	14.48
G021	HCG (human chorionic gonadotrophins) quantitative.....	15.51

Note:

G021 is *not eligible for payment* for pregnancy tests. See G005.

G022	Testosterone	14.48
G023	Testosterone, free	25.85
G024	Androstenedione.....	38.78
G025	Dehydroepiandrosterone sulphate (DHEAS).....	20.68
G026	17-OH progesterone	31.02
G027	Seminal fluid examination (complete).....	11.37
G028	Cervicovaginal mucous specimen for cellular analysis for postcoital testing.....	10.34

Note:

G028 is *not eligible for payment* for obtaining, preparing or interpreting a papanicolaou smear.

G029	Antithrombin III assay	28.44
G030	Circulating anticoagulant (e.g., lupus anticoagulant).....	5.17
G032	Anti-DNA.....	23.27
G033	Anti-RNA.....	23.27
G034	Serial tube 4 or more antigens.....	15.51
G035	Titre - serial tube single antigen.....	7.76
G036	Sperm antibodies – screen	10.34
G037	Sperm antibodies – titre	20.68

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

LABORATORY MEDICINE

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
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Payment rules:

1. For the purposes of opioid agonist maintenance treatment, G040, G042, G041 and G043 are *only eligible for payment* to a physician who has an active general exemption for methadone maintenance treatment or chronic pain treatment with methadone pursuant to Section 56 of the *Controlled Drugs and Substances Act* 1996.
2. 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.
3. 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.
4. 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.
5. 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.
6. G039 is limited to a maximum of two (2) tests per patient per *week*, any physician.
7. G039 is *only eligible for payment* when rendered to rule out urine tampering.
8. Only one of G040, G041, G042 or G043 is eligible for payment per urine sample.

C. Miscellaneous Tests

G031	Prothrombin time	6.20
G001	Cholesterol, total	5.50
G002	Glucose, quantitative or semi-quantitative	2.18
G481	Haemoglobin screen and/or haematocrit (any method or instrument).....	1.32
G004	Occult blood.....	1.53
G005	Pregnancy test.....	3.88
G009	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)...	4.30
G010	One or more parts of above without microscopy	2.07
G011	Fungus culture including KOH preparation and smear.....	12.60
G012	Wet preparation (for fungus, trichomonas, parasites).....	1.86
G014	Rapid streptococcal test	5.50

Payment rules:

G009 and G010 are not insured when rendered for the monitoring of adverse effects resulting from a calorie restricted weight loss program.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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	192.10
# 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.....	242.90
# G408	2nd to 10th day, inclusiveper diem	121.45
# G409	11th to 21st day, inclusiveper diem	60.70

Note:

G412, G408, G409 includes complete patient care.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 weeks.
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, E111A 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
# G222	Spinal or epidural injection of narcotic (duration of action more than 4 hours).....	55.00

Payment rules:

G222 is *not eligible for payment* with G248, G125, G118 or G062.

[Commentary:

Spinal or epidural injection of short-acting narcotics such as fentanyl or sufentanil does not constitute G222 and is *not eligible for payment.*]

G260	Major plexus block.....	80.00
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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
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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.*

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
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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
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# G065 Epidural blood patch injected through existing epidural catheter	62.50
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G224 Nerve block by same physician performing the procedure.....	15.55
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[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
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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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

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, fax or e-mail 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*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

PREAMBLE

- 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.]

- 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.
- For anaesthesia services in support of interventional pain injection procedures, see General Preamble Anaesthesiologist Services.
- Injections listed in this section include the injection of contrast, medication and/or other solution, unless separately listed.
- 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.]

- 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.
- 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:

- 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
- the purpose of any diagnostic pain-related injection and the subsequent response to the procedure, indicating a positive or negative result.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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	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 MOHLTC. 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.

Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy

# N556	First site	142.80	6
# E396	- each additional site to N556	71.40	

Sacroiliac joint injections

G916	Percutaneous diagnostic and/or corticosteroid sacroiliac joint injection with fluoroscopic guidance, unilateral.....	75.00
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Nerve root injections

G917	Percutaneous diagnostic selective nerve root block with fluoroscopic guidance, with or without contrast – any number of sites	160.00
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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*.

# N534	Percutaneous radio frequency posterior dorsal root rhizotomy - any number of levels.....	379.45	8
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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

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 G918add	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 G918add	80.00
# E833	- with insertion of subcutaneous port, G117, G119, G246 or G918add	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 MOHLTC. 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 anesthetic 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 J57.
2. For epidural blood patch, refer to G068 and G065 page J56.]

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 anesthetic 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

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 MOHLTC. 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
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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 eligible for payment same patient same *day* with G232.

[Commentary:

For percutaneous provocation vertebral discography, refer to J006 Discogram page E3.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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. Local infiltration used as an anesthetic for any procedure is *not eligible for payment*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCKS - PERIPHERAL/OTHER INJECTIONS

	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 GP28.]

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
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%

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NEUROLOGY

		Fee
Z804	Lumbar puncture.....	67.60
# Z805	- with instillation of medication or other therapeutic agent	75.10
Note:		
Z804 and Z805 are <i>not eligible for payment</i> with C-suffix anaesthesia services rendered for surgical procedures, obstetrical anaesthesia procedures or with epidural services described in the nerve block sections of the <i>Schedule</i> .		
E871	- lumbar puncture using image guidance following a failed blind attempt, to Z804 or Z805	add 25%.
Note:		
E871 is <i>only eligible for payment</i> when a lumbar puncture 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 images for the purpose of guidance of the lumbar puncture are <i>not eligible for payment</i> to any physician.		
# 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.		
G419	Tensilon test.....	20.60
# 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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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.....	24.40
G415	Routine EEG - professional component	23.15
G418	Routine EEG - professional component (16 - 21 channel EEG).....	50.00

Sleep-deprived/induced EEG

A sleep-deprived/induced EEG is an EEG recording (*with or without* video monitoring) performed after:

- a. an overnight period of sleep deprivation of greater than 4 hours; or
- b. the administration of a sedative/hypnotic agent prior to the EEG recording for the purposes of sleep induction.

G541	- technical component.....	39.00
G543	- professional component.....	60.00

Note:

1. G543 is *only eligible for payment* if the EEG recording includes 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.

2. The amount payable for a sleep-deprived/induced EEG that does not meet the above requirements will be reduced to that for a routine EEG fees (i.e. G414 and G415/G418).

[Commentary:

Examples of physiological parameters include ECG, respirations, EMG, extra-ocular movements, oxygen saturation, and temperature.]

3. G414 is *not eligible for payment* with G541.

4. G415 and G418 are *not eligible for payment* with G543.

5. 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).

Prolonged EEG monitoring

Videotape recording of clinical signs in association with spontaneous EEG. Unit means $\frac{1}{4}$ hour or major part thereof. See General Preamble GP5 for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG.

G540	- technical component.....	per unit	9.05
G545	- professional component.....	per unit	14.70

Note:

G540 and G545 are each limited to a maximum of 12 units.

Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add to routine fees.

G542	- technical component	23.10
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.....	46.30
G555	- professional component.....	47.75

Polygraphic recording of parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.)

G544	- technical component, per item	add	8.30
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Note:

G544 limited to a maximum of 3.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NEUROLOGY

T

P

EVOKED POTENTIALS

Upper or lower limbs

G140	- technical component.....	40.15
G138	- professional component.....	71.65

Note:

When only one limb is tested, claim the applicable fee - G140 or G138 at 50%.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 Z819, 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 *referrals*, 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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, G791 or 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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OPHTHALMOLOGY

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	41.60	6

[Commentary:

Follow up services are payable in addition to contact lens fitting (G424) for *children* 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
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Note:

G424, G423 - Contact lens fitting is not a benefit except under certain specific conditions. Please check with the Ministry of Health and Long-Term Care *Medical Consultant*.

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
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Note:

G435 may not be claimed in conjunction with an ophthalmological consultation or specific assessment as this is included in these services.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OPHTHALMOLOGY

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.....	20.40
G438	- professional component.....	22.15

Dark adaptation curve (Goldmann adaptometer or equivalent)

G851	- technical component.....	30.55
G437	- professional component.....	22.90

Electro-retinography with report

G852	Full field or multi-focal electro-retinography - technical component.....	33.15
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.....	21.95
G425	- professional component.....	44.40

Fluorescein angiscopy

G854	- technical component.....	6.40
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.....	6.30
G428	- professional component.....	6.85

Tonomography (to include tonometry) with or without water

G856	- technical component.....	9.05
G433	- professional component.....	9.90

Visual fields - kinetic (with permanent record)

G857	- technical component.....	4.40
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.....	13.30
G432	- professional component.....	26.95

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
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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.

G811	Keratometry, professional component	4.80
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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
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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
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Payment rules:

Specular photomicroscopy rendered for other indications is not an insured service.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 <i>12 month period</i> and a maximum of 16 services per patient for 24 consecutive <i>months</i> .	
2. G822 is <i>only eligible for payment</i> 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 <i>12 month period</i> .	
2. G818, G820, G821 and G822 are <i>not eligible for payment</i> 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 <i>not eligible for payment</i> .	
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 <i>only eligible for payment</i> 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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OPHTHALMOLOGY

Fee

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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OPHTHALMOLOGY

T P

Visual evoked response - simple

G149	- technical component.....	17.60
G147	- professional component.....	12.30

Visual evoked response - threshold

G152	- technical component.....	30.10
G150	- professional component.....	19.20

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 months 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 months.
2. PDT performed for treatment of clinical conditions other than described above is uninsured.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OTOLARYNGOLOGY

		Fee
#	G103 Debridement of maxillectomy cavity	6.05
+	G420 Ear syringing and/or extensive curetting or debridement unilateral or bilateral	11.25
Note:		
	G420 is <i>not eligible for payment</i> when rendered in addition to Z906, Z907, Z908 or Z913.	
+	G403 Particle repositioning maneuvre for benign paroxysmal positional vertigo	21.15

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 GP42.
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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OTOLARYNGOLOGY

T P

BASIC DIAGNOSTIC HEARING TESTS

Pure tone threshold audiometry with or without bone conduction

G440	- technical component.....	10.30
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.....	17.90
G526	- professional component.....	15.70

ADVANCED DIAGNOSTIC HEARING TESTS

Impedance audiometry by manual or automated methods

G442	- technical component.....	3.25
G529	- professional component.....	1.86

Note:

G442, G529 *may include* stapedial reflex and/or compliance testing.

Sound field audiometry (*infants and children*)

G448	- technical component.....	21.70
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	7.80
G530	- professional component, to a maximum of 1	per test	5.95

Cortical evoked audiometry

G143	- technical component.....	36.00
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.....	36.00
G144	- professional component.....	19.15

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OTOLARYNGOLOGY

T

P

Electrocochleography (per ear): to include myringotomy if performed

G815	- technical component.....	36.00
G816	- professional component.....	104.45

DIAGNOSTIC BALANCE TESTS

Positional testing with electronystagmography (ENG)

G104	- technical component.....	18.55
G105	- professional component.....	20.90

Caloric testing with ENG

G451	- technical component.....	18.55
G533	- professional component.....	18.30

Fee

G454	Stroboscopy.....	16.80
G191	Optokinetic tests	12.40
G108	Computerized rotation tests	20.20

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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	17.75
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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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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	62.75
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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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PHYSICAL MEDICINE

T

P

NEEDLE ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

PREAMBLE

- 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 physician in addition to the EMG.
- 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.
- 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*.
- 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.....	27.40
G456	- professional component.....	99.90

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.....	18.40
G457	- professional component	61.95

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PHYSICAL MEDICINE

T

P

Schedule C

A complete procedure for complex neuromuscular disorders requiring a minimum of 60 minutes to perform the procedure that includes either:

- a. at least two motor and sensory NCS in each of three limbs; and
- b. needle EMG studies of at least two muscles in two separate segments.

or

- a. at least two motor and sensory NCS in two limbs;
- b. needle EMG studies of at least two muscles in each of two separate segments; and
- c. repetitive nerve stimulation studies of at least one nerve/muscle pair.

Note:

For the purposes of G471/G473, the cranial, cervical, thoracic and lumbosacral regions represent separate segments.

G471	- technical component.....	27.40
G473	- professional component, when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results	191.00

Payment rules:

1. G473 is *not eligible for payment* with G456 or G457 same patient same day.
2. G471 is *not eligible for payment* with G455 or G466 same patient same day.
3. 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 GP6 and GP45 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.]

	Fee
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Single fibre electromyography

G458	Single fibre electromyography	191.70
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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	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	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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PSYCHIATRY AND RESPIRATORY DISEASE

Fee Anae

PSYCHIATRY

Electroconvulsive therapy (ECT) cerebral - single or multiple

# G478	- in-patient	80.30	6
# G479	- out-patient	92.60	6

Note:

Electrosleep therapy or Sedac therapy are not insured benefits.

RESPIRATORY DISEASE

G404	Chronic ventilatory care outside an Intensive Care Unit.....	61.00
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Note:

Maximum 2 per week. Any other amount payable for consultations or assessments same patient, same physician, same day will be reduced to nil.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 months 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 and Long-Term Care 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 components*.

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). Fees for the *technical component* of these services are only payable under the *Independent Health Facilities Act* and are listed in the *Schedule of Facility Fees*.

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 MOHLTC. Despite the foregoing, where prior approval to exceed a limit is not requested from the MOHLTC 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 GP5.]

Claims submission instructions:

Submit claims for *professional and technical components* 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)

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 components*.]

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*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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
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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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

SLEEP STUDIES

H I 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 independent health facility.]

- ii. where the previous study was rendered at an independent health facility and the repeat diagnostic study is rendered at a different independent health facility (the “different facility”) than the independent health facility 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 *Independent Health Facilities Act*; 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
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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 J90, “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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

SLEEP STUDIES

H P

Therapeutic study for sleep related breathing disorders - Level 1

J895	- therapeutic study.....	370.75	97.50
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Payment rules:

1. There is a limit of one therapeutic study per patient during any two consecutive *12 month periods* 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.
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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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 *adults* with conditions such as amyotrophic lateral sclerosis or polio; or
- b. a paediatric hospital where there is a Paediatric ICU and that treats *children* 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
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Specialized facility therapeutic study

J889	- therapeutic study.....	370.75	97.50
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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
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J894	Maintenance of wakefulness test.....	68.95	49.90
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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).

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

UROLOGY

		Fee	P
#	G900 Residual urine measurement by ultrasound	12.70	
Note:			
Residual urine measurement by ultrasound (G900) is <i>not eligible for payment</i> 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 <i>with or without</i> 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 EMGadd	8.35	
G477	Interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel).....	5.40	
+ G476	Prostatic massage	5.40	

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 GP14).
- 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 GP58).
- 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 GP14).
- 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 GP14) 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 GP54).

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 *monthly* visits to 28 weeks, 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.
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 anaesthetist, 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 *newborns* to another physician, the latter may not claim a consultation for these *transfers*. 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 *newborns* 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.

OBSTETRICS

PREAMBLE

- 14.** Physicians may claim for assisted breech delivery (P020) when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and head.
- 15.** See General Preamble GP65 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 anaesthetist should add the suffix "C" to the listed procedural code.

OBSTETRICS

PRENATAL CARE

Asst Surg Anae

P003	General assessment (major prenatal visit)	77.20
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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	45.15
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P004	Minor prenatal assessment	33.70
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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	74.70
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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	161.15
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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	207.80
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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.]

OBSTETRICS

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 33.70

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 399.00

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.]

OBSTETRICS

LABOUR DELIVERY

		Asst	Surg	Anae
# P006	Vaginal		498.70	
# P020	Operative delivery, i.e. mid-cavity extraction or assisted breech delivery.....		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	837.25	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 *infants*, 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
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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*.

P009	Attendance at labour and delivery	498.70
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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
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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 GP44 for definition of special visit.

C989	- special visit for first obstetrical delivery with sacrifice of office hours	76.40
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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%
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OBSTETRICS

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	93.80	6
P007	Postnatal care in hospital and/or home	55.15	
P008	Postnatal care in office	33.70	

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 GP60				
# P014C	- introduction of catheter for labour analgesia including first dose	-	6	
# E111A	Combined spinal-epidural for labour analgesia, to P014C add	50.00		
# P016C	- maintenance of obstetrical epidural anaesthesia (one unit for each $\frac{1}{2}$ hour to a maximum of 12)	-		
# E100C	attendance at delivery - per $\frac{1}{4}$ hour - time units only	-		

Payment rules:

1. Anaesthesia extra units listed on GP61 are *not eligible for payment* with P014C except for E010C, E022C and E017C.
2. G222, Z804 or Z805 are *not eligible for payment* with P014C or P016C.
3. Anaesthesia extra units listed on GP61 are *not eligible for payment* with P016C or E100C.

[Commentary:

Anaesthesia extra units listed on GP61 and G222 are eligible for payment with other C-suffix anaesthesia service rendered the same day as P014C/P016C/E100C, unless otherwise listed.]

OBSTETRICS

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
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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
# Z777	Breech presentation - external cephalic version <i>with or without</i> 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 cauterity 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.

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 SERVICES WHICH ARE NOT LISTED AS A "Z" CODE

In addition to the above, the fee for this service includes the following:

1. Pre-operative Care and Visits

Pre-operative hospital visits which take place 1 or 2 days prior to surgery.

2. Post-operative Care and Visits

Post-operative care and visits associated with the procedure for up to two weeks post-operatively, and making arrangements for discharge, to a hospital in-patient except for:

- a. the first and second post-operative visits in hospital (payable at the specialty specific subsequent visit fee); and
- b. subsequent visit by the *Most Responsible Physician (MRP)* - day of discharge (C124).

The *specific elements* for pre- and post-operative visits are those for assessments.

[Commentary:

For surgical services not listed with a "Z" code, C122 or C123 (subsequent visit by the *MRP* - day following, or second day following the hospital admission assessment) and C142 or C143 (first and second subsequent visits by the *MRP* following transfer from an Intensive Care Area/Neonatal Intensive Care) are *not eligible for payment* to the surgeon for visits rendered either 1 or 2 days prior to surgery or in the first two weeks following surgery.]

SURGICAL PREAMBLE

PREAMBLE

OTHER TERMS AND DEFINITIONS

FOR DEFINITION OF THE ROLE OF THE SURGICAL ASSISTANT - SEE GENERAL PREAMBLE GP54.

FOR DEFINITION OF THE ROLES OF THE ANAESTHESIOLOGIST - SEE GENERAL PREAMBLE GP58.

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.

If special visits to hospital are required at any time post-operatively, the surgeon may claim the minimum special visit premiums even if the basic hospital visit fees may not be claimed (under these circumstances the hospital visits should be claimed on an N/C (\$00.00) basis).

The surgical benefit as noted above does not include the major pre-operative visit - i.e. the consultation or assessment fee which may be claimed when the decision to operate is made and the operation is *scheduled*, 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.

Routine subsequent hospital visits may be claimed for visits rendered more than two days prior to surgery. Other visits (excluding admission assessments) prior to admission may be claimed for in addition to the surgical fee.

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 *Holidays*
A consultation or assessment, the appropriate special visit premium, the procedural benefit plus the surgical premium E409 or E410.
(see General Preamble GP44 to GP52 and GP65).
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.
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.

SURGICAL PREAMBLE

PREAMBLE

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 during the remainder of the procedure, he/she may also claim time units for 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.]

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 and Long-Term Care 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 terms and conditions for payment as described in the 'Surgical Services which are not listed as a "Z" code' section of this *Schedule* are also applicable to the *IOP* service(s).

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 GP8).

SURGICAL PREAMBLE

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 and Long-Term Care 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 anaesthetist 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, hip, peritoneal cavity, pelvis or retroperitoneum and:

- a. the patient has a *Body Mass Index (BMI)* greater than 40 for major surgery on the peritoneal cavity, pelvis, retroperitoneum and hip or 45 for major surgery on the neck;
- b. the surgery is rendered under *general anaesthesia* using either an open technique for the neck and 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, cauterity, 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	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	E756	E757	E762	E764	E765	E766	E767	E768	E769	E771	E794	E796
E852	E853	E854	E855	E857	E860	E880	E882	E883	E884	E885	F098	F099	F100
F101	F135	M081	M082	M084	M090	M099	M100	P018	P041	P042	P050	P055	P056
P057	P058	P059	P060	R216	R241	R269	R330	R423	R439	R440	R443	R470	R481
R488	R491	R553	R569	R590	R627	R628	R639	R686	R783	R784	R785	R786	R800
R802	R803	R805	R806	R807	R811	R814	R815	R817	R823	R825	R826	R834	R839
R852	R855	R856	R858	R860	R861	R910	R877	R885	R905	R915	R932	R933	R934
R935	R936	R937	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	S205	S206	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	S402	S403	S405	S408	S410
S411	S412	S413	S415	S416	S420	S422	S423	S424	S427	S428	S430	S431	S432
S433	S434	S435	S436	S437	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	S647	S650	S651
S652	S653	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	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 only when lysis requires at least 60 minutes beyond the average duration of the major procedure. E673 less than 60 minutes in duration or rendered in conjunction with E718 is an insured service payable at nil.

E673 Lysis of extensive intra-abdominal adhesions add 62.05

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 GP54).

28. Bariatric surgery

S120 (gastric bypass or partition), S189 (intestinal bypass) and S114 (sleeve gastrectomy) are insured services only when all of the following four criteria are satisfied:

1. Presence of morbid obesity that has persisted for at least the preceding 2 years, defined as:
 - a. *Body mass index (BMI)* exceeding 40; or
 - b. BMI greater than 35 in conjunction with any of the following severe co-morbidities:
 - i. Coronary heart disease;
 - ii. Diabetes mellitus;
 - iii. Clinically significant obstructive sleep apnea (i.e. patient meets the criteria for treatment of obstructive sleep apnea); or
 - iv. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);
2. The patient's bone growth is completed (18 years of age or documentation of completion of bone growth);
3. The patient has attempted weight loss in the past without successful long-term weight reduction; and
4. The patient must be recommended for the surgery by a multidisciplinary team at a Regional Assessment and Treatment Centre in Ontario.

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

- subcutaneous

Z101	- one.....		nil	25.75
Z173	- two			30.35
Z174	- three or more			40.80
Z104	- perianal			20.10
Z106	- ischiorectal or pilonida			44.35
Z103	- palmar or plantar spaces.....			44.35
E542	- when performed outside hospital.....add			11.15

Abscess or haematoma - General anaesthetic

- subcutaneous

# Z102	- one.....		44.35	6
# Z172	- two or more.....		66.60	7
# Z105	- perianal		66.00	6
# Z107	- ischiorectal or pilonidal.....		108.00	6
# Z108	- palmar or plantar spaces.....		72.00	6

Foreign body removal

Z114	- local anaesthetic		25.25	
E542	- when performed outside hospital.....add		11.15	
# Z115	- general anaesthetic.....	6	88.80	6
# Z100	- complicated (see General Preamble GP8).....	6	I.C	7
# Z227	Intramuscular abscess or haematoma.....		101.65	6
Z118	Aspiration of superficial lump for cytology		28.25	

Biopsy(ies)

Z116	- any method, when sutures are used.....		29.60	
E542	- when performed outside hospital.....add		11.15	
Z113	- any method, when sutures are not used.....		29.60	

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).

# Z155	Biopsy(ies) - extensive, complicated or requiring general anaesthetic when sole procedure (see General Preamble GP8)	I.C	I.C
# Z245	Biopsy for malignant hyperthermia, three or more	152.85	10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

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	20.00	6
Z157	- two lesions	26.50	6
Z158	- three or more lesions	44.25	6
E542	- when performed outside hospital.....add	11.15	

Removal by electrocoagulation and/or curetting

Z159	- single lesion	10.55	6
Z160	- two lesions	15.85	6
Z161	- three or more lesions	26.20	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	20.00	6
Z163	- two lesions	26.50	6
Z164	- three or more lesions	44.25	6
E542	- when performed outside hospital.....add	11.15	
#Z165	Congenital (extensive) (see General Preamble GP8)	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst	Surg	Anae
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Group 3 - cyst, haemangioma, lipoma

Face or neck - Local anaesthetic

Z122	- single lesion	nil	38.50
Z123	- two lesions		67.80
Z124	- three or more lesions		78.00
E542	- when performed outside hospital.....add		11.15

Face or neck - General anaesthetic

# Z145	- single lesion	6	65.35	6
# Z146	- two lesions	6	98.55	6
# Z147	- three or more lesions	6	162.55	6
# Z148	- extensive or massive (see General Preamble GP8).....	6	I.C	7

Other areas - Local anaesthetic

Z125	- single lesion	nil	32.00
Z126	- two lesions		45.00
Z127	- three or more lesions		60.00
E542	- when performed outside hospital.....add		11.15

Other areas - General anaesthetic

# Z149	- single lesion	6	50.00	6
# Z150	- two lesions	6	65.55	6
# Z151	- three or more lesions	6	98.55	6
# Z152	- extensive or massive (see General Preamble GP8).....	6	I.C	6

Group 4 - other lesions

Z096	Lipoma - 5 to 10 cm	6	80.00	6
E542	- when performed outside hospital.....add		11.15	
# Z097	Lipoma - over 10 cm	6	160.00	6
# R034	Congenital dermoid cyst adult	6	124.40	6
# R043	- infant or child	6	201.10	6
# R042	- midline, e.g. nasal	6	272.80	6
# R037	Giant cell tumour.....	6	200.00	6

Pilonidal cyst

# R035	- simple excision or marsupialization		200.00	6
# R054	- simple excision or marsupialization, if patient's BMI greater than 40.....	6	250.00	6
# R036	- excision and skin shift	6	280.00	6

Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hydadenitis

# R059	- unilateral	6	248.80	6
# R060	- with skin graft(s) or rotation flap(s).....	6	377.90	7

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

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	53.20	6
R161	- two lesions	6	87.40	6
R162	- three or more lesions	6	174.75	6
E542	- when performed outside hospital	add	11.15	

Other Areas

Simple excision

R163	- single lesion	6	43.60	6
R164	- two lesions	6	71.80	6
R165	- three or more lesions	6	143.55	6
E542	- when performed outside hospital	add	11.15	

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. Actinic/Solar Keratosis
3. Chemical and other pre-malignant keratoses
4. Large Cell Acanthoma
5. Erythroplasia of Queratrat
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.....	29.00
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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.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

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	92.15	6
R049	- two lesions	6	139.20	7
R050	- three or more lesions	6	233.00	7
E542	- when performed outside hospital.....add		11.15	

Other areas

Simple excision

R094	- single lesion	6	58.15	7
R040	- two lesions	6	95.70	6
R041	- three or more lesions	6	191.40	7
E542	- when performed outside hospital.....add		11.15	

Malignant melanoma

R010	- wide excision in any area and must include > 1 cm margins and layered closure	6	124.10	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 biopsy refer to Z427 p R2.]

Note:

When excision of benign, pre-malignant or malignant lesions are corrected by advancement, rotation, transposition, Z-plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of foregoing excision benefits.

Face or neck

Curettage, electrodesiccation or cryosurgery

R018	- single lesion	6	68.55	6
R019	- two lesions	6	112.90	7
R020	- three or more lesions	6	225.75	6

Other areas

Curettage, electrodesiccation or cryosurgery

R031	- single lesion	6	55.05	6
R032	- two lesions	6	90.70	7
R033	- three or more lesions	6	181.55	6
# R051	Laser surgery on Group 1 - 4, pre-malignant and malignant lesions (see General Preamble GP8)		I.C	I.C

Note:

Physicians treating vascular ectasias by laser may obtain from their Ministry of Health and Long-Term Care *Medical Consultant* the current Ministry policy regarding conditions approved for coverage under the Plan.

Chemical and/or cryotherapy treatment of skin lesions

Z117	- Chemical and/or cryotherapy treatment, one or more lesions	11.65
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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.]

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

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 weeks.
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 weeks 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.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

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	20.00
Z081	- two	30.00
Z082	- three	45.00
Z083	- four or more	60.00

Debridement of wound(s) and/or ulcer(s) extending into any of the following structures: tendon, ligament, bursa and/or bone

Z084	- one	60.00
Z085	- two or more	90.00
E542	- when performed outside hospital, to Z080, Z081, Z082, Z083, Z084 or Z085.....add	11.15

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 GP42 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 anaesthetists' and assistants' services, the following fee codes apply.

# R030	Minor burns	6	-	6
# R038	Moderate burns.....	6	-	10
# 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 GP11). 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 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 $\frac{1}{4}$ 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 are *not eligible for payment* in addition to R691, R692 or R693.

[Commentary:

See General Preamble GP6 for definitions and time-keeping requirements. As noted on GP6, 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	28.90
# R661	- dorsum, palm - each	47.95
# R662	- nose, cheek, lip, ear, forehead, scalp, neck, eyelid - each	28.90
# R637	Debridement and excision, per % of total body treated other than hand, head or neck	29.65

Skin allograft procurement

R690	- for banking purposes, per % of total body harvested, other than hand, head or neck	7	17.25	7
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NECROTIZING FASCIITIS

Debridement, excision and flap and/or graft closure - in Operating Room

# R698	Debridement, excision and flap and/or graft closure for necrotizing fasciitis	per unit	6	100.00	10
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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 $\frac{1}{4}$ 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.

[Commentary:

1. For reconstruction services, the appropriate fee codes apply.
2. See General Preamble GP5 for definitions and time-keeping requirements. As noted on GP5, start and stop times must be recorded in the patient's permanent medical record or the service is *not eligible for payment*.]

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

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	20.00	6
Z154	- up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers	35.90	6
Z175	- 5.1 to 10 cm	35.90	6
Z177	- 5.1 to 10 cm if on face and/or requires tying of bleeders and/or closure in layers	71.30	6
Z179	- 10.1 to 15 cm	50.40	6
Z190	- 10.1 to 15 cm if on face and/or requires tying of bleeders and/or closure in layers	101.45	6
Z191	- more than 15.1 cm - other than face	77.30	6
Z192	- more than 15.1 cm - on face	154.95	7
E530	- if inhalation general anaesthesia (other than 50% N ₂ O/O ₂ mixture) is used, when suture of laceration is sole procedure	add 50.40	
E531	- if extensive debridement is required (see General Preamble GP8)	add I.C	
E542	- when performed outside hospital.....	add 11.15	
R024	- Acute laceration earlobe, unilateral.....	100.65	
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 vermillion 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	92.30
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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).....	92.30
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INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

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..... 92.30

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 require advancement, graft or other surgical method of closure, see specific listings for surgical repair in the Integumentary System or Musculoskeletal 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 M11.]

Muscle repair

# R525	- Simple muscle repair(s) to include repair of involved skin	6	88.60	7
# R528	- Complex (see General Preamble GP8)	6	I.C	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

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 biopsy refer to Z427 p R27.]

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-plastics

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

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		134.75	
# R101	Delay, Small/Intermediate flap	6	132.45	7
# R100	Delay, major flap	6	291.90	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst Surg Anae

D. Myocutaneous, myogenous or fascia-cutaneous flaps

Note:

To include closure by any means.

# R005	Sterno-mastoid, tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), trapezius	6	545.00	6
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# 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 GP8).....	I.C	I.C	I.C

SKIN GRAFTS

A. Split thickness grafts (for burn grafts see pages M7 & M8)

# 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 Consultant* may be requested to determine 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 Consultant* may be requested to determine 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 GP8)	I.C	I.C	I.C
# R058	Revision of above (see General Preamble GP8).....	I.C	I.C	I.C

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

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

	Asst	Surg	Anae
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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

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE		Asst	Surg	Anae
FREE ISLAND FLAPS				
# 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 GP8)	10	I.C	10
# R106	Skin flaps and grafts - other than listed above (see General Preamble GP8)	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	17.45
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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	33.10	6
Z129	- multiple.....	35.70	6
E542	- when performed outside hospital.....add	11.15	

Radical, including destruction of nail bed

# Z130	- one	nil	62.75	6
# Z131	- multiple.....		82.65	6
E542	- when performed outside hospital.....add		11.15	

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.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

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
# R152	Intermediate.....	6	259.20
# R153	Major.....	6	388.00
# R154	Extensive major	6	568.95

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.....		58.95	
# E528	- additional expander, different incision.....		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 and Long-Term Care (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		11.15
Z143	- large core breast biopsy - (14 gauge or larger bore needle).....			132.75

Aspiration of cyst

Z139	- one or more.....		nil	37.20
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Drainage of intramammary abscess or haematoma

# Z140	Single or multiloculated - local anaesthetic.....			33.00
# Z740	Single or multiloculated - general anaesthetic.....		75.00	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 mammographic wire localization, to R107	add	41.55	
# R111	Partial mastectomy or wedge resection for treatment of breast disease, with or without biopsy, e.g. carcinoma or extensive fibrocystic disease	6	269.40	7
# E525	- after mammographic wire localization, to R111	add	41.55	
# 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 biopsy refer to Z427 p R2.]

Mastectomy - female (with or without biopsy)

# R108	- simple.....	6	330.00	7
# R117	- subcutaneous with nipple preservation.....	6	273.95	7
# E505	- with limited axillary node sampling, to R108 or R117	add	178.05	

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
2. R117 - Mastectomy - subcutaneous with nipple preservation.]

# R109	Mastectomy, radical or modified radical (with or without biopsy).....	6	685.00	7
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[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* biopsy), e.g. carcinoma

# R148	- simple.....	6	273.95	7
# R149	- subcutaneous with nipple preservation.....	6	273.95	7
# E505	- with limited axillary node sampling, to R148 or R149	add	178.05	

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS OF THE BREAST

Asst	Surg	Anae
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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 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 and Long-Term Care 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

Note:

Prior authorization of payment from the Ministry of Health and Long-Term Care is required for R110 and R112 (see Surgical Preamble SP3; 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. 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.
- B. 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.
- C. The benefit for total joint replacement also includes denervation of the joint, all tenotomies and division and repair of muscle.
- D. The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which bone grafting is included.
- E. For the supervision of limb fitting and 6 months 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, R436, R437, R438, R439, R440, R441, R443, R453, R454, R456, R479, R481, R482, R483, R485, R486, R487, R488, R491, R493, R496, R497, R498, R499, R500, R509, R510 add	175.00
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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 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. The service includes all related follow-up treatment by the physician for 2 weeks from the date of treatment of the fracture or dislocation except:
 - a. for the first and second post-treatment visits to a hospital in-patient;
 - b. for the subsequent visit by the MRP - day of discharge (C124);
 - c. for the first post-treatment visit when the patient is no longer a hospital in-patient;
 - d. if additional reductions are necessary;
 - e. if the patient is transferred to another surgeon; or
 - f. if the patient is a paraplegic.

[Commentary:

The first and second post-treatment visits in hospital for 2 weeks from the date of treatment of the fracture or dislocation are payable at the specialty specific subsequent visit fee.]

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PREAMBLE

6. 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.
7. 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%.
8. Emergency splinting of fractures in the emergency department should be on the basis of appropriate visit benefit, plus application of cast if appropriate.
9. Transferred cases:
 - a. When patients are transferred to a chronic or convalescent facility, additional visit benefits on a chronic care basis shall be allowed to other than the operating surgeon (and also to the surgeon after 2 weeks).
 - b. 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.
 - c. 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.
10. Pseudoarthrosis may be allowed as the appropriate benefit after the fracture is 4 *months* old.
11. For fractures and dislocations not requiring reduction, visit fees apply unless a specific fee is listed. If the listed fee is less than the consultation, the consultation should be claimed under the fracture/dislocation fee code number.

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
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Allograft

# R200	- cadaver - per long bone, each		144.80
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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, F013 or F016	add 75%	

Note:

E569 is *not eligible for payment* with E826.

# E590	- rigid external fixation - pseudoarthrosis	add	76.10
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Removal of internal fixation device

# R267	- general anaesthetic.....	6	158.65	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
# 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
# E556	- extensive debridement of compound fractures or dislocations, to reduction fee.....	add 50%	
# Z783	Secondary closure		97.35

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.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

GENERAL FEES

Asst Surg Anae

ORTHOPAEDIC TUMOUR SURGERY

R226	Biopsy of suspected sarcoma, or resection of a complex bone or complex soft tissue tumour(s), per 15 minutes.....	10	100.00	15
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Payment rules:

1. R226 is eligible for payment only to an oncological orthopaedic surgeon with fellowship training in orthopaedic oncology. Documentation of fellowship training 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 surgeons to render components of the same procedure simultaneously or sequentially, R226A is eligible for payment to each surgeon.

Claims submission instructions:

Submit R226A claims for a second surgeon using the manual review indicator and accompanied by operative report.

[Commentary:

In accordance with the Surgical Preamble, if a surgeon who is not an oncological orthopaedic surgeon 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.]

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

GENERAL FEES

Asst Surg Anae

CASTS

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 weeks 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 GP42 to GP42 of the General Preamble (Delegated Procedures) are met.

Z201	Finger.....	10.25		
E584	- application of plaster cast outside hospital	add	11.15	
Z202	Hand	14.90	6	
E584	- application of plaster cast outside hospital	add	11.15	
Z203	Arm, forearm or wrist	24.10	6	
E584	- application of plaster cast outside hospital	add	11.15	
Z199	Foot.....	14.90	6	
E584	- application of plaster cast outside hospital	add	11.15	
# 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	
E584	- application of plaster cast outside hospital	add	11.15	
# 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 in other than fracture treatment.....		10.25	
Z200	Application of Unna's paste		14.90	
Z873	Application of cast brace (must include hinge)		67.75	
Z204	Removal of plaster (not associated with fractures or dislocations within 2 weeks of initial treatment)		10.25	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

	Asst	Surg	Anae
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AMPUTATION

# R606	Phalanx.....	161.45	6
# R608	Metacarpal or metaphalangeal joint.....	190.20	7
# E583	- each additional.....add	94.60	
# R610	Trans. metacarpal 2nd to 5th ray.....	279.35	7
# R611	Hand - all metacarpals.....	6	289.50
# R612	Wrist.....	6	289.50
# R629	Revision of amputated finger tip	6	241.55

ARTHRODESIS

# R465	Finger-thumb	6	256.15	7
# R466	Wrist.....	6	400.00	6

ARTHROPLASTY

# E564	- revision of arthroplasty.....add 35%			
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Wrist

# R437	- interposition.....	6	374.00	7
# R485	- total	6	426.90	6
# R479	- removal only.....	6	193.00	6

Hand - interposition

# R435	- single.....	6	254.35	7
# R436	- multiple.....	6	459.40	7
# R489	Single joint - total (arthrodesis and/or arthroplasties) maximum of 4	6	290.55	7
# R209	Basal thumb - first carpometacarpal joint.....	6	363.05	7
# R500	Removal only	6	144.80	6
# R236	Carpal replacement	6	322.05	7

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
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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 than 90 minutes in duration is included in R682.
2. Only one of E482 or E483 is eligible for payment same patient same day.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

Asst	Surg	Anae
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ARTHROTOMY

# R409	Finger.....		168.00	6
# R410	Wrist.....	6	212.50	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	212.50	6

Soft tissue

# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site.....		31.20	

DECOMPRESSION - DENERVATION

# N290	Decompression median nerve at wrist (carpal tunnel syndrome).....	6	156.75	6
# N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding carpal tunnel nerve).....	6	256.15	7

INCISION AND DRAINAGE

# R409	Finger joint.....		168.00	6
# R410	Wrist joint	6	212.50	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	225.00	6

EXAMINATION/MANIPULATION

Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP4).		24.10	6
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Note:

Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

	Asst	Surg	Anae
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EXCISION

Bone

# R316	Proximal row carpectomy	6	338.75	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 GP8).....	I.C	I.C	I.C

Joint

Synovectomy/capsulectomy/debridement

# R425	- finger joint	6	226.40	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	177.80	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, one or more 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. R551 is not payable for treatment of Dupuytren's by aponeurotomy.
2. A maximum of one R551 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 R551.
2. R551, E832 and E831 include the palmar and digital components of the Dupuytrens procedure, when rendered.

Muscle

# R522	- simple.....	6	193.00	6
# R523	- complex.....	6	484.35	7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

Asst Surg Anae

RECONSTRUCTION

Bone - Pseudoarthrosis/non-union/avascular necrosis

# R321	Phalanx, metacarpal	6	260.75	7
# R322	Scaphoid.....	6	500.00	6
# R345	Carpal bone, other than scaphoid.....	6	260.75	6
# E497	- pedicled vascularized bone graft, to R322 or R345.....add		350.00	

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	6	162.65	6
# R258	- middle proximal or metacarpal	6	193.20	7
# E591	- each additional.....add		158.65	

Ligaments

# R597	Simple/single repair - wrist.....	6	301.60	7
# R548	Extensive/multiple repair - wrist	6	511.45	7
# R601	Metacarpal phalangeal repair	6	316.75	7

Note:

Reconstruction - Nerve - see page X8.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

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	306.30	7
# E052	- each additional.....	add	259.85	

# R586	Reconstruction of flexor tendon pulley, per finger.....		97.35	7
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Silicone rod insertion

# R554	- one	6	294.20	7
# E051	- each additional.....	add	245.90	

Transplant/transfer

# R563	- single.....	6	284.95	7
# E054	- each additional.....	add	236.10	

Tendon repair - extensor

# R578	- single.....	6	164.10	7
# E580	- each additional*	add	70.95	

Flexor

# R585	- single.....	6	307.60	7
# E581	- each additional*	add	128.95	

Mallet finger

UVC	- closed.....		visit.fee	
# R574	- K-wire.....		133.95	7
# R573	- open	6	147.20	6

Boutonniere

UVC	- closed.....		visit.fee	
# R577	- open	6	147.30	6
# R582	- late	6	246.65	7

Note:

*If additional tendon repair(s) requires a separate incision, bill according to Surgical Preamble SP2.

Extremities

# R602	Pollicization.....	6	596.35	6
# R603	Digital reimplantation involving microvascular and neuro anastomosis.....	8	1586.20	8
# R604	Revision of R602, R603 (see General Preamble GP8)	I.C	I.C	I.C
# R605	Reconstruction and plastic repair of traumatically amputated extremities (see General Preamble GP8)	I.C	I.C	I.C

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

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.....	73.70 7

Tendon release (open)

# R536	- finger/palm	156.50 6
# E592	- more than one, to R536	133.05
# R537	- wrist.....add	175.00 6
# E571	- more than one, to R537	148.75

REDUCTION

Fractures

Phalanx

F004	- no reduction, rigid immobilization.....	49.20
F005	- closed reduction.....	99.25 6
E584	- application of plaster cast outside hospital	11.15
E558	- each additional.....add	22.25
# F007	- open reduction	6 298.45 7

Metacarpal

F008	- no reduction, one or more, rigid immobilization	49.20
F009	- closed reduction.....	99.25 6
E584	- application of plaster cast outside hospital	11.15
E504	- each additional.....add	22.20
# F011	- open reduction	6 262.60 7
E559	- each additional (open)	142.90

Intra-articular

F006	- closed reduction.....	119.75
E584	- application of plaster cast outside hospital	11.15
E503	- each additional.....add	26.85
# F010	- open reduction	6 335.80 7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

Asst Surg Anae

REDUCTION

Fractures

Bennett's

F012	- no reduction, rigid immobilization.....		49.20	
E584	- application of plaster cast outside hospital	add	11.15	
# F013	- closed reduction.....	6	119.80	6
# F015	- open reduction	6	335.80	7

Carpus

F102	- no reduction, rigid immobilization.....		49.20	
E584	- application of plaster cast outside hospital	add	11.15	
# F016	- closed reduction, one or more		115.10	6
# F017	- open reduction, one or more.....	6	346.15	7

Scaphoid

F018	- no reduction, rigid immobilization.....		49.20	
E584	- application of plaster cast outside hospital	add	11.15	
# F019	- open reduction	6	480.00	7
# F020	- excision	6	193.00	7

Dislocations

Finger

D001	- closed reduction.....		57.50	6
E584	- application of plaster cast outside hospital	add	11.15	
E576	- each additional.....		10.25	
# D003	- open reduction	6	196.50	6

Metacarpal/phalangeal

D004	- closed reduction.....		57.50	6
E584	- application of plaster cast outside hospital	add	11.15	
E577	- each additional.....		10.25	
# D006	- open reduction	6	181.85	7

Carpal

D007	- closed reduction.....		128.05	6
E584	- application of plaster cast outside hospital	add	11.15	
# D008	- open reduction	6	241.30	7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

		Asst	Surg	Anae
AMPUTATION				
# R613	Through radius and ulna.....	6	306.30	7
# R614	Elbow disarticulation	6	289.50	6
ARTHRODESIS				
# R466	Elbow	6	400.00	6
ARTHROPLASTY				
# E564	revision of elbow arthroplasty	add 35%		
# R281	Ulna replacement (lower end).....	6	296.90	6
# R288	Implant radial head	6	251.55	6
# R499	Removal of total replacement	6	402.75	7
# R486	Complete arthroplasty replacement.....	6	619.90	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 <i>Schedule</i> 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 <i>not eligible for payment</i> 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 <i>not eligible for payment</i> with E478 for the same fracture.				
# E481	Osteochondroplasty (extensive bone and arthrotibiotic 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 than 90 minutes in duration is included in R683.			
3.	Osteochondroplasty less than 2 hours in duration is included in R683.			
ARTHROTOMY				
# R445	Elbow, loose body, etc.....	6	199.55	7
ASPIRATION/INJECTION				
See Diagnostic and Therapeutic Procedures - Injections and Infusions.				

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

	Asst	Surg	Anae
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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.....		31.20	

DECOMPRESSION/DENERVATION

# R495	Fasciotomy for compartment syndrome (not including secondary closure wound) .	6	320.20	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)	6	215.35	7
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis.....	6	279.25	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	355.35	7
# R229	Saucerization and bone grafting	6	452.90	7

EXAMINATION/MANIPULATION

Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP4).		24.10	6
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Note:

Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

	Asst	Surg	Anae
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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	207.90	6
# R291	Olecranon with fascial repair	6	309.00	7

Bursae

# R595	Olecranon	6	101.25	6
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Joint Contents

# R421	Synovectomy/capsulectomy/debridement, etc.	6	311.85	7
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Muscles

# R524	Myositis ossificans.....	6	289.50	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	165.20	7
# R295	- simple excision.....	6	289.50	7
# R293	- extensive with replacement.....	6	677.50	6

RECONSTRUCTION

Bone - Pseudoarthrosis

# R323	Radius or ulna.....	6	304.40	7
# R473	Radius and ulna.....	6	411.20	6
# R950	Radius and ulna - circular external fixation.....	6	291.40	7

Bone - Deformity

Osteotomy

# R259	- ulna	6	297.85	7
# R261	- radius with or without ulna	6	411.20	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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

	Asst	Surg	Anae
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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	301.60	7
# R548	Extensive/multiple repair.....	6	511.45	7

Tendons

Suture extensor tendon

# R578	- single.....	6	164.10	7
# E580	- each additional	add	70.95	

Suture flexor tendon

# R585	- single.....	6	307.60	7
# E581	- each additional	add	128.95	

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	284.95	7
# E056	- each additional	add	91.90	
# R583	Steindler flexoplasty.....	6	344.85	7

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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

Asst	Surg	Anae
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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	375.80	7

Olecranon

# F034	- no reduction, rigid immobilization.....		126.25	6
# F035	- closed reduction.....	6	129.00	6
# F036	- open reduction	6	224.55	7

Radius and ulnar shaft

# F024	- no reduction, rigid immobilization.....		67.75	
# F025	- closed reduction.....	6	148.50	6
# F026	- open reduction	6	368.40	7

Radius and ulna - Monteggia

# F014	- no reduction, rigid immobilization.....		67.75	
# F022	- closed reduction.....		144.80	6
# F023	- open reduction of ulna plus closed reduction radial head.....	6	242.25	7

Radius or ulna

F031	- no reduction, rigid immobilization.....		81.30	
E584	- application of plaster cast outside hospital	add	11.15	
# F032	- closed reduction.....	6	117.85	6
# F033	- open reduction	6	274.00	7

Radius - distal, e.g. Colles', Smith's, or Barton's fracture

F027	- no reduction, rigid immobilization.....		67.75	
E584	- application of plaster cast outside hospital	add	11.15	
# F028	- closed reduction, under local or regional anaesthetic.....		109.45	
# F046	- closed reduction, under general anaesthetic	6	149.35	6
# F030	- open reduction	6	420.00	7

Osteochondral

# F021	- open reduction	6	392.40	7
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MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

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	369.35	6
ARTHRODESIS				
# R467	Shoulder	6	468.65	6
ARTHROPLASTY				
# E564	- revision of prosthesis	add 35%		
# R438	Humeral prosthesis	6	449.20	10
# R487	Total prosthesis	8	695.10	10
# R240	Revision total arthroplasty shoulder	8	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 <i>Schedule</i> 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 <i>not eligible for payment</i> 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 <i>not eligible for payment</i> 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 <i>not eligible for payment</i> in addition to R401.				
ARTHROTOMY				
# R411	Shoulder	6	223.65	7
ASPIRATION/INJECTION				
See Diagnostic and Therapeutic Procedures - Injections and Infusions.				

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

	Asst	Surg	Anae
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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.....		31.20	

Incision and Drainage

# R222	Humerus/clavicle/scapula	6	262.60	7
# Z226	Bursae/soft tissue		97.35	7
# R411	Joint	6	223.65	7
# R225	Sequestrectomy.....	6	290.55	7
# R223	Saucerization with bone graft	6	387.90	7

EXAMINATION AND MANIPULATION

Z223	Manipulation under general anaesthetic (see Surgical Preamble SP4)		49.20	6
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Note:

Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

EXCISION

Clavicle or Acromion

# R298	Simple (includes ligament).....	6	211.60	7
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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	165.20	7
# R295	Benign tumour	6	289.50	7
# R297	Malignant tumour with reconstruction	6	681.10	6

EXCISION

Joint

# R422	Synovectomy and debridement	6	425.10	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
# 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%.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

Asst Surg Anae

RECONSTRUCTION

Pseudoarthrosis

# R329	Clavicle	6	269.10	6
# R325	Humerus	6	346.15	6
# R956	Humerus - circular external fixation	6	291.40	7

DEFORMITY

Osteotomy

# R260	- humerus	6	292.35	7
# R298	- clavicle	6	211.60	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	434.25	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
# 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 R594add 30%			

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
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	327.55	6
Neck with dislocation of head				
# F050	- no reduction		67.80	
# F051	- closed reduction.....	6	183.80	6
# F052	- open reduction	6	385.15	6
Shaft				
# F042	- no reduction		67.80	
# F043	- closed reduction.....	6	147.60	6
# F044	- open reduction	6	323.05	6
Clavicle				
UVC	- no reduction		visit.fee	
# F110	- closed reduction with anaesthetic.....	6	62.20	7
# F118	- open reduction	6	300.00	7
Scapula				
# F119	- no reduction		67.80	
# F121	- open reduction	6	242.25	6
Sternum				
# F123	- closed reduction.....		115.95	
# F124	- open reduction - pleura open (see General Preamble GP8)	9	I.C	13
# F125	- pleura closed (see General Preamble GP8)	6	I.C	6
Ribs				
UVC	- no reduction		visit.fee	
# F131	- pleura closed (see General Preamble GP8)	6	I.C	6
Dislocations				
Acromio-clavicular/sterno-clavicular				
# D014	- no reduction		67.80	
# D025	- closed with anaesthetic.....	6	134.55	6
# D023	- open reduction	6	231.10	7
# R596	- late	6	286.70	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	379.50	10
# E058	- revision/repair following previous glenohumeral joint surgery, to R401		add 30%	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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ARTHROPLASTY

# R433	Temporomandibular joint - unilateral.....	6	349.30	10
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BIOPSY

Bone

# Z869	- punch, simple.....	48.50	7
# Z870	- punch, x-ray control	120.70	6
# Z242	- open	193.00	7

INCISION AND DRAINAGE

# Z234	Mandibular sequestrectomy.....	7	281.25	7
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EXCISION

# R272	Bone - tumour (see General Preamble GP8)	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*.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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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	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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ORTHOGNATHIC SURGERY

LeFort I advancement

# R379	- in one segment	10	803.80	20
# E961	- in two segments.....add		296.60	
# E962	- in three segmentsadd		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 segmentsadd		594.20	

LeFort I cleft palate

# R580	- in one segment*	10	1525.30	20
# E967	- in two segments.....add		256.40	
# E968	- in three segmentsadd		511.90	
# E969	- with SMR		204.80	
# E970	- with pharyngoplasty.....add		307.15	
# E971	- with closure alveolar fistula with or without bone graft		383.65	
# E972	- with closure hard palate fistula with or without bone graft		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	Coronoideectomy.....	6	307.15	6

Note:

* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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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.]

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.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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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	178.90		
# R655	- bilateral	409.55	7	
# E974	- when in conjunction with coronal approach for main operation	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		154.00	

Note:

* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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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
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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
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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	
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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.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

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
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Note:

R347 requires elevation of bicoronal flaps with exposure of the upper half facial skeleton and subsequent closure and re-suspension of soft tissues.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

Asst Surg Anae

REDUCTION

Fractures

Orbit - open reduction rim/wall fracture			
# E173 Zygomatic fracture dislocation	6	594.70	7
# E933 - with miniplate(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	667.00	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 miniplate(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 miniplate(s)**, per major fracture line	add	107.20	
# E932 - unilateral	add	205.00	
# E935 - bilateral	add	307.70	

Note:

E932, E934, and E935 are not to be billed with Z263, Z264, Z265, Z266, E975, or E976.

Midface fractures

Application of craniofacial suspension wires and external fixation devices (not to be billed in addition to maxillary repair).

# F143 - middle 1/4 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.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

	Asst	Surg	Anae
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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	575.00	6
# E828	- rigid internal fixation, any method, to F139.....add		104.00	

Note:

Rigid internal fixation *may include* the use of a miniplate(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	
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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 GP8)	I.C	I.C	I.C
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Dislocations

Temporomandibular joint

# D062	- closed reduction.....		51.65	6
# D063	- open reduction	6	256.40	7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
AMPUTATION				
# R631	Hemipelvectomy - hindquarter.....	10	796.20	15
# R630	Hip disarticulation	10	449.20	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	490.95	10
# R440	Total hip replacement - acetabulum and femur.....	8	696.00	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	8	1304.80	15
# E589	- bone graft to acetabulumadd		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	353.25	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 R686add		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 arthrotibiotic tissue removal requiring a minimum of 2 hours to resect), to R686		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.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

	Asst	Surg	Anae
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ARTHROTONY

# 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
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BIOPSY

Bone

Z212	- punch needle		89.70	
# Z217	- under general anaesthetic		72.35	7
# Z214	- open	6	144.80	6

Joint

# R415	- open	6	301.60	7
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Soft tissue

# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site.....		31.20	

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	6	256.15	7
# N177	Sciatic nerve in buttock.....	6	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.....	6	379.50	7
# R250	Saucerization and bone graft.....	6	627.30	6

EXAMINATION/MANIPULATION

Z252	Manipulation - under general anaesthetic.....		39.00	6
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Note:

Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

	Asst	Surg	Anae
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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	289.50	7

Joint

# R423	Synovectomy/debridement	6	470.50	7
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Bursae

# R590	GT trochanteric/ischial	6	201.40	7
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RECONSTRUCTION

Pseudoarthrosis

# R364	Pelvis	8	580.90	10
# R328	Hip	6	477.90	6

Osteotomy

Pelvis

# R265	- infant	8	399.00	8
# R273	- other.....	8	580.90	8
# R263	Hip	6	539.15	7

Muscle/tendon

# R521	Muscle release.....	6	314.60	7
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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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

Asst | Surg | Anae

REDUCTION

Fractures

Coccyx

UVC	- no reduction		visit.fee		
# F115	- excision.....	6	208.80	6	

Pelvic ring

UVC	- no reduction		visit.fee		
# F134	- closed reduction.....	6	442.45	6	
# F135	- open reduction	6	680.30	8	

Sacrum

UVC	- no reduction		visit.fee		
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Femoral neck trochanteric, subtrochanteric

UVC	- no reduction		visit.fee		
# F098	- closed reduction/traction.....	6	426.90	6	
# F099	- open reduction - pin only.....	6	408.30	8	
# F100	- open reduction - pin and plate/screws (cannulated included).....	6	498.95	10	
# F101	- open reduction - primary prosthesis, femur only (includes Moore, Thompson, Unipolar, Bipolar)	6	490.95	10	
# R600	- delayed/staged graft.....	6	289.50	8	

Slipped epiphysis

# R607	- closed reduction/traction	6	387.00	8	
# R642	- closed reduction/internal fixation.....	6	387.00	8	
# R627	- open reduction/fixation.....	6	580.90	8	

Dislocations

Acetabulum

UVC	- no reduction		visit.fee		
# D052	- open reduction - lips.....	7	612.45	8	
# D046	- open reduction - one pillar	6	967.90	10	
# D047	- open reduction - two pillars	8	1451.45	12	

Hip

# D042	- closed reduction.....		268.25	6	
# D043	- open reduction	7	406.45	7	
# R628	- late, after four weeks - open	7	774.90	10	

Note:

May not be claimed with D042 at the same time.

Sacro-iliac

# D059	- closed, traction, spica, etc.....		428.50	6	
# D060	- open reduction	6	593.00	6	

Sacro-coccygeal

UVC	- closed reduction.....		visit.fee		
# D061	- open, removal of coccyx	6	193.00	6	

Congenital 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	
Z291	- Application Pavlik Harness or C.D.H. Splint.....		24.10		

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FEMUR

		Asst	Surg	Anae
AMPUTATION				
# R625	Gritti-Stokes or Callander.....	6	305.25	7
# R626	Through femur	6	306.30	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.....		31.20	
# R256	Injection into bone cysts		117.00	
INCISION AND DRAINAGE				
# R242	Bone	6	325.75	7
# R245	Sequestrectomy.....	6	395.25	7
# R243	Saucerization and graft.....	6	619.90	6
# Z226	Soft tissue		97.35	7
EXCISION				
Bone				
# R314	Simple cyst/exostosis	6	225.50	6
Bone tumour				
# R330	- simple.....	6	629.65	7
# R216	- with reconstruction/graf.....	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	477.90	6
# R967	Circular external fixation	6	291.40	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FEMUR

Asst Surg Anae

RECONSTRUCTION

Deformity

# R262	Osteotomy femoral shaft.....	6	532.65	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 additionaladd		77.05	
# R571	Tendon or muscle transfer	6	307.15	7
# E049	- each additionaladd		87.20	
# R524	Excision of myositis	6	289.50	7

Fractures

No reduction				
UVC	- cast and bed rest		visit.fee	
Closed reduction				
F094	- traction - infant or child.....	6	258.00	6
# F095	- traction - adult or adolescent.....	6	407.35	6
# F097	- cast	6	258.90	6
# F096	- open reduction	6	493.80	8
Femoral shaft/supracondylar				
# E048	- intramedullary nail with distal and proximal locking screws - femuradd		108.75	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
AMPUTATION				
# R625	Through knee - disarticulation	6	305.25	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. Marmor).....	8	619.90	7
# R441	Total replacement/both compartments.....	8	619.90	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	353.25	8
Claims submission instructions:				
When a unicompartmental 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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

KNEE

Asst Surg Anae

ARTHROSCOPY

- | | | | | |
|--------|--|---|-------|---|
| # R687 | Knee arthroscopy set-up, includes when rendered synovial biopsy and/or resection or trimming of plica..... | 6 | 97.35 | 7 |
|--------|--|---|-------|---|
- Note:**
1. A knee procedure listed in the Knee section of the *Schedule* performed arthroscopically is eligible for payment in addition to R687 if that procedure is not described as a component of R687 or described by an E-add-on code to R687.
 2. Arthroscopic E-add-on codes listed below are *not eligible for payment* in addition to R687 when the service described by the E-code is a generally accepted component of a procedure described in Note #1.
 3. R687 is an *uninsured service* for arthroscopic lavage of the knee alone (without debridement) for osteoarthritis.

[Commentary:

1. Arthroscopic lavage of the knee alone (without debridement) is not recommended for any stage of osteoarthritis.
2. The routine use of debridement for treatment of osteoarthritis of the knee is not recommended by the Ontario Health Technology Advisory Committee (OHTAC). See <http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/ohtas-reports-and-ohtac-recommendations/arthroscopic-lavage-and-debridement>.]

- | | | | |
|--------|--|-----|--------|
| # E476 | Removal of symptomatic loose body(ies) and/or screw, to R687 | add | 192.00 |
|--------|--|-----|--------|

Note:

Removal of iatrogenic loose body(ies) is *not eligible for payment*.

- | | | | |
|--------|---|-----|--------|
| # E491 | Lateral release, to R687 | add | 161.45 |
| # E492 | Synovectomy - for diseased synovium, anterior, posterior or complete, to R687 | add | 231.30 |
| # E493 | Drilling of defect (includes removal of loose body(ies)), to R687 | add | 251.55 |
| # E478 | Pinning of osteochondral fragment, to R687 | add | 251.55 |

Note:

F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

- | | | | |
|--------|--|-----|--------|
| # E494 | Debridement - 1 or more compartments, must include substantial debridement of pathologic articular cartilage and includes when rendered synovectomy, meniscal trimming and/or chondroplasty, to R687 | add | 299.00 |
|--------|--|-----|--------|

Payment rules:

E492 is *not eligible for payment* in addition to E494.

- | | | | |
|--------|--|-----|--------|
| # E489 | Microfracture and/or abrasion arthroplasty, for osteoarthritic cartilage deficiency (includes removal of loose body(ies)), to R687 | add | 250.00 |
| # E495 | Menisectomy, partial or total, for symptomatic meniscal tear, to R687 | add | 240.45 |
| # E496 | Repair medial or lateral meniscus, includes when rendered debridement of attachment site, to R687 | 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 are *not eligible for payment* in addition to E496 for debridement of attachment site.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

KNEE

	Asst	Surg	Anae
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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.....		31.20	

DENERVATION/DECOMPRESSION

# R426	Denervation of knee.....	6	258.00	7
# N285	Denervation of gastrocnemius	6	256.15	7

INCISION AND DRAINAGE

# Z226	Soft tissue		97.35	7
# R444	Joint	6	193.00	7

EXAMINATION/MANIPULATION

Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP4).		24.10	6
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Note:

Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

KNEE

	Asst	Surg	Anae
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RECONSTRUCTION

Meniscus

# R508	Suturing of medial or lateral meniscus.....	6	242.25	7
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Muscles/Tendons

Tenoplasty

# R584	- one	6	144.80	7
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# E050	- each additional.....	add	77.05	
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Suture of patellar or quadriceps tendon

# R589	- early	6	227.40	7
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# R587	- late	6	387.00	7
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Transplant of tendon

# R571	- single.....	6	307.15	7
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# E049	- each additional.....	add	87.20	
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Tenotomy

- closed

# Z237	- one		49.20	6
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# Z238	- multiple.....		72.35	7
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- open

# R564	- one	6	232.00	7
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# R566	- multiple.....	6	253.30	6
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# R516	Release patellar retinaculum	6	161.45	7
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Ligaments

# R599	- simple - one	6	361.95	6
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# R542	- extensive ligament reconstruction (including synthetics) includes when rendered preparation of intracondylar notch	6	517.85	7
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# E059	- revision/repair following previous reconstruction of knee ligaments, to R542	add 30%		
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# R539	- removal of synthetics	6	213.45	7
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REDUCTION

Fractures

Patella

# F085	- no reduction		67.75	
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# F087	- open reduction or excision with or without repair.....	6	275.65	7
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# F021	Osteochondral fracture - open reduction	6	392.40	7
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Dislocations

Knee

# D038	- closed reduction.....		207.90	6
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# D039	- open reduction	6	309.00	7
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Patella

- closed reduction

# D040	- without anaesthetic		62.20	
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# D031	- with anaesthetic		97.35	6
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- open reduction

# D041	- early		290.55	7
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# R255	- late	6	484.35	7
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# R403	- repair recurrent dislocation (includes inspection of joint)	6	393.40	7
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# R515	Congenital dislocation - knee (open)	6	484.35	7
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MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FIBULA AND TIBIA

	Asst	Surg	Anae
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AMPUTATION

# R624	Tibia/fibula	6	306.30	7
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BIOPSY

Bone

# Z870	- simple - punch.....	120.70	6
# Z242	- open	193.00	7

Soft tissue

# Z228	- open	97.35	6
Z219	Muscle needle biopsy, soft tissue, per site.....	31.20	
# R256	Injection into bone cysts	117.00	

DECOMPRESSION/DENERVATION

# R495	Decompression of fascial compartments.....	6	320.20	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 perineal nerve.....	6	165.20	7

INCISION AND DRAINAGE

# R237	Bone	6	308.10	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	201.40	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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FIBULA AND TIBIA

	Asst	Surg	Anae
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RECONSTRUCTION

Pseudoarthrosis

# E041	- intramedullary nail with distal and proximal locking screws - tibia	add	81.55	
# R326	Tibia/fibula.....	6	348.00	6
# R327	By-pass fibular graft.....	6	341.45	6
# R372	Congenital pseudoarthrosis	6	484.35	6
# 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	Osteotomy repair recurrent dislocation (includes inspection of the joint)	6	393.40	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	356.40	6

Intramedullary nail with distal and proximal locking screws

# E041	- tibia	add	81.55	
# F081	- medial or lateral tibial plateau	6	394.45	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	230.20	7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

	Asst	Surg	Anae
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AMPUTATION

# R620	Metatarsal/phalanx disarticulation.....	6	155.90	6
# E585	- each additional.....	add	47.30	
# R621	Ray (single).....	6	217.15	6
# R623	Sykes.....	6	285.80	7
# R622	Transmetatarsal/transtarsal	6	235.75	7
# R619	Terminal Sykes	6	144.80	6

ARTHRODESIS

# R466	Ankle.....	6	400.00	6
# R552	- revision of arthrodesis.....	6	506.65	7
# R471	Interphalangeal	6	151.85	6
# E575	- each additional.....	add	41.70	
# R477	Metatarsophalangeal	6	247.25	7
# R695	Subtalar	6	450.00	6
# E511	- additional midtarsal(s), to R695	add	100.00	
# R696	Midtarsal, single joint	6	500.00	6
# E512	- additional midtarsal(s), to R696	add	100.00	
# R697	Metatarsal-tarsal (fusion of one or more joints)	6	300.00	6
# R475	Pan-talar, one stage.....	6	626.45	6

Note:

1. 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 day.

ARTHROPLASTY

# E564	- revision of arthroplasty.....	add 35%		
# R493	Ankle - total replacement	8	1177.50	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
Metatarsophalangeal interposition				
# R456	- single.....	6	144.80	6
# E538	- each additional.....	add	38.00	
# R453	Metatarsophalangeal (Swansons, etc.).....	6	289.50	7
# R454	- multiple.....	6	387.00	7
# R500	Removal - prosthesis without replacement.....	6	144.80	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

Asst Surg Anae

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 <i>Schedule</i> 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 <i>not eligible for payment</i> 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	
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# E478	Pinning of osteochondral fragment, to R688	add		251.55	
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Note:

F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

# E481	Osteochondroplasty (extensive bone and arthrotibiotic tissue removal requiring a minimum of 2 hours to resect), to R688	add		500.00	
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# E483	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to R688	add		326.55	
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# R689	Excision of Os Trigonum (sole procedure)		6	230.00	7
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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	144.80	6

ASPIRATION

See Diagnostic and Therapeutic Procedure - Injections or Infusions.

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
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Soft tissue

# Z228	- open			97.35	6
Z219	Muscle needle biopsy, soft tissue, per site.....			31.20	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
INCISION AND DRAINAGE					
# R220	Bone		6	227.40	7
# Z226	Bursae			97.35	7
# R503	Joints		6	167.10	6
# Z228	Soft tissue - open.....			97.35	6
# R201	Sequestrectomy.....		6	193.00	7
# R202	Saucerization and bone graft.....		6	387.00	7
EXAMINATION/MANIPULATION					
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP4).			24.10	6
Note: Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.					
Club foot, etc. - manipulation and cast/strapping					
Z235	- without anaesthetic			19.45	
E584	- application of plaster cast outside hospital	add		11.15	
# Z224	- with anaesthetic			39.00	6
EXCISION					
Bone					
# R299	Phalanx.....		6	127.15	6
# R309	Metatarsal head		6	175.45	6
# E587	- each additional.....	add		41.70	
# 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	100.15	6
# R308	Os calcis, talus.....		6	283.95	7
# R301	Sesamoid, one or both.....		6	142.00	6
# R306	Tarsal bar		6	230.20	7
# R266	Tumour (foot)		6	241.30	6
Joint					
# R420	Ankle synovectomy		6	273.75	7
Metatarsophalangeal synovectomy					
# R425	- one		6	226.40	6
# R414	- two or more		6	339.65	7
Soft Tissue					
# R506	Bursa		6	149.45	6
# R549	Ganglion - simple or complex		6	177.80	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 (<i>with or without</i> 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 <i>not eligible for payment</i> 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

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

	Asst	Surg	Anae
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RECONSTRUCTION

Pseudoarthrosis

# R363	Malleoli.....	6	296.05	7
# R321	Tarsals/metatarsals/phalanx	6	260.75	7

Deformity

Osteotomy

# R259	- os calcis	6	297.85	7
# R276	- metatarsals and phalanx.....	6	144.80	7
# E596	- each additional.....add		41.70	
# R277	- midtarsal/tarsal.....	6	242.25	7

Shortening metatarsal

# R337	- one	6	225.50	6
# R338	- two or more	6	272.80	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 and hammer toe.....	6	151.25	6
# E594	- each additional hammer toe	add	41.70	

Hallux Valgus

# R304	- e.g. Mayo, Keller	6	217.15	7
# R355	- e.g. Joplin, McBride	6	267.25	7
# R360	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints	6	459.45	7
# R446	Overlapping 5th toe	6	136.35	7

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	165.20	6

Ligaments

Ankle

# R597	- one	6	301.60	7
# R548	- extensive/multiple	6	511.45	7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE		Asst	Surg	Anae
Tendons				
# R640	Exploration - tendon sheath.....	6	126.25	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	258.90	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	164.10	7
# E580	- each additional.....	add	70.95	
Suture flexor tendon				
# R585	- one	6	307.60	7
# E581	- each additional.....	add	128.95	
Achilles tendon repair				
# 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		193.00	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	171.70	7
# R555	- closed.....		132.70	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

Asst Surg Anae

REDUCTION

Fractures

Ankle

# F074	- no reduction - rigid immobilization		67.75	
# F075	- closed reduction.....	6	144.80	6
	- open reduction			
# F076	- one malleolus.....	6	237.50	7
# F077	- multiple malleoli or ligaments	6	400.00	7

Ankle fracture with tibial Plafond burst

# F104	- closed reduction.....	6	242.25	6
# F108	- open reduction	6	362.95	6

Metatarsus

F061	- one or more.....		49.20	
F062	- with rigid immobilization		67.75	
	- closed reduction			
F063	- one or more.....	6	98.35	6
E584	- application of plaster cast outside hospital	add	11.15	
	- open reduction			
# F064	- one	6	178.20	7
# F065	- two or more	6	249.65	7

Os calcis

F070	- no reduction - rigid immobilization		97.35	
F071	- closed reduction.....		161.45	7
E584	- application of plaster cast outside hospital	add	11.15	
	- open reduction			
# F072	- with repair of both the subtalar and calcaneocuboid joints	6	500.00	6

Phalanx

F056	- no reduction - rigid immobilization		49.20	
E584	- application of plaster cast outside hospital	add	11.15	
E560	- each additional	add	12.05	
F058	- closed reduction - one.....		72.35	6
E584	- application of plaster cast outside hospital	add	11.15	
E561	- each additional	add	14.90	
# F060	- open reduction	6	172.30	7

Tarsus excluding os calcis

F066	- no reduction - rigid immobilization		98.10	
F067	- closed reduction.....	6	165.20	6
E584	- application of plaster cast outside hospital	add	11.15	
# F068	- open reduction	6	237.50	7

Intra-articular fracture - I.P. Joint

F057	- closed reduction.....		77.95	
E584	- application of plaster cast outside hospital	add	11.15	
# F059	- open reduction	6	144.80	7

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

Asst Surg Anae

REDUCTION

Dislocations

Ankle

# D035	- closed reduction.....	6	111.35	6
# D036	- open reduction	6	252.45	7
# R402	- recurrent dislocation and/or subluxation	6	367.45	7

Interphalangeal

D027	- closed reduction.....		57.50	6
E584	- application of plaster cast outside hospital	add	11.15	
E578	- each additional	add	10.25	
# D029	- open reduction	6	151.25	6

Metatarsophalangeal

D030	- closed reduction.....		57.50	6
E584	- application of plaster cast outside hospital	add	11.15	
E579	- each additional	add	10.25	
# D032	- open reduction	6	163.35	7

Tarsus

D033	- closed reduction.....		147.60	6
E584	- application of plaster cast outside hospital	add	11.15	
# D034	- open reduction	6	252.45	7

Tarso-metatarsal

D026	- closed reduction, one or more joints		147.60	6
D028	- open reduction, one joint.....	6	300.00	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
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Z298	Nasopharynx (including oropharynx, oral cavity and hypopharynx) 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, hypopharynx or larynx) (IOP)				
Z296	- with flexible endoscope - if only operative procedure performed		19.20	
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	
# 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 Z304add		19.20	
# 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 Z309add		19.20	
# 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		19.20	
# Z312	- general anaesthetic.....		50.90	6
# M010	Excision of intranasal lesions by lateral rhinotomy approach	6	493.90	7
# M011	Excision of other intranasal lesions (see General Preamble GP8).....	I.C	I.C	I.C

RESPIRATORY SURGICAL PROCEDURES

NOSE

	Asst	Surg	Anae
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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 M014add		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 and Long-Term Care *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 M016add		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 M031add		119.20	

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		19.20	
# 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
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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
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[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
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External or transantral ethmoidectomy

# M023	- unilateral (to include Caldwell-Luc with transantral approach).....	6	360.45	10
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Sphenoid

# M061	Trans-septal sphenoidectomy for tumour or radical exenteration of disease		355.65	10
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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
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Closure of antral fistula

# M067	- under general anaesthetic (to include Caldwell-Luc if necessary).....		345.15	7
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RESPIRATORY SURGICAL PROCEDURES

ACCESSORY NASAL SINUSES

	Asst	Surg
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	Anae
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ACCESSORY NASAL SINUSES – ENDOSCOPIC APPROACH

# Z318	Trephine or endoscopic frontal sinusotomy	133.30	7
# M054	Intranasal maxillary antrostomy – unilateral – by endoscopic or endonasal approach	6	123.70

Ethmoidectomy/Antrostomy

# M083	Intranasal ethmoidectomy including maxillary antrostomy, with endoscope – unilateral (not eligible for payment with M061 or M054)	350.00	10
# E844	- bilateral procedure, to M083	add 200.00	
# 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 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
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ENDOSCOPY

Laryngoscopy

# E600	- using operating microscope - to charges for laryngoscopy	add	33.60	
	Direct			
# Z321	- with or without 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:

E600 is *not eligible for payment* in addition to E643.

# 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.....		182.10	7
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EXCISION

Laryngectomy

# M081	- total	6	838.90	13
# E882	- with thyroid lobectomy, to M081		177.40	
# E883	- with thyroid lobectomy, must include excision of isthmus and pyramidal tract, to M081		266.60	
# E884	- with total thyroidectomy, to M081		374.00	
# M082	Laryngofissure	6	444.80	8

Note:

Excision to include laryngoscopy.

Laryngectomy

# M084	- segmental, including reconstruction.....	6	888.85	9
# M085	Arytenoideectomy 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.....		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
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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 <i>in situ</i> ; specimens labeled as to site, to Z327	add	76.45
# E638	- with transbronchial lung biopsy under image intensification only, 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
# 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
# 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
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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 3 ribs or cartilages		9	650.00	13
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material to M105.....add			75.00	
Chest wall reconstruction					
# E640	- after chest wall resection where a significant defect (minimum 5 cm in diameter) remains requiring repair with synthetic material			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 when required.....		6	408.00	6
# M106	Mediastinal tumour		9	1004.00	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 or by video-assisted thoracic surgery (VATS), to M106 or M108..... add 25%				
REPAIR					
Chest wall - pleura					
# M109	- closed (see General Preamble GP8)			IC	6
# M110	- open (see General Preamble GP8)			IC	13
# M116	- fixation for trauma		6	350.00	7
# E604	- for fixation of each additional rib exceeding four ribs.....add			55.60	2
# M117	Sternal fixation for trauma.....		6	251.45	6
# R352	Pectus excavatum or carinatum repair (by reconstruction, not implant).....		6	750.00	11
SURGICAL COLLAPSE					
Thoracoplasty					
# M111	- one stage		9	304.20	10
# E605	- for each additional rib (more than 3) to a maximum of 3 additional.....add			55.60	
# Z742	Phrenicotomy		6	106.45	6
INCISION					
# Z353	Incisional biopsy of chest wall tumour		6	110.90	7
# Z354	Excisional biopsy of rib for tumour.....		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
# Z333	- with transbronchial biopsy under image intensification (including bronchoscopy)		6	317.20	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
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INTRODUCTION - THORACENTESIS

Z331	Aspiration for diagnostic sample	32.45		
Z332	Aspiration with therapeutic drainage with or without diagnostic sample	59.15	6	
E542	- when performed outside hospital..... add	11.15		
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.	228.40	7
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INCISION

# Z340	Biopsy of lung, needle	137.85	7
# Z336	Biopsy of pleura, needle - including diagnostic aspiration	59.15	6
# Z341	Closed drainage effusion or pneumothorax.....	69.80	6
# Z349	Intrapleural administration of chemotherapy or sclerosing agent - by any method	23.25	
# Z337	Rib resection for drainage.....	6	133.10
# M133	Thoracotomy for removal of foreign body	9	390.65
# M137	Thoracotomy with or without biopsy	9	390.65
# M134	Thoracotomy for post-operative haemorrhage or empyema	9	390.65
# M132	Thoracotomy with repair of ruptured diaphragm	9	507.45
# M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal).....	9	584.75
# 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	800.00
# Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia	6	182.90
			6

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					
# Z338	Biopsy of pleura or lung - with limited thoracotomy		9	202.80	13
# 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	1400.00	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	1285.00	13
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy, to M142, M143, S089 or S090.....	add		207.45	
# E683	- when performed thorascopically or by video-assisted thoracic surgery (VATS), to M142 or M143	add 25%			
Note:					
E644 is <i>only eligible for payment</i> when performed in conjunction with M142 or M143 following preoperative chemotherapy and/or radiotherapy.					
# M144	Segmental resection, including segmental bronchus and artery		10	1285.00	13
# E683	- when performed thorascopically or by video-assisted thoracic surgery (VATS), to M144.....	add 25%			
# M145	Wedge resection of lung		10	818.45	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 thorascopically or by video-assisted thoracic surgery (VATS), to M145, M149 or M151.....	add 25%			

RESPIRATORY SURGICAL PROCEDURES

LUNGS AND PLEURA

	Asst	Surg
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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	248.40	
# E614	- omental graft.....	add	162.45	
# E615	- intra-pericardial dissection.....	add	120.80	
# 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.....	add	142.10	
# E617	- with pleural tent.....	add	78.80	
# E618	- with decortication of remaining lobe(s).....	add	121.85	
# E619	- sleeve lobectomy.....	add	162.45	
# 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	75.00	
# E607	- re-operation more than 30 days subsequent to previous excision, to appropriate excision fee.....	add	152.30	
# M155	Lung transplant (one lung).....	18	2054.25	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 endarterectomy, 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.

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 366.50 28

E682 - axillary artery graft for cardiopulmonary bypass, to E650 add 423.85

Note:

Anaesthesiologist - see General Preamble GP58 to GP61.

Extracorporeal Membrane Oxygenator (ECMO)

Z788 - includes cannulating and decannulating, by any method, heart, vein and/or artery and repair of vessels if rendered 366.50 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
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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 with pump

# E670	- following previous thoracotomy	add	224.70
# E671	- following previous sternotomy	add	337.00

Note:

More than one *month* after original operation.

Cardiac massage

# R765	- open	13	231.30	13
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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
# Z445	Repositioning of permanent endocardial electrode (as separate procedure)		323.75
# Z435	Insertion of permanent endocardial electrode(s)		154.10
# Z436	Exposure of vein and implantation of pack		166.55
# R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	6	454.55
# R751	Implantation of epicardial electrode(s) plus implantation of pack	6	465.00
# Z429	Implantation of coronary sinus lead for biventricular pacing	6	299.25

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

	Asst	Surg	Anae
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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 days.
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
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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	1001.40	20
Cardiotomy				
# R712	- with exploration.....	18	525.75	20
# R713	- with removal of foreign body.....	18	635.45	20
# R714	- with removal of tumour	18	525.75	20
# E660	- epicardial E.P.S. mapping..... add		185.15	
# E661	- endocardial E.P.S. mapping		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 <i>may include</i> cryoablation, microwave, or radiofrequency (unipolar or bipolar) ablation.]				
# R710	Resection/ablation for ventricular tachycardia (to include cardiotomy, mapping with or without HIS bundle)		1112.15	20
Excision				
# R920	Ventricular tumour	18	712.15	28
# R746	Ventricular aneurysm.....	18	864.50	28
# R747	Aneurysm of sinus of Valsalva.....	18	783.55	28
# E648	- excision of extensive endocardial scar, to ventriculotomy or aneurysm repair		135.80	
# R741	Coronary artery endarterectomy and/or gas endarterectomy.....	18	730.70	20
# E651	- when done in conjunction with coronary artery repair		202.05	

Note:

R741, E651 - for multiple or complex procedures, assessment by the *Medical Consultant* is available and may be requested.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

	Asst	Surg	Anae
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Coronary artery repair

# R742	- one	18	895.55	20
# R743	- two	18	1255.00	20
# E654	- each additional	add	187.70	
# E645	- off pump coronary artery bypass grafting, to R742 or R743.....	add	366.50	40

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. See General Preamble GP61.
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.
3. Where a single segment of vein is used for more than 2 anastomoses, the second and subsequent anastomoses are to be claimed at 50% of the E654 fee.

# E652	- use of internal mammary or epigastric or radial artery for construction of bypass graft, to R742 or R743.....	add	186.70	
# 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	730.70	20

Resection coarctation

# R757	- infant	13	785.90	20
# R756	- child.....	13	755.80	20
# R758	- adolescent or adult.....	13	967.10	20
# R759	Congenital heart procedures - e.g. Blalock, Glenn, Potts, Waterston or Central....	13	755.80	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	755.80	20
# R716	- endocardial cushion and valve defect.....	18	1124.70	20
# R717	- with anomalous 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.

Percutaneous transluminal catheter assisted closure for Secundum arterial 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	1443.05	28
# R872	Donor cardectomy.....	7	481.40	8
# R874	Cardiopulmonary transplantation.....	18	2534.25	28
# M157	Donor Heart - Lung removal	8	906.45	8

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
REPAIR				
# R720	Total repair Tetralogy of Fallot - with or without previous arterial shunt	18	1261.80	28
# R722	Total anomalous pulmonary venous drainage	18	1124.70	28
# R723	Total correction transposition of great vessels.....	18	1124.70	28
# R721	Arterial repair of transposition.....	18	1687.50	28
# R921	Complete A-V canal.....	18	1480.40	28
# R922	Single ventricle	18	1687.50	28
# R923	Double outlet - right/left ventricle	18	1480.40	28
# R924	Double outlet ventricle with transposition	18	1687.50	28
# R925	Truncus arteriosus	18	1687.50	28
# R926	Interrupted aortic arch.....	18	1480.40	28
# R927	Aorto-pulmonary window	18	948.75	28
# R928	R-V outflow tract with valve and tubular graft	18	1064.55	28
# R929	Debanding arterioplasty of pulmonary artery.....	18	943.45	28
# R768	Pulmonary artery banding.....	13	628.95	20
# R769	- with pressure studies by anaesthetist, extra/hour.....		-	6
# R770	Correction of cor triatriatum	18	864.40	20
# R771	Vascular ring	18	755.80	20

CARDIOVASCULAR SURGICAL PROCEDURES

VALVES

		Asst	Surg	Anae
# R724	Pulmonary valvotomy	18	663.10	28
# R725	Pulmonary valvotomy and infundibular resection	18	758.80	28
# R772	Pulmonary valve replacement	18	758.80	28
# R726	Tricuspid valvotomy	18	778.25	20
# R727	Tricuspid annuloplasty	18	662.55	20
# R728	Tricuspid valve replacement	18	758.80	28
# R729	Mitral valvotomy	18	717.25	20
# R730	Mitral valvotomy - restenosis	18	798.80	20
# R734	Mitral annuloplasty	18	770.70	20
# R735	Mitral replacement	18	948.70	28
# R733	Mitral valvoplasty	18	963.40	28
Mitral valve reconstruction				
# R773	- simple (includes annuloplasty)	18	1618.50	28
# R774	- complex (includes annuloplasty and repair of both the anterior and posterior leaflets)	18	2021.05	28
# R930	Aortic valvoloplasty	18	837.70	28
# R736	Aortic valvotomy	18	707.85	20
# R737	Aortic infundibular resection (ventriculomyotomy)	18	869.70	28
# R738	Aortic valve replacement	18	1036.50	28
# E647	- patch aortoplasty with pericardium or graft, to R738 and/or aortic annuloplasty	add		264.70
# E656	- aortic annuloplasty (reconstruction and enlargement of aortic annulus), to R738 and/or patch aortoplasty	add		288.85
# R863	Replacement of aortic valve, replacement of ascending aorta, and reimplantation of coronary arteries (Modified Bentall)	18	2021.05	28
# R876	Valve sparing aortic root replacement or remodelling	18	2021.05	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	95.80	6
# R776	- hepatic artery	6	263.05	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
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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 (e.g. R784, R785) 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

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	1396.90	17
# E627	- ruptured aneurysm, to R875.....add			400.00	
# E510	- for branched or fenestrated devices, to R875	add		838.15	
# E509	- conduit to aorta or common iliac artery, to R875	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 perioperative morbidity or death from open surgical repair.
2. For open repair of abdominal aorta aneurysms, see page Q11.]

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	841.00	10
# E665	- with patch graft, to R792add		419.00	

Note:

R815 is *not eligible for payment* with R792.

# R796	- carotid body tumour	10	769.85	10
# R798	- aneurysm - reconstruction or excision with graft.....	10	820.70	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	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.....	18	1455.30	20
# R800	- arch.....	18	1807.10	20
# R801	- descending with or without temporary shunt.....	10	1260.30	20
# E667	- ruptured	add	266.60	
# R803	Thoraco-abdominal aneurysm.....	18	2566.70	30

Note:

If the services of a second anaesthetist are required, the second anaesthetist is also permitted to claim R803C.

Abdominal aorta - repair or excision with graft

# R802	- aneurysm repair alone or including unilateral common femoral repair	10	1500.00	17
# R817	- aneurysm repair and bilateral common femoral repair.....	10	2202.00	17
# R877	- aneurysm with repair of iliac artery aneurysm (unilateral or bilateral).....	10	2002.75	17
# E626	- with implantation of inferior mesenteric artery, to R802, R817 or R877....add		174.35	
# E627	- ruptured aneurysm to R802, R803, R817 or R877	add	400.00	

[Commentary:

For endovascular aneurysm repair, see page Q10.]

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	954.10	10
Note:				
Use R935 for excision of celiac ganglion.				
# R940	Pulmonary thromboendarterectomy (PTE) - includes circulatory arrest with hypothermia	18	2021.05	28
Aorto-Iliac repair				
# R783	- including common iliac repair (uni- or bilateral)	10	2002.00	17
# R784	- plus unilateral common femoral repair.....	10	2102.00	17
# R785	- plus bilateral common femoral repair.....	10	2202.00	17
# E626	- plus implantation of inferior mesenteric artery	add	174.35	
# R814	- embolectomy or thrombectomy of bifurcation (aorta or graft).....	10	461.50	10
# R858	Total removal of infected aortic graft (stem and limbs)*.....	10	918.35	17
# E664	- closure of duodenum	add	127.05	
# R859	Partial removal of infected aortic graft (one limb only)*.....	10	344.00	10
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-bifemoral graft	10	1200.00	10
# R934	Aorto-femoral unilateral graft (for bilateral see R785).....	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/popliteal/ 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 R783, R784, R785, 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	857.35	10
# E672	- composite femoral popliteal/tibial bypass (vein PFPE, dacron).....add		133.40	
# R794	- with prosthetic graft.....	10	733.15	10

Femoro-anterior/posterior tibial/peroneal bypass graft

# R787	- with saphenous vein	10	1006.75	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	490.00	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

# R797	- popliteal	10	1414.15	17
# R804	- tibial	10	1643.00	17

CARDIOVASCULAR SURGICAL PROCEDURES

VEINS

Asst Surg Anae

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 *months* 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

# 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
# R838	I.V.C. - transvenous (umbrella)	6	303.00	10

CARDIOVASCULAR SURGICAL PROCEDURES

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 J31 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 <i>with or without</i> femoral vein ligation	10	446.50	10
# E657	- plus I.V.C. ligation	add	446.50	
# R829	Thrombectomy, other than above	7	302.80	10
# R865	Distal spleno-renal shunt	10	1259.55	10

ANASTOMOSIS

# R822	Porto-caval.....	10	919.10	10
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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	440.00	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.....	33.90	
# Z408	Bone marrow core biopsy (with biopsy needle).....	63.35	6

Note:

1. If Z403 and Z408 are both performed through the same site or with the same biopsy needle, only Z408 is *eligible for payment*. Maximum of 1 Z408 per patient, per day.
2. If the aspiration does not result in any material for examination, the service is *not eligible for payment*.

[Commentary:

If Z408 and Z403 are performed through different sites, both services are payable.]

Bone marrow transplantation - team fee

# Z425	- aspiration from donor	506.75	8
# Z426	- infusion into recipient	62.55	6

[Commentary:

Bone marrow transplantation is not an insured benefit for treatment of some conditions. Please refer to Ministry of Health and Long-Term Care *Medical Consultant* for qualifying diagnoses.]

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	489.30	8	
Axillary or inguinal lymph nodes				
# R913 - radical resection, unilateral	6	367.95	7	
# R914 - limited resection, unilateral	6	207.30	6	
BIOPSY				
# Z405 Anterior cervical lymph node(s), unilateral.....	6	186.90	6	
# Z411 Axillary or inguinal lymph node(s), unilateral	6	62.95	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	108.05	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	11.15	
# Z537	- requiring general anaesthetic.....		97.05	6

Tongue tie, release of

Z111	- simple.....		15.35	
# Z112	- complex or requiring general anaesthetic		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	11.15	
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 GP58, also Bulletin #4203) .			8
# S021	Repair of extensive laceration (see General Preamble GP8).....	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

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

	Asst	Surg	Anae
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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 or lateral	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	

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.....		178.35	6
# S065	Adenoidectomy		101.25	6
E839	- with flexible endoscope, to S063 or S065.....	add	19.20	

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

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIPS

	Asst	Surg	Anae
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INCISION

# Z503	Biopsy	35.40	6
E542	- when performed outside of hospital.....add	11.15	

EXCISION

Wedge resection of lip

# S011	- vermillion.....	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		11.15	
# S012	Lip shave vermillionectomy	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 GP8)		I.C	I.C

Note:

Cleft lip reconstruction (S013, S014, S015) is *not eligible for payment* with M030, M031 or M032.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

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.

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 anaesthetists 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, <i>with or without</i> duodenoscopy				
# Z399	- elective.....	nil	92.50	4
# Z400	- for active bleeding.....	nil	125.10	4
# 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 GP8)	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	

[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

INCISION

Oesophagostomy

Cervical

# S084	- other than neonatal	212.35
# S085	- neonatal	304.20
	Intrathoracic oesophageal stent	
# S082	- via laparotomy.....	410.55
# S083	- via oesophagoscope (includes Z515)	304.20
# 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)	1081.55
# S090	Total thoracic oesophageal resection	1465.35
# E730	- with reconstruction..... add	678.85
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material, to S089 or S090	75.00
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/ or radiotherapy, to S089 or S090..... add	207.45

Note:

1. E644 is *only eligible for payment* when performed in conjunction with S089 or S090 following preoperative chemotherapy and/or radiotherapy.
2. S086 is *not eligible for payment* with S088.
3. Z505 is *not eligible for payment* with S086.

# S093	Enucleation of benign oesophageal tumour	584.15
# E683	- when performed thorascopically or by video-assisted thoracic surgery (VATS), to S087, S089, S090, S093..... add 25%.	

REPAIR

# S161	Oesophageal myotomy, partial (below aortic arch).....	584.15
# E758	- with oesophageal hiatus hernia repair	217.35
# S100	Total thoracic oesophageal myotomy (as sole procedure)	738.90
# E758	- with oesophageal hiatus hernia repair	217.35
# E683	- when performed thorascopically or by video-assisted thoracic surgery (VATS), to S100, S161..... add 25%.	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

Asst Surg Anae

REPAIR

Oesophageal hiatus hernia

# S091	- abdominal or transthoracic approach with fundal plication	750.00
# S092	- recurrent.....	709.85
# E793	- laparoscopic or laparoscopic assisted, to S091 or S092add 25%	
# E744	- with gastroplasty, to either S091 or S092add	115.80
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material, to S091 or S092add	75.00
# E742	- when S091 or S092, with or without gastroplasty, is done in conjunction with cholecystectomy, and/or vagotomy with or without drainage procedures, add E742 to S091 or S092 (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	507.00
# S097	Oesophago-gastrostomy for bypass (as sole procedure).....	608.30
# E683	- when performed thorascopically or by video-assisted thoracic surgery (VATS), to S095, S096, S097..... add 25%	

Oesophageal bypass, abdomen to neck

# S098	- with stomach	912.60
# S099	- with colon or jejunum	1264.05
# E683	- when performed thorascopically or by video-assisted thoracic surgery (VATS), to S098 or S099	add 25%

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.....	1153.85

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
# 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	314.80	10

Gastrostomy

# S118	Gastrostomy	6	345.85	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
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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 S122add 25%			

Partial or subtotal

# S123	- distal.....	7	840.00	8
# S125	- proximal	7	900.00	8
# E731	- with suture of bleeding peptic ulceradd		247.05	
# E708	- with vagotomy.....add		122.05	
# E709	- with cholecystectomy.....add		122.05	
# E711	- after previous gastro-enterostomy		106.55	
# E706	- with choledochotomy		122.05	
# E712	- after previous vagotomy and pyloroplasty		111.10	
# E713	- after previous partial gastrectomy.....add		137.55	
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy, to S125		207.45	

Note:

E644 is *only eligible for payment* when performed in conjunction with S125 following preoperative chemotherapy and/or radiotherapy.

# 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		122.05	
# E706	- with choledochotomy		122.05	
# 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%		
# 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	503.10	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 <i>only eligible for payment</i> 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 <i>not eligible for payment</i> in conjunction with S120.					
4. S160 is <i>not eligible for payment</i> 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	300.00	10
Note:					
S113 is <i>only eligible for payment</i> 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 <i>Health Insurance Act</i> .					
2. Morbid obesity refers to patients with a <i>Body Mass Index (BMI) > 40</i> .]					

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	122.05	
# S134	Gastroduodenostomy or gastrojejunostomy	7	406.85	7
# E716	- either of above plus vagotomy	add	147.30	
# E711	- after previous gastroenterostomy	add	106.55	
# E721	- with choledochotomy	add	122.05	
# 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	503.15	7
# S140	Closure of gastrocolic fistula.....	7	574.40	7

Note:

For suture of duodenal ulcer, refer to S139 above.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

	Asst	Surg	Anae
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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 duodenumadd	137.05	
# Z584	Small bowel push enteroscopy	185.15	
# Z512	Endoscopy of ileostomy or colostomy, or reduction of obstructed Koch ileostomy .	36.80	4
# E747	- to cecumadd	31.40	
# Z514	- with biopsy	44.55	4

SIGMOIDOSCOPY

# Z580	Sigmoidoscopy (using 60 cm. flexible endoscope).....	nil	57.70	5
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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 GP61 are *not eligible for payment* with anaesthesia services for Z580C.
4. E003C is not payable for anaesthesia services rendered for Z580.

COLONOSCOPY

Colonoscopy for Risk Evaluation

# Z497	Confirmatory colonoscopy - sigmoid to descending colon.....	nil	51.95	5
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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 (e.g. a first degree relative or at least two second degree relatives with colorectal cancer or a premalignant lesion) – sigmoid to descending colon	nil	51.95	5
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Payment rules:

Z499 is only insured for a patient 40 years of age or older or 10 years younger than the earliest age of diagnosis of the youngest affected relative.

# Z492	Five year follow up of normal colonoscopy (Z499), absence of intervening signs or symptoms - sigmoid to descending.....	nil	51.95	5
# Z493	Ten year follow up of normal colonoscopy (Z497, Z555), absence of intervening signs or symptoms - sigmoid to descending	nil	51.95	5

[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 hyperplastic polyposis syndrome who are at increased risk for adenomas and colorectal cancer and need to be identified for more intensive follow-up evaluation. See Z494.
4. A patient with sessile adenomas 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 months) to verify complete removal. See Z491.]

Payment rules:

1. Z492 is an *uninsured service* for the same patient in the five year period following Z499.
2. Z493 is an *uninsured service* for the same patient in the ten year period following Z497 and Z555.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

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 guidelines.					
2. Z498 is eligible for payment when rendered for follow up of adenomatous polyps:					
a. after 5 years if 1-2 small (<1 cm) tubular adenomas with low grade dysplasia;					
b. after 3 years if polyp(s) removed completely and 3-10 adenomas, or any large adenoma (>1 cm), or villous features, or high grade dysplasia, or right-sided sessile serrated adenoma;					
c. after less than 3 years if > 10 adenomas.					
#	Z495	Follow up of unsatisfactory colonoscopy	nil	51.95	5
Payment rules:					
Z495 is <i>only eligible for payment</i> 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 <i>only eligible for payment</i> 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 <i>not eligible for payment</i> if performed more than six months 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 <i>uninsured service</i> 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.
2. Time units and anaesthesia extra units listed on GP61 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.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

			Asst	Surg	Anae
# E740	- to splenic flexure, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add	nil	51.95	
# E741	- to hepatic flexure, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add	nil	31.40	
# E747	- to cecum, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555.....	add	nil	31.40	
# E705	- into terminal ileum, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add		30.50	
# 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 angiodyplastic lesion(s) (one or more), to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z555 or Z580.....	add		27.05	
# E785	- multiple screening biopsies (> 34 sites) for malignant changes in ulcerative colitis, 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	

[Commentary:

E749 is *not eligible for payment* in a hospital.

Note:

1. E717 rendered in conjunction with E785 is *not eligible for payment*.
2. For sigmoidoscopy with rigid scope, see Z535 (Rectum).

[Commentary:

For assessments claimed same day as colonoscopy by Internal Medicine (13) or Gastroenterology (41) see A120.]

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)		Asst	Surg	Anae
# Z513	Hydrostatic - Pneumatic dilatation of colon stricture(s) through colonoscope		107.50	
# Z570	Fulguration of first polyp through colonoscope		49.80	4
# E719	- each additional polyp (maximum of 4).....add		24.25	
# Z571	Excision of first polyp greater than or equal to 3mm through colonoscope	nil	150.15	4
# E720	- each additional polyp greater than or equal to 3mm (maximum of 2).....add		77.50	
	Excision of obstructive tumour or stricture through colonoscopy			
# Z764	- less than 2 cm.....		69.80	
# Z765	- 2 cm or greater.....		131.75	
# E687	- with laser debulking	add	69.80	
# E685	- total excision of very large sessile polyp (> 3 cm) through colonoscope, and may include fulguration, each	add		227.65

Note:

Z570 payable at nil if claimed with E685 or Z571 for same polyp.

INCISION

Enterotomy

# S149	Ileostomy	6	406.85	7
# S150	Small intestine - including excision of polyps or biopsy	6	406.85	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	406.85	7
# S155	Colonoscopy with laparotomy	6	387.40	7
# S156	Exteriorization of intestine (Mickulicz).....	6	406.85	6
# S157	Colostomy.....	6	406.85	7
# S158	Cecostomy.....	6	387.40	7
# S160	Enter-enterostomy	6	406.85	7
# E793	- laparoscopic or laparoscopic assisted, to S149 or S157.....add 25%			

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

			Asst	Surg	Anae
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	746.10	7	
# S165	- other.....	6	687.55	7	
# S166	Small and large intestine terminal ileum, cecum and ascending colon (right hemicolectomy).....	7	799.55	7	
# S167	Large intestine - any portion	7	799.55	7	
# E796	- with mobilization of splenic flexure, to S167		102.40		
# S169	Total colectomy with ileo-rectal anastomosis.....	9	1242.90	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	1082.95	8	
# E808	- neo-rectal pouch formation, to S169 or S171		150.00		
# E793	- laparoscopic or laparoscopic assisted, to S165, S166, S167, S169, S171 or S172		add 25%		
Ileostomy					
# S168	- subtotal colectomy	7	1057.70	7	
# S170	- plus total colectomy plus abdomino-perineal resection	9	1790.60	10	
# E793	- laparoscopic or laparoscopic assisted, to S168 or S170		add 25%		
Two-surgeon team					
# S173	- abdominal	9	1632.80	10	
# S174	- perineal		481.00		
# E738	- with continent ileostomy, to either S168, S169, S170, S173 or S174.....add		387.40		
E718	- bowel resection following previous resection with anastomosis, or following S217, S213, S214 or S215.....add			142.40	
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	544.35	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.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

Asst | Surg | Anae

Intestinal obstruction (mechanical)

One stage

# S175	- without resection	6	620.00	7
# S176	- with entero-enterostomy	6	748.00	7
# S177	- with resection	6	900.00	7
# S180	- with enterotomy.....	6	672.00	7

Note:

If staged procedure, refer to Surgical Preamble SP2.

# S178	Intestinal atresia (newborn)	6	682.90	7
# S179	Meconium ileus.....	6	682.90	7

REPAIR

Revision of ileostomy or colostomy

# S181	- skin level	6	131.75	7
# S182	- full thickness	6	350.65	7
# S192	Simple revision of continent ileostomy pouch.....	6	387.40	7
# S191	Complete reconstruction of continent ileostomy to include valve repair	6	951.20	7
# S193	Revision of standard ileostomy into continent ileostomy pouch	6	793.50	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	122.05	
# S185	Closure of colostomy or enterostomy - with or without resection and/or anastomosis	6	406.85	7
# S187	Plication of small intestine for adhesions	6	528.85	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
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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	239.20	7
# S205	Appendectomy.....	6	336.60	7
# S206	- with gross perforation and peritonitis	6	451.50	7

TRANSPLANT

Small bowel transplant

# S201	- donor.....	6	964.50	8
# S202	- recipient	20	2748.75	30

Multivisceral transplant

# S196	- donor.....	6	2748.75	8
# S197	- recipient, without evisceration.....	25	7934.35	35
# E807	- recipient, with evisceration, to S197	add	2644.75	

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.
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.]

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

	Asst	Surg	Anae
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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 hospital	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

# S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	8	1100.00	8
# E808	- neo-rectal pouch formation, to S213.....	add	150.00	
# S214	Abdomino-perineal resection or pull through	8	1300.00	10
# E793	- laparoscopic or laparoscopic assisted, to S213 or S214	add 25%		

Two surgeon team

# S215	- abdominal surgeon	8	1009.85	10
# S216	- perineal surgeon		459.05	
# S217	Hartmann procedure.....	8	890.00	9
# S218	Colon reconstruction following Hartmann procedure.....	8	1030.00	8
# E796	- with mobilization of splenic flexure, to S218	add	102.40	
# 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
# E710	- each additional biopsy	add	45.55	
# S222	Presacral or trans-sacral proctotomy and excision of lesion	6	350.65	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	329.65	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, use codes Z570, Z571 (page S16).

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

		Asst	Surg	Anae
REPAIR				
# S223	Anastomosis of rectum	6	488.20	6
Rectal prolapse				
# S225	- excision of mucous membrane	6	239.20	7
# S226	- perineal repair - major	6	356.50	6
# S227	- abdominal approach	6	554.10	8
# S228	- insertion of Thiersh wire	6	190.85	6
SUTURE				
# S229	Suture of rectum, trauma-external approach	6	239.20	7
Closure of fistula				
# S231	- rectovaginal (any repair)	6	338.55	7
# S525	- rectovesical	6	446.90	7
MANIPULATION				
# Z541	Dilation and/or disimpaction or removal of foreign body under general anaesthetic (as sole procedure)		58.15	6
# Z756	Fecal disimpaction - no anaesthetic		36.80	
Note: The fees for excision, ligation, injection of haemorrhoids and treatment of intra or perianal condylomata acuminata include anoscopy.				
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	11.15	
# S241	Sphincterotomy(ies) under local anaesthesia	6	88.20	
# S243	Sphincterotomy(ies) under general anaesthesia	6	200.00	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

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	34.60	
# Z566	Barron ligation(s) plus cryotherapy (not to exceed 6 in any one year)	nil	39.10	
# S249	Local excision for malignancy.....	6	153.05	7
Z757	Excision of benign anal lesion(s)	6	47.15	6
E542	- when performed outside hospital.....add		11.15	
# S251	Fistula-in-ano	6	213.15	6

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	1801.00	7
# S256	Excision of scar, for stenosis	6	142.40	6
# S257	Anoplasty, for stenosis	6	275.05	6
# S258	Repair of anal sphincter.....	6	275.05	7
# S259	Repair of anal sphincter and ano-rectal ring	6	356.50	6

DESTRUCTION

Z548	Cauterization of fissure		34.90	6
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Fulguration of condylomata

Z549	- local anaesthetic		30.95	
# Z758	- general anaesthetic.....	6	97.65	6

MANIPULATION

Z550	Dilation of anal sphincter		12.05	6
# S248	Peter Lord procedure.....		43.60	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIVER

Asst Surg Anae

INCISION

Biopsy

# Z554	- incisional		102.10	
# Z551	- needle		87.80	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
Formal anatomical resection				
# S270	- one or two liver segments	12	1184.60	12
# S267	- three or four liver segments	12	1652.15	12
# S271	- five or more liver segments	12	1784.60	12
# 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		
# S274	Deceased donor, liver removal	6	964.50	8
# S294	Deceased donor, liver transplant	20	2748.75	30
# S295	Repeat liver transplant.....	30	3776.20	40
# S265	Living donor, hepatectomy.....	20	4760.60	35
# S266	Living donor, orthotopic liver transplant	25	5289.55	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		

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	

Note:

E662, E666, E668, E702, E680, E681, E669 are payable with Z561, Z558 or Z760.

# Z593	Nasobiliary catheter insertion	55.25
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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	610.20	8
# S280	Transduodenal sphincterotomy and choledochotomy (previous cholecystectomy)	7	844.65	9
# S281	Choledochoduodenostomy or choledochoenterostomy or choledochocholechochostomy.....	7	721.70	9
# E704	- with choledochoscopy, to S276, S280, S281 or S287 plus E721add		46.50	
Note: S281 cannot be claimed with S276.				
# S282	Cholecystogastrostomy	7	447.45	7
# S283	Cholecystoenterostomy	7	447.45	7
# E743	- with entero-enterostomy, to S281 or S283	add	153.05	
# S285	Intrahepatic choledochoenterostomy (anastomosis above the common hepatic duct bifurcation)	9	915.30	12
EXCISION				
# S287	Cholecystectomy	7	478.00	7
# E721	- with choledochotomy	add	122.05	
# E722	- with transduodenal sphincterotomy	add	162.70	1
# E728	- with truncal or selective vagotomy.....	add	167.65	
# E729	- with highly selective vagotomy	add	284.75	
# E794	- with intra-operative cholangiogram, to S287	add	35.85	
# S291	Choledochectomy for tumour*	8	406.85	8
REPAIR				
# S292	Common duct stricture, dissection and/or resection*	7	203.40	10
# S293	Biliary duct atresia, infant (see General Preamble GP8)	8	I.C	12
# Z596	Extracorporeal shock wave lithotripsy for bile duct calculi.....		314.20	6

Note:

* For reconstruction, refer to S281.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

PANCREAS

Asst | Surg | Anae

INCISION

Biopsy

# Z762	- needle		102.10	
# Z577	- incisional		122.05	7
# S297	Drainage of acute pancreatitis or abscess or marsupialization of cyst	7	406.85	7

EXCISION

Pancreatectomy

# S298	Complete with splenectomy	9	1270.20	13
# S300	"Whipple type" procedure	9	1785.45	13
# S301	Local complete excision of tumour or lesion	8	508.55	8
# S309	Distal - body, tail with splenectomy with or without anastomosis	9	986.05	11
# S299	Distal - body, tail with preservation of spleen, with or without anastomosis	9	1250.00	11
# E793	- laparoscopic or laparoscopic assisted, to S298, S299, S300, S301 or S309	add 25%		
# E709	- with cholecystectomy, to S299, S300 or S309.....	add	122.05	

REPAIR

Pancreatic cyst

# S305	- gastrostomy	7	589.95	8
# S306	- duodenostomy	8	589.95	8
# S307	- jejunostomy.....	8	589.95	8
# S304	Lateral pancreateoduodenostomy or anastomosis of filleted pancreatic duct to intestine (Puestow)	9	813.60	10

TRANSPLANT

# S302	Donor pancreas removal	6	679.50	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.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

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	11.15	

INCISION

# Z563	Needle biopsy of peritoneum	48.00	
# 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	330.00

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. Omentectomy for tumour debulking - professional assessment by the Ministry of Health and Long-Term Care *Medical Consultant* is available and may be requested.

# E745	- insertion of tubes and post-operative continuous peritoneal lavage when combined with any other abdominal procedure	add	94.85	
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Laparotomy

# S321	- for acute trauma.....	6	397.15	6
# E733	- with repair of intestine - single	add	142.40	
# E734	- multiple and/or with resection	add	211.15	
# E735	- with splenectomy (partial or complete)	add	284.75	
# E736	- with repair of lacerated liver.....	add	187.90	
# E739	- with repair of diaphragm	add	122.05	
# E723	- with repair of lacerated spleen.....	add	284.80	
# E693	- with repair of ruptured bladder.....	add	-	
# E694	- with nephrectomy.....	add	-	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

	Asst	Surg	Anae
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INCISION

Peritoneal abscess

# S313	- subphrenic	7	370.95	7
# S314	- abdominal	6	264.45	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.....		288.30	
# 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	
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Insertion of peritoneo-jugular shunt for ascites

# S203	- primary	7	281.85	7
# S209	- revision.....	7	208.15	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 GP8)	I.C	7	
# S317	Umbilectomy - plastic.....	6	111.45	7

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 pannus 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 MOHLTC 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 pannus 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	335.15	6
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DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

		Asst	Surg	Anae
ENDOSCOPY				
Peritoneoscopy, culdoscopy or laparoscopy				
# Z552	- without biopsy	6	131.45	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants	6	173.25	6
REPAIR				
# S325	Omentopexy - as sole operative procedure.....	6	305.05	7
Herniotomy				
Inguinal and/or femoral				
# S322	- infants	6	325.00	7
# S326	- children	6	275.00	6
# S323	- adolescents and adults	6	331.80	7
Unilateral with exploration of other side				
# S328	- infants and children.....	6	329.30	7
Strangulated or incarcerated				
# S329	- without resection of bowel.....	6	425.00	7
# S330	- with resection of bowel.....	6	660.50	7
Umbilical				
# S332	- adolescent or adult.....	6	300.00	6
# S333	- child (operative)	6	222.75	6
# E764	- umbilical hernia repair when done in conjunction with other abdominal surgery, to other surgeryadd		96.85	
# E756	- with resection of strangulated contents		111.45	
# E757	- without resection of strangulated contents		55.25	
Omphalocele and gastroschisis				
# S348	Primary or first stage repair.....	7	375.80	7
# E691	- requiring mobilization of abdominal wall musculature, to S348add		100.00	
# S349	Second or subsequent stage repair.....	7	475.80	7
Congenital diaphragmatic hernia				
# S346	Primary or first stage repair.....	9	576.90	13
# S347	Second or subsequent stage repair	9	366.00	13
# S340	Ventral - post-operative.....	6	370.95	7
# S344	Massive incisional hernia.....	6	500.00	7
# E793	- laparoscopic or laparoscopic assisted, to S344.....add 25%			
# S345	Massive sliding inguinal hernia	6	400.00	7
# E725	- recurrent - all types, except oesophageal.....add	4	130.00	
# E726	- repeat recurrent inguinal hernia (more than 2 repairs), to S322, S323, S326, S329 or S330.....add	4	226.00	
# S342	Epigastric.....	6	239.20	6
# E727	- hydrocele - extra - applicable to adults only		65.90	
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			143.55	6
# S401	Drainage of kidney abscess.....	7	411.30	7	
# S402	Drainage of perinephric abscess	7	267.60	7	
# S403	Exploration of renal and peri-renal tissues (with or without biopsy or unroofing of cyst)	7	356.70	7	
# E792	- when performed laparoscopically, to S403add 25%				
# S400	Laparoscopic placement of probe(s) for ablation of renal tumour	7	404.95	7	
Payment rules:					
This service is <i>not eligible for payment</i> in addition to J069.					
# S405	Nephrolithotomy - open	7	482.40	7	
# S408	Pyelolithotomy - open	7	437.20	7	
# S430	Removal of staghorn calculus filling renal pelvis and calyces - open, with or without x-ray control and/or anatomic nephrolithotomy.....	7	657.75	9	
EXCISION					
# S410	Calycectomy with diversion of urine	7	512.00	7	
# S411	Partial or heminephrectomy.....	7	875.00	7	
# E792	- when performed laparoscopically, to S411add 25%				
# S423	Partial or heminephrectomy with total ureterectomy.....	7	757.85	7	
Nephrectomy					
# S412	- ectopic kidney	7	467.00	7	
# S413	- lumbar	7	467.00	7	
# E792	- when performed laparoscopically, to S413add 25%				
# S415	- transperitoneal	7	522.50	7	
# S416	- thoraco-abdominal or radical nephrectomy.....	9	875.00	13	
# E766	- with gland dissection.....add		29.70		
# E767	- with repair of vena cava for thrombus - below the hepatic vein	add	138.15		
# E768	- with repair of vena cava for thrombus - above the hepatic vein	add	236.70		
# E792	- when performed laparoscopically, to S416add 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	939.70	10	
# S420	Nephroureterectomy, total, with resection of ureterovesical junction.....	7	673.10	10	
# E792	- when performed laparoscopically, to S420add 25%				
REPAIR					
# S422	Pyeloplasty (with or without nephropexy)	7	679.25	7	
# E792	- when performed laparoscopically, to S422add 25%				
# E754	- with removal of calculus.....add		57.50		
# S428	Symphysiotomy for horseshoe kidney with or without nephropexy and associated procedures	7	437.20	7	
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		314.20	6	

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND UPPER URINARY TRACT

		Asst	Surg	Anae
PERCUTANEOUS PROCEDURES				
# Z629	Percutaneous nephrostomy		153.35	6
# Z623	Insertion of stent		95.10	
# Z624	Dilatation of tract		105.25	
# Z625	Selective catheterization of calyces (one or more)		52.70	
# Z626	Nephroscopy, percutaneous or retrograde		95.95	6
# Z627	Removal of renal calculi.....	6	167.85	7
# E759	- if disintegrated by any method, to Z627..... add		95.95	
# E772	- percutaneous removal of staghorn calculus filling renal pelvis and extending into calyces		175.50	
# Z636	Endoscopic ureterotomy or pyelotomy		273.25	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 to renal transplantation procedures..... add		301.05	
# S435	Kidney transplant	9	1553.15	13
# E769	- team fee (not to be billed when assistant fees are billed)..... add		260.05	
# S434	Kidney re-transplant	9	1858.15	13
# E771	- team fee (not to be billed when assistant fees are billed)..... add		343.40	
# S436	Donor nephrectomy - unilateral or bilateral (to include renal perfusion with hypothermia when rendered by surgeon)	7	653.20	8
# E753	- live donor		156.30	
# E792	- when performed laparoscopically, to S436		add 25%	
Note:				
For nephrological components - see Diagnostic and Therapeutic Procedures.				
# S437	Renal autotransplantation	7	1161.60	10
# 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 <i>not eligible for payment</i> with Z638.				
Cystoscopy and diagnostic Ureteroscopy				
# Z628	- above intramural		125.65	6
# E819	- diagnostic ureteroscopy of second ureter, to Z628		54.65	
# E822	- ureteroscopy to upper third of ureter or renal pelvis, to Z628		37.70	
# E760	- with removal of calculus		167.85	
# E761	- intracorporeal lithotripsy by any method		95.95	
# E820	- with biopsy of one or more sites in ureter and/or pelvis using ureteroscope		49.75	
# E823	- resection and fulgurization of one or more ureteral or renal pelvic tumours, to Z628		233.65	

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND UPPER URINARY TRACT

Asst Surg Anae

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	437.20	7
# S450	- other e.g. partial	6	331.70	7

REPAIR

# S452	Ureteroileal conduit.....	6	788.15	9
# S454	- with ureterectomy and ileal replacement	6	893.50	9
# S457	Ureteroureterostomy	6	552.30	8
# E792	- when performed laparoscopically, to S457	add 25%		

Re-implantation

# S451	Ureterovesical anastomosis or re-implantation unilateral	6	437.20	8
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Note:

Not to be billed in addition to S482.

# S561	Re-implantation of ureter with extensive tapering with or without ureterolysis	6	657.75	8
# S562	Re-implantation of bifid ureter.....	6	482.40	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.

Ureterointestinal anastomosis

# S455	- unilateral	6	331.70	7
# S462	- bilateral	6	438.35	6

Ureterostomy

Cutaneous

# S458	- unilateral	6	260.85	6
# S463	- with lower third ureterotomy.....	6	381.60	6
# S459	Ureterovaginal fistula	6	557.85	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND UPPER URINARY TRACT

Asst Surg Anae

Ureterolysis for periureteral fibrosis

# S460	- unilateral	6	437.20	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	331.70	6
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Bladder flap (Boari)

# S427	- to include re-implantation of ureter	6	502.45	6
# E792	- when performed laparoscopically, to S427	add 25%		

SUTURE

Traumatic rupture, or transection (partial or complete)

Immediate

# S465	- upper 2/3	6	381.60	6
# S466	- lower 1/3	6	437.20	6

Late repair

# S467	- upper 2/3	6	437.20	6
# S468	- lower 1/3	6	482.40	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
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ENDOSCOPY - CYSTOSCOPY

Diagnostic and Therapeutic Procedures

# Z606	Diagnostic with or without urethroscopy	71.00	5
# Z607	Repeat within 30 days	35.50	5
# E775	- with catheterization of the ureter and collection of the ureteral specimen, unilateral	15.35	
# E817	- with catheterization of the ureter and retrograde injection of opaque media, unilateral	15.35	
# E776	- with unilateral brush biopsy of renal pelvis and/or ureter, and/or transurethral biopsy of bladder	24.90	
# E818	- with insertion of ureteric stent, unilateral	24.90	
# E777	- with cystometrogram (to include urethral pressure profile if necessary)....add	11.50	
# E780	- with needle biopsy of prostate	32.60	
# E783	- with secondary surgical evacuation of bladder clots and control of haemorrhage	99.65	
# E784	- with hydrodistention of bladder - general anaesthetic	49.85	
# E824	- with bladder biopsy - general anaesthetic	49.85	
# E773	- with placement of ureteric stent past obstructing lesion (unilateral)	49.90	

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 GP61 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 perirethral injection of bulking agents.....add	26.00	
# E781	- with electrocoagulation - tumour(s).....add	49.90	
# E782	- with electrocoagulation - Hunner ulcer	49.90	
# E786	- with resection or incision bladder neck, female	99.70	
# E787	- with resection or incision bladder neck, male	260.40	
# E788	- with ureteral meatotomy, by any means	99.70	
# E789	- with removal foreign body or calculus.....add	99.70	
# E790	- with removal of ureteric catheter.....add	8.80	
# E751	- with insertion of chemotherapeutic agent(s)	54.70	

Note:

E751 is *not eligible for payment* with Z602, 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.....	271.35	6
# Z633	- single tumour over 2 cm diameter.....	437.20	6
# Z634	- multiple tumours.....	437.20	6

Note:

No additional claim for cystoscopy when done at the same time as excision of tumour(s).

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

Asst Surg Anae

INTRODUCTION

Catheterization

Z602	- office	8.55
Z603	- home	16.25
# Z611	- hospital.....	8.55

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. Z602, Z603 or Z611 is *not eligible for payment* in addition to Z610.

[Commentary:

Z610 is not payable for indications other than bladder cancer.]

INCISION

Z605	Aspiration.....	12.50	
# S478	Cystotomy or cystostomy.....	215.80	6
# Z480	Cystotomy with trochar and cannula and insertion of tube	85.30	6
# E750	- when done in conjunction with another procedure	add	26.05
# S481	Cystolithotomy - when sole operative procedure	6	260.65
# E792	- when performed laparoscopically, to S481	add 25%	7
# S476	Cutaneous vesicostomy.....	6	437.20
			6

EXCISION

Cystectomy - Partial

# S482	- partial for tumour or diverticulum (single or multiple)	6	381.60	6
# S483	- with reimplantation of ureter.....	6	552.30	7
# S490	- with reimplantation of ureters	6	733.50	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	657.75	10
# S485	- with ureterointestinal transplant	8	984.65	13
# S453	- with ureteroileal conduit	9	1250.30	15
# S440	- with continent urinary diversion.....	9	1475.70	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	630.00	7
# S441	Creation of continent urinary diversion	9	1013.45	15
# S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	296.30	6
# E792	- when performed laparoscopically, to S471	add 25%		
Extrophy - excision of bladder and repair of abdominal wall				
# S488	- inclusive of graft.....	6	215.80	6
# S491	Plastic repair of extrophy using bladder and including skin flaps	6	657.75	6
REPAIR				
# S512	Repair of ruptured bladder.....	6	330.90	6
# S513	Cystoplasty, using intestine	8	657.75	9
Plastic repair of bladder neck				
# S518	- child.....	6	331.70	6
# S519	- adolescent or adult.....	6	437.20	7
DESTRUCTION				
# S521	Litholapaxy and removal of fragments.....		215.80	6
# E792	- when performed laparoscopically, to S521.....add 25%			
SUTURE				
Closure of fistula				
# S522	External, suprapubic.....	6	260.85	7
	Vesicovaginal			
# S523	- vaginal approach.....	6	772.40	6
# S524	- transvesical approach (with or without omental flap)	6	467.00	6
# S525	Vsicorectal or vesicosigmoid.....	6	446.90	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.....		35.50	6
# Z618	- with biopsy		77.70	6
# S547	Removal of foreign body or calculus.....		170.65	7

INCISION

# Z616	Biopsy of urethra (without endoscopy)		23.55	6
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Urethrotomy

# S530	- external	6	215.80	6
# S532	- transurethral (visual)	6	166.05	6
# S538	- repeat procedure within 6 months by same surgeon	6	95.75	6
# S531	Urethrostomy	6	215.80	6
# Z604	Meatotomy and plastic repair		31.60	6
# Z609	Periurethral abscess		31.60	6

EXCISION

# S536	Caruncle	6	85.30	6
# S537	Urethral papilloma, single or multiple.....		85.30	6
# S541	Diverticulectomy - male or female	6	260.85	7
# S542	Posterior urethral valve.....	6	331.70	6
# S543	Prolapse urethra	6	85.30	7
# S544	Urethrectomy - radical	6	215.80	6

REPAIR

# S548	Urethral sling.....	6	381.60	6
# S815	Tension free vaginal tape mid-urethral sling, by any method/approach.....	6	381.60	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	376.70	6
# S546	- repeat procedure for failed retropubic or vaginal surgery for stress incontinence.....	6	489.70	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	776.70	6
# S540	Revision or removal of artificial urinary sphincter	6	239.75	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	381.60	6
SUTURE				
# S551	Rupture, anterior urethra (diversion of urine extra).....	6	170.65	7
# Z612	Endoscopic urethral realignment for urethral trauma.....	6	250.00	6
Payment rules:				
Cystoscopy, urethroscopy, retrograde urethrogram or insertion of guidewire/catheter is <i>not eligible for payment</i> with Z612.				
Posterior urethra				
# S552	- immediate repair	6	437.20	7
# S553	- late repair	6	552.30	7
Fistula				
# S554	- penile urethra (diversion of urine extra)		92.10	6
# S555	- perineal urethra	6	325.95	6
# S556	Rectourethral with diversion, colostomy and closure of colostomy	6	552.30	7
DESTRUCTION				
# S557	Urethrovesicostomy - when sole operative procedure	6	215.80	6
# S564	Transurethral incision or resection of external sphincter - when sole operative procedure		325.95	6
MANIPULATION				
Dilatation of stricture				
Z621	- male, local anaesthetic		13.65	
# Z619	- male, general anaesthetic.....		52.70	6
Dilatation of urethra				
Z622	- female		5.65	
# Z620	- female, general anaesthetic.....		41.65	6
# Z615	Filiform and follower urethral dilation and may include bladder catheterization		59.75	6

Note:

Z619, Z620, Z621, Z622 payable at nil if claimed with Z615.

UROGENITAL AND URINARY SURGICAL PROCEDURES

NOT ALLOCATED

MALE GENITAL SURGICAL PROCEDURES

PENIS

Asst	Surg	Anae
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INCISION

Slit of prepuce (complete care)

# S567	- newborn	14.35	
# S568	- infant	21.50	6
# S569	- adult or child.....	30.25	6

EXCISION

Circumcision - for physical symptomatology only

# S573	- for patients aged one year or older	6	179.40	6
# S577	- for infants less than one year of age.....	6	90.05	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	23.55	6
E542	- when performed outside of hospital.....	add	11.15

Amputation

# S574	- partial	6	170.65	7
# S575	- partial with inguinal glands 1 or 2 stages	6	437.20	7
# S576	- radical with inguinal and femoral glands 1 or 2 stages	6	552.30	7

Condylomata

Z701	- local anaesthetic	32.60	
# Z767	- general anaesthetic.....	78.60	6
# S599	Excision plaque for Peyronies disease	6	210.95

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	287.75	7
# S571	- with advancement of meatus into glans.....	6	383.50	6
# S572	- into glans using island flap pedicle (penoscrotal)	6	662.45	6
# S579	Chordee repair.....	6	215.80	6
# S580	Plastic reconstruction, urethra	6	331.70	7
# S581	Closure urethro-cutaneous fistula.....		92.10	7
# S597	Penile prosthesis for impotence.....	6	306.85	7
# E755	- with inflatable prosthesis.....	add	55.15	
# S588	Surgical removal of prosthesis.....	6	110.15	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		55.15	6
BIOPSY				
# Z704	Single		55.15	7
# Z705	Bilateral.....		83.35	7
# Z706	- with vasography.....		120.80	6
Note: See also Diagnostic Radiology - GU Tract.				
Orchidectomy				
# S589	- unilateral	6	170.65	7
Radical orchidectomy for malignancy				
# S598	- unilateral	6	235.35	7
# S590	Retroperitoneal lymph node dissection (RPLND) for testicular tumour	6	834.25	8
# E792	- when performed laparoscopically, to S590add 25%			
REPAIR				
Orchidopexy				
# S591	- for undescended testis, any type, one or two stages to include hernia repair where required	6	331.70	7
# S593	Exploration for undescended testicle, without orchidopexy	6	260.85	7
# E792	- when performed laparoscopically, to S591 or S593add 25%			
# S600	Reduction of torsion of testis or appendix testis and orchidopexy (one or both sides) if required	6	235.35	6
# S595	Ruptured testicle.....	6	170.65	7
# S596	Insertion of testicular prosthesis	6	170.65	6

Note:

Insertion of testicular prosthesis performed at the time of orchidectomy is *not eligible for payment*.

[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		55.15	6
# S601	Spermatocele or spermatic granuloma excision	6	205.35	6
Epididymectomy				
# S602	- unilateral	6	170.65	6
TUNICA VAGINALIS				
Z708	Hydrocele aspiration		16.25	
# S611	Hydrocele excision - unilateral	6	205.35	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	20.10	
# Z768	- general anaesthetic.....	55.15	6
# S616	- and exploration - unilateral.....	85.30	7

EXCISION

# S618	Resection of scrotum.....	6	215.80	7
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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.

MALE GENITAL SURGICAL PROCEDURES

VAS DEFERENS

Asst Surg Anae

INCISION

# Z710	Vasography	55.15	6
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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	107.40	6
E545	- when performed outside hospital	add	11.15	

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	205.35	6
	Varicocele excision			
#	S631 - single.....	6	205.35	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		85.45	6
# Z713	- with drainage abscess	6	92.10	6
# S644	Biopsy, perineal, open operation	6	215.80	6

EXCISION

Prostatectomy

# S645	Perineal.....	6	574.60	7
# S646	Perineal with vesiculectomy.....	8	875.00	11
# S647	Suprapubic - with or without removal of bladder stones.....	6	600.75	6
	Retropubic - <i>with or without</i> removal of bladder stones			
# S650	- simple.....	6	600.75	6
# S651	- radical	6	1008.35	10
# E792	- when performed laparoscopically, to S647, S650 or S651	add 25%		

Note:

1. Prostatectomy (S645-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.]

# S653	Laparoscopic radical prostatectomy	8	1411.70	10
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ENDOSCOPY

Transurethral resection of prostate

# S655	- and may include cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy		450.60	7
# S654	- for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		411.20	6
# S656	- Transurethral drainage of abscess.....		85.30	6

MALE GENITAL SURGICAL PROCEDURES

NOT ALLOCATED

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 biopsy, 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 procedureadd 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 junctionadd 170.00

FEMALE GENITAL SURGICAL PROCEDURES

VULVA AND INTROITUS

	Asst	Surg	Anae
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Abscess of vulva, Bartholin or Skene's gland - incision and drainage

Z714	- local anaesthetic	17.30	
E542	- when performed outside hospital.....add	11.15	
# Z715	- general anaesthetic.....	6	50.90
# Z716	Marsupialization of Bartholin's cyst or abscess	6	71.90

EXCISION

Biopsy(ies) - when sole procedure

Z477	- local anaesthetic	26.85	
E542	- when performed outside hospital.....add	11.15	
# Z475	- general anaesthetic.....	6	50.90
# S707	Hymenectomy (with or without perineotomy) or hymenotomy.....		92.30
# S706	Cyst of Bartholin's gland	6	112.00

Condylomata - single or multiple

Chemical and/or cryosurgery

Z733	- one or more.....	11.05	
	Surgical excision or electrode desiccation or CO ₂ laser		
Z736	- local anaesthetic	26.85	
# Z769	- general anaesthetic.....	115.10	6

Vulvectomy

# S703	- simple.....	6	257.05	6
# S704	- radical - without gland dissection	6	431.45	6

REPAIR

# S708	Non-obstetrical injury to vulva and/or vagina, and/or perineum (see General Preamble GP8)	I.C	I.C
# S701	Repair of infibulation - resulting from female genital mutilation		115.00

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

Asst Surg Anae

ENDOSCOPY

Z478	Vaginoscopy (premenarchal) with or without medication.....	50.90	6
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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.....	92.30	6

EXCISION

Biopsy(ies) - when sole procedure

Z722	- local anaesthetic	26.85	
E542	- when performed outside of hospital, to Z722..... add	11.15	
# Z723	- general anaesthetic.....	92.30	6
# S715	Excision of cyst(s), or benign tumour(s)	6	123.70
# S742	Colpectomy - e.g. for carcinoma.....	6	349.00
# S702	Excision of congenital vaginal septum.....	6	123.70

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
REPAIR				
# S716	Anterior or posterior repair.....	6	164.00	7
Anterior and posterior				
# S717	- repair.....	6	303.40	7
# S718	- repair of enterocoele and/or vault prolapse.....	6	349.00	7
Posterior repair and repair of				
# S719	- enterocoele and/or vault prolapse.....	6	307.80	7
# S723	- anal sphincter.....	6	272.40	6
Anterior repair				
# S720	- with or without posterior repair and repair of uterine prolapse (Fothergill or Watkin's interposition)	6	349.00	7
# S721	Anterior, posterior repair with excision of cervical stump	6	349.00	7
Post hysterectomy vault prolapse				
# S722	- repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	6	349.00	7
# S812	- repeat - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	6	453.70	7
Abdominal approach to vaginal vault prolapse				
# S760	- vaginal sacropexy	6	349.00	6
# S813	- repeat - vaginal sacropexy	6	453.70	6
# S761	Combined abdominal/vaginal approach for vaginal vault prolapse	7	431.45	7
# E862	- when performed laparoscopically, to S760, S813 or S761add 25%			
# S724	Perineorrhaphy (not eligible for payment with delivery or other vaginal surgery procedures).....	6	122.75	6
# S725	Colpocleisis (LeFort or modification)	6	257.05	7
# S726	Construction of artificial vagina (see General Preamble GP8)	6	I.C	6
Closure of fistula				
# S523	Vesicovaginal.....	6	772.40	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	376.70	6
# S546	Repeat procedure for failed retropubic or vaginal surgery for stress incontinence..	6	489.70	7
# E862	- when performed laparoscopically, to S549 or S546add 25%			
# S815	Tension free vaginal tape mid-urethral sling by any method/approach.....	6	381.60	6

Payment rules:

Cystoscopy (Z606) is *not eligible for payment* with S815 unless the cystoscopy is rendered for suspicion of disease.

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

Asst

Surg

Anae

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 cystocele. 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.]

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	50.90	6
UVC	Removal of IUD without GA.....	visit.fee	

FEMALE GENITAL SURGICAL PROCEDURES

CERVIX UTERI

Asst | Surg | Anae

ENDOSCOPY

Z731	Initial investigation of abnormal cytology of vulva and/or vagina or cervix under colposcopic technique with or without biopsy(ies) and/or endocervical curetting	50.90
Z787	Follow-up colposcopy with biopsy(ies) with or without endocervical curetting.....	50.90
Z730	Follow up colposcopy without biopsy with or without endocervical curetting.....	25.50

Note:

1. A screening colposcopy is included in the assessment.
2. Z720 is *not eligible for payment* with Z730, Z731 or Z787.

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).....	78.00		
# S744	Cervix - cone biopsy - any technique, with or without D&C	173.15	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	173.55	6	

Cervical stump

# S766	- abdominal	6	321.90	6
# S767	- vaginal.....	6	321.90	7

Note:

Excision of cervical polyp(s) under *general anaesthesia*, submit using Z720.

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

	Asst	Surg	Anae
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REPAIR

# S774	Repair of incompetent cervix - not associated with pregnancy.....	6	142.50	6
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ENDOSCOPY

Hysteroscopy

# Z582	- diagnostic.....	105.40	6
# Z583	- with uterine biopsy and/or D&C	131.40	6
# Z585	- with cannulization of tube(s), lysis of intrauterine adhesions	131.40	6
# Z587	- with resection of one or more endometrial polyps, with or without D&C	200.00	6
# Z586	- with lysis of intrauterine adhesions/synechiae requiring a minimum of 60 minutes of surgical time	349.00	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		34.05	
E542	- when performed outside hospital.....	add	11.15	
# S772	Endometrial ablation by any method		218.65	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	93.00	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		112.40	6
# S770	- hysterotomy	6	245.40	7
# S783	- hysterotomy with tubal interruption	6	257.05	6
# S754	Diagnostic curettage (with or without cauterization, biopsy of cervix removal of polyps, or hysterosalpingography)		92.30	6
# S764	Myomectomy	6	383.90	7

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

Asst | Surg | Anae

INCISION OR EXCISION

Hysterectomy - with or without adnexa (unless otherwise specified)

# S757	- abdominal - total or subtotal.....	6	463.00	7
# S816	- vaginal.....	6	463.00	7
# S758	- with anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	6	616.60	6
# S759	- with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	6	523.55	7
# E090	- removal of one or both ovaries with moderate or severe endometrosis, to S757, S758 or S759add		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.....	6	680.65	6
# S763	- radical (Wertheim or Schauta) - includes node dissection	8	893.55	8
# S762	- radical trachelectomy - excluding node dissection.....	8	801.10	8
# E862	- when performed laparoscopically, to S710, S763, S762add 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.

# S776	Staging pelvic lymphadenectomy for carcinoma (laparoscopic or open).....	6	431.20	6
# S781	Staging Para-aortic lymphadenectomy for carcinoma (laparoscopic or open) (not eligible for payment when rendered with Z578 and/or S776).....	6	431.20	6

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
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EXCISION, SUTURE OR REPAIR

Ectopic pregnancy

# S784	- management by any surgical technique	6	306.85	7
# E852	- with tuboplastyadd		47.90	
# E860	- diagnostic laparoscopy prior to laparotomyadd		131.45	
# S738	Salpingectomy or salpingo-oophorectomy (uni- or bilateral)	6	306.85	7
# S741	Tubal occlusion/interruption/removal by any method or approach for the purpose of sterilization	6	155.70	6

Tubal plastic operation with/without operating microscope (unilateral or bilateral)

# S735	- fimbriolysis	6	306.85	6
# S736	- salpingostomy	6	359.55	7
# S739	- fimbriolysis and salpingostomy	6	407.45	7
# E862	- when performed laparoscopically, to S735, S736 or S739add 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	616.60	8
# E862	- when performed laparoscopically, to S743add 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	131.45	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants	6	173.25	6
# E855	- with dye injection	add	25.85	
# E857	- with D&C.....add		78.45	
# Z737	Laser treatment of extensive pelvic disease.....	6	215.80	7

FEMALE GENITAL SURGICAL PROCEDURES

OVARY

			Asst	Surg	Anae
EXCISION (UNILATERAL OR BILATERAL)					
# S780	Biopsy of ovaries by laparotomy		6	257.05	7
Oophorectomy					
# S745	- and/or oophorectomy.....		6	306.85	7
# E090	- removal of contralateral ovary with moderate or severe endometriosis, to S745	add		260.80	
# S782	- with total omentectomy		6	410.40	6
# S747	Para ovarian cystectomy		6	306.85	7
# S714	Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy		6	431.45	6
# 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	884.85	8
# E853	- with resection of diaphragm including reconstruction, to S727.....add			145.00	
# S750	Radical resection pelvic and para-aortic nodes for cancer		6	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
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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
# S789	- subtotal	6	618.25	10
# S790	- hemi	6	525.15	10
# S793	- completion following previous subtotal or hemi-thyroidectomy	6	650.00	10
# E880	- parathyroid(s) re-implantation..... add		184.60	

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 or by video-assisted thoracic surgery (VATS), to S797	add 25%			
Adrenalectomy or exploration					
# S798	- unilateral		10	646.30	10
# S799	- bilateral, with or without oophorectomy.....		10	1032.70	11
Adrenalectomy					
# S800	- unilateral for pheochromocytoma.....		10	871.80	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			244.80	
# E921	- repeat cranial procedure - payable in addition to any intracranial procedure and N111, N114 and N116 but excluding N127add			252.20	

BRAIN

Craniotomy plus excision

Astrocytoma, oligodendrogloma, glioblastoma or metastatic tumour

# N103	- supratentorial	15	1562.90	15
# N151	- infratentorial	15	1726.80	15
# N152	Craniotomy plus lobectomy	15	1575.80	15
# E901	- with operating microscope	add	234.65	
	Meningioma and other tumourous lesions, including pituitary tumours			
# N102	- supratentorial	15	1726.80	15
# N153	- infratentorial or basal	15	2345.00	15
# E901	- with operating microscope	add	234.65	
# 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	2140.15	20
# N154	Vertebrobasilar circulation, including aneurysm of vein of Galen	15	2140.15	20
# E901	- with operating microscope, to N105 or N154.....add		234.65	
# E898	- lesion greater than 2.5 cm, to N105 or N154	add	229.55	
# 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	1622.50	20
# N155	- infratentorial	15	1532.10	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		234.65	
# 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	1178.35	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).....add	15	1711.40	15

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

	Asst	Surg	Anae
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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
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INTRACRANIAL ENDOVASCULAR SURGERY

Intracranial aneurysm repair

Endovascular approaches

# N122	Carotid circulation - per vessel	15	2140.15	20
# N125	Vertebrobasilar circulation, including aneurysm of vein of Galen	15	2140.15	20
# E894	- aneurysm greater than 2.5 cm, to N122 or N125	add	229.55	

Cerebral arteriovenous malformation

Endovascular approach for obliteration

# N107	Endovascular approach to include balloon catheter or embolization techniques for arteriovenous malformation	15	1456.95	15
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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
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SPONTANEOUS INTRACEREBRAL HAEMORRHAGE

Craniotomy plus removal

# N104	- supratentorial	15	1100.00	15
# N157	- infratentorial	15	1241.65	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
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NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
INTRACRANIAL ABSCESS				
# N117	Craniotomy	15	1416.50	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	453.60	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	774.90	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	2184.20	15
# N128	Repair of encephalocoele	15	798.80	15
# N129	Posterior fossa decompression for Arnold Chiari malformation.....	15	1110.00	15
# E901	- with operating microscope, to N129	add	234.65	
# 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	538.40	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	1551.20	11
Note:				
N123 performed in conjunction with N124 is an insured service payable at nil.				
# N119	Intracranial implantation of chronic surface electrodes.....	11	901.25	11
# Z823	Implantation or revision of stimulation pack or leads (peripheral nerve, brain).....	6	307.40	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
Ventriculoscopy				
# Z825	- to include burr hole		408.95	7
# E916	- with biopsy	add	233.30	
# E917	- with interventriculostomy	add	301.70	
# E918	- with removal of foreign body	add	132.80	
# Z819	External ventricular drainage	nil	215.35	7
# Z820	Insertion of intracranial catheter or transducer for purposes of monitoring	nil	317.85	7
# Z812	Subsequent revisions or replacements within 30 days..... each	6	279.55	7

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

Asst Surg Anae

CRANIO-CEREBRAL INJURIES

UVC	Non-operative care	visit. fee
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Reduction of skull fracture

# N139	- simple, depressed.....	7	634.90	7
# N140	- compound	11	773.15	11
# E912	- with repair of dural laceration.....add		233.30	

Extracerebral haematoma and/or hygroma

# N143	Drainage by burr hole(s) - unilateral	7	559.60	7
# N144	Drainage and/or removal by craniotomy.....	11	863.25	11

CEREBRAL INJURY

# N148	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	15	1040.65	15
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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	638.05	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
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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	481.90	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	1232.35	11
# E901	- with operating microscope, to N266 or N267		234.65	
# 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

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 Q10 of the Cardiovascular Surgical Procedures section.]

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
CSF SHUNTING PROCEDURES				
# N230	CSF shunting procedures - all types.....	11	737.00	11
Revision of CSF shunt				
# N245	- operative - all types.....	7	420.70	7
# Z801	- non-operative		51.50	
Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial)				
# N174	- includes removal of existing shunt.....	7	420.30	7
# N246	Removal of shunt - any type	7	289.70	7
# Z809	Insertion of CSF reservoir (Ommaya) including burr holes.....	11	370.50	11
# N249	Third ventriculostomy.....	11	777.80	11
# Z821	Injection of diagnostic or therapeutic agent into shunt apparatus.....		53.10	
SKULL				
Repair of skull defect				
# N161	Acrylic or metal cranioplasty	11	600.85	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	
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	234.65	

NEUROLOGICAL SURGICAL PROCEDURES

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
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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 N116add	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).....	1879.00	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	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	500.00	

NEUROLOGICAL SURGICAL PROCEDURES

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	800.00
E890	- complex endonasal endoscopic resection from cavernous sinuses, to N114 or N116	add	800.00
E891	- complex endonasal endoscopic resection from frontal or temporal lobe or brainstem, to N114 or N116	add	800.00

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.]

NEUROLOGICAL SURGICAL PROCEDURES

PERIPHERAL NERVES

Asst Surg Anae

# E906	- to basic fee for neurolysis, tumour excision, nerve suture or graft when using operating microscope	add 40%
# E925	- to basic fee for a repeat peripheral nerve procedure, (e.g. repair, transposition, graft or tumour excision) when repair delayed for more than 4 weeks.....	add 30%

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	6	256.15	7

Note:

N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.

# N282	Brachial plexus (excluding thoracic outlet syndrome or cervical rib)	6	1000.00	6
# N177	Sciatic nerve in buttock.....	6	430.75	7
# N286	Tumour or neuroma - major nerve	6	317.85	7

Nerve suture

# N289	- minor - (sensory/cutaneous nerve)	6	250.00	7
# N287	- major - (mixed sensory and motor nerve, or pure motor nerve)	6	500.00	7

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	

Note:

Nerve graft fees include harvesting of the nerve(s) required for grafting.

# Z816	Implantation of electrode for peripheral nerve stimulation	6	241.00	6
# Z823	Implantation or revision of stimulation pack or leads, (peripheral nerve, brain).....	6	307.40	8
# N290	Carpal tunnel release.....	6	156.75	6
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow).....	6	215.35	7
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis.....	6	279.25	7
# N283	Decompression, exploration for thoracic outlet syndrome including excision of cervical and/or first rib and to include scalenotomy	6	389.05	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%		

OCULAR AND AURAL 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	
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REPAIR

# E104	Removal of intraocular foreign body	6	542.00	6
# E105	Non-magnetic - posterior segment	6	424.35	6

Penetrating wound

# E106	- with prolapse of intraocular tissue.....	6	640.00	7
# E107	- without prolapse of intraocular tissue.....	6	496.00	7

OCULAR AND AURAL SURGICAL PROCEDURES

CORNEA

Asst	Surg	Anae
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INCISION

# Z851	Paracentesis	70.00	6
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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 GP8).....	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
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EXCISION

Pterygium

# E206	- simple (unilateral).....	175.00	6	
# E205	- with partial keratectomy	355.00	6	
# E207	- with lamellar graft.....	453.00	6	
# E937	- with autogenous conjunctival transplant.....add	100.00		
# E948	- with mucous membrane graft	113.20		
# 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 biopsy 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

Payment rules:

E117 is not eligible for payment with E124.

# E123	Division of iris to cornea.....	161.75	6
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OCULAR AND AURAL SURGICAL PROCEDURES

SCLERA, IRIS AND CILIARY BODY

		Asst	Surg	Anae
SCLERA				
# E127	Sclerotomy, posterior		166.45	4
IRIS AND CILIARY BODY				
# E131	Laser iridotomy	6	161.75	6
# E134	Laser angle surgery		205.55	7
# E130	Iridectomy - surgical - when sole procedure	6	308.30	6
# E132	Glaucoma filtering procedures.....	6	550.00	6
# E983	- following previous glaucoma filtering procedure, to E132	add 25%		
# E136	- with intraocular implant of seton, to E132.....	add		290.00
# E214	Glaucoma filtering procedure and cataract extraction (same eye)	6	729.00	6
# E950	- insertion of intraocular lens, to E214	add	92.50	
# E984	- following previous glaucoma filtering procedure, to E214	add	137.50	
# E136	- with intraocular implant of seton, to E214.....	add	290.00	
# 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 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 AND AURAL SURGICAL PROCEDURES

CRYSTALLINE LENS

		Asst	Surg	Anae
INCISION				
# E137	Needling (discission) - primary or subsequent.....	6	161.75	5
# E139	Capsulotomy	6	161.75	5
EXCISION				
Cataract				
To include retrobulbar injection when administered by surgeon				
# E140	- all types of, by any procedure, includes insertion of intraocular lens.....		397.75	5
# E141	- dislocated lens extraction.....	6	505.45	5
# E950	- insertion of intraocular lens, to E141	add	92.50	
# E143	Excision of secondary membrane with corneal section following cataract extraction	6	450.00	5
# E138	Fixation of intraocular lens and/or capsular tension device by suturing	6	450.00	5
# E144	Removal of intraocular lens	6	450.00	5
# E145	Repositioning surgical of dislocated intraocular lens		350.00	5
# E146	Insertion of secondary intraocular lens	6	400.00	5

Payment rules:

1. Time units and anaesthesia extra units listed on GP61 are *not eligible for payment* with anaesthesia services for E137C, E138C, E139C, E140C, E141C, E143C, E144C, E145C or E146C.
2. E003C is not payable for anaesthesia services rendered for E137, E138, E139, E140, E141, E143, E144, E145 or E146.

[Commentary:

1. Refer to E023C on GP63 for anaesthesia services other than procedural sedation rendered in support of E137, E138, E139, E140, E141, E143, E144, E145 and E146.
2. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment*.]

OCULAR AND AURAL SURGICAL PROCEDURES

VITREOUS

			Asst	Surg	Anae
Anterior vitrectomy					
# E940	- when done in conjunction with another intraocular procedure	add		105.00	
# E148	Vitrectomy by infusion suction cutter technique.....		6	720.00	7
# E938	- with transscleral retinal suturing	add		213.20	
# E147	Intravitreal injection of medication for the treatment of wet macular degeneration..		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
# E142	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation.....		6	830.00	6

Payment rules:

1. Time units and anaesthesia extra units listed on GP61 are *not eligible for payment* with anaesthesia services for E147C or E149C.
2. E003C is not payable for anaesthesia services rendered for E147 or E149.

[Commentary:

1. Refer to E023C on GP63 for anaesthesia services other than procedural sedation rendered in support of E147 or E149.
2. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment*.]

Vitreous exchange (air, gas or artificial vitreous substance)

# E936	- to vitrectomy	add	90.00
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OCULAR AND AURAL 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, photocoagulation or cryopexy, primary or subsequent procedure	6	700.00	7
# E153	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon 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 – one eye.....		750.00	6
# E126	Laser retinopexy for Retinopathy of Prematurity – both eyes		1245.00	6
# E155	Cryopexy - extraocular or sub-conjunctival - one eye.....		205.00	6

REPAIR

Strabismus procedures

# E159	- one muscle, one or both eyes.....	6	369.00	6
# E158	- two muscles, one or both eyes	6	460.00	6
# E162	- three or more muscles, one or both eyes	6	542.00	6
# E949	- for adjustable sutureadd		100.00	
# E952	- repeat strabismus procedure	add	175.00	

OCULAR AND AURAL SURGICAL PROCEDURES

ORBIT

		Asst	Surg	Anae
INCISION				
# E164	Drainage of abscess		350.00	7
EXCISION				
# E102	Enucleation, with or without primary implant	6	542.00	7
# E103	Evisceration, with or without primary implant.....	6	542.00	7
# E109	Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles	6	677.50	7
Note: E102 or E103 are <i>not eligible for payment</i> 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	450.00	6
# E167	- posterior exposure	6	640.00	7
# E172	Biopsy (anterior)		200.00	6
# E168	Biopsy (posterior exposure).....		308.30	6
# E165	Lateral orbitotomy (Kronlein)	6	590.00	7
Decompression				
# E169	- two walls	6	542.00	6
# E170	- three walls.....	6	575.85	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	100.00	
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 AND AURAL SURGICAL PROCEDURES

EYELIDS

Asst	Surg	Anae
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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.....	11.15		
# Z856	- general anaesthetic.....	150.00	6	

Note:

See Appendix D Surface Pathology.

Epilation

Z857	- by hyfrecator, electrolysis	26.60	6	
Z858	- by cryopexy.....	65.70	6	

Note:

Verruca, keratosis, etc. - see Skin and Subcutaneous Tissue - Integumentary System also Lid Tumours or Unlisted Plastic Procedures.

SUTURE

# E190	Tarsorrhaphy.....	150.00	6	
# E191	Double adhesion.....	161.75	7	

REPAIR

# E192	Ptosis	6	313.15	6
# E193	- repeat or second repair.....	6	393.00	6
# E194	Distichiasis - unilateral.....	6	289.00	6
# E195	Trichiasis, repair by tarsal transplantation	6	241.70	7
# E196	Entropion, other than Zeigler puncture	6	290.00	6
# E945	- repeat by second surgeon	add	52.40	
# E948	- with mucous membrane graft	add	113.20	
# E197	Ectropion, other than Zeigler puncture	6	310.00	6
# E945	- repeat by second surgeon	add	52.40	
Z860	Zeigler punctures (for entropion/ectropion).....		26.60	6

Note:

With skin graft - see Plastic Surgery Procedures - Integumentary System.

# E199	Laceration, full thickness	225.00	6	
# E198	- including lid margin	300.00	7	
# E221	Laceration of eyelid including levator palpebrae superioris with ptosis	6	329.30	7

OCULAR AND AURAL SURGICAL PROCEDURES

EYELIDS

Asst	Surg	Anae
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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 and Long-Term Care 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	
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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%			
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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	
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OCULAR AND AURAL 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	100.00	6
# E948	- with mucous membrane graftadd	113.20	
E937	- with autogenous conjunctival transplant.....add	100.00	

OCULAR AND AURAL 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	65.70	6	
EXCISION				
# E215	Dacryocystectomy	6	496.00	6
REPAIR				
Lacerated canaliculus				
# E216	- immediate repair	6	350.00	6
# E217	- delayed repair	6	411.20	6
# E218	Dacryocystorhinostomy	6	542.00	6
# E939	- repeat procedure by second surgeon.....	add	150.00	
# E954	- with lacrimal bypass procedure (e.g. Lester Jones) or canicular reconstruction	add	80.90	
Lacrimal bypass procedure (e.g. Lester Jones)				
# E219	- when sole procedure (both stages).....	250.00	6	
MANIPULATION				
Z901	Irrigation of nasolacrimal system - unilateral or bilateral.....	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		

OCULAR AND 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
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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

OCULAR AND AURAL SURGICAL PROCEDURES

EXTERNAL EAR

Asst	Surg	Anae
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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

OCULAR AND 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.]

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		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		

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

# E336	Type 1 (myringoplasty with exploration of middle ear)	345.15	7	
# E337	- with ossiculoplasty	468.85	10	
# E957	- with mastoidectomy	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

OCULAR AND 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

OCULAR AND AURAL SURGICAL PROCEDURES

NOT ALLOCATED

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 (P9).
5. Laparotomy performed in conjunction with spinal procedures by a surgeon not performing the spinal surgery constitutes S312 (S28).
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 weeks 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 through the sacral segments S4-S5.
- 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)	9	918.00	10
# N501	Vertebrectomy (removal of vertebral body and excision of adjacent discs).....	9	1020.00	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 <i>eligible for payment</i> 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
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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	765.00
# 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	765.00
# 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		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/retroperitoneal 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	1208.70	17
# E374	- foramen magnum decompression < 3cm as part of cervical decompression, to N510		357.00	
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N509 or N510		255.00	
# N520	One level - laminoplasty (includes fixation of lamina)	9	1514.70	14
# E380	- each additional level - laminoplasty (includes fixation of lamina), to N520		357.00	
# E368	- first disc excision, to N509, N510 or N520		306.00	

Lumbar

# N511	One level - unilateral	8	800.70	15
# N512	One level - bilateral	8	1004.70	15
# E368	- first disc excision, to N511 or N512		306.00	
# N524	One level - bilateral canal enlargement - unilateral approach	9	1208.70	15
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N511, N512 or N524		255.00	
# N571	Percutaneous discotomy	6	255.00	8
# E385	- each additional level of percutaneous discotomy, to N571		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
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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	867.00
# 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	867.00
# E366	- each additional disc level fused, to E370.....	add	153.00
# E387	- fusion to sacrum, to N511, N512, N575, N576, N560 or N561	add	153.00

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	- fusion to sacrum, to N513.....	add	153.00

Posterior Interbody Implant/Graft/Nuclear Replacement

# E372	- one disc level, to N511, N512 or N513	add	510.00
# E376	- each additional disc level stabilized, to E372	add	255.00

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS AS SOLE PROCEDURE

Asst	Surg	Anae
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All levels

# E378	- 3D stereotactic spinal procedure	add	510.00
# E379	- 2D stereotactic spinal procedure	add	510.00

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	- fusion to sacrum, to N582.....	add	153.00	
# 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.

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 F201add		255.00	
# N572	Open reduction, any single level, spine fracture/dislocation, anterior/posterior	8	1020.00	11
# E395	- open reduction, additional level, spine fracture/ dislocation, anterior/posterior, to N572add		306.00	
# 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		510.00	
# E379	- 2D stereotactic spinal procedure, to N572		510.00	
# N573	Anterior odontoid screw fixation	8	1020.00	11
# E378	- 3D stereotactic spinal procedure, to N573		510.00	
# E379	- 2D stereotactic spinal procedure, to N573		510.00	
# N570	Vertebroplasty (injection of bone cement) as sole procedure, first level	7	569.15	9
# E388	- vertebroplasty combined with any other procedure, first level, to other procedure		204.00	
# E391	- vertebroplasty, each additional level, to N570 or E388		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		510.00	
# E393	- kyphoplasty, each additional level, to N583 or E392		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
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E386 - extradural decompression - spinal cord or cauda equina - tumour or infection add 40%

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	1530.00	10
# N561 Intradural intramedullary spinal tumour(s) - partial or total removal.....	9	1765.75	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	2805.00	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 N540add			255.00	
# E387	- fusion to sacrum, to N539 or N540			153.00	
# E378	- 3D stereotactic spinal procedure, to N539 or N540.....add			510.00	
# E379	- 2D stereotactic spinal procedure, to N539 or N540.....add			510.00	
# E383	- acute spinal cord injury premium, to N539 or N540.....add			255.00	

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.....			102.00	
# 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 N529add			255.00	
# N564	Open myelotomy for lesion - unilateral or bilateral		8	1020.00	10
Note:					
No decompressive codes are <i>eligible for payment</i> when rendered with N529 or N564.					
# N523	AV malformation of cord - excision/obliteration.....		10	1530.00	13
# E383	- acute spinal cord injury premium, to N523add			255.00	
Note:					
No other decompressive codes are <i>eligible for payment</i> when rendered with N523.					
# N555	Insertion / revision of implantable infusion pump.....			510.00	8
# N530	Implantation of spinal cord stimulating electrode by laminectomy		8	816.00	10
Note:					
N530 is <i>not eligible for payment</i> when rendered with any decompressive codes.					
# N563	Implantation of permanent subcutaneous reservoir including laminectomy		11	510.00	11
Note:					
N563 is <i>not eligible for payment</i> when rendered with any decompressive codes.					
# N531	Removal of any stimulation pack or electrode		6	306.00	7
Note:					
N531 is <i>not eligible for payment</i> 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 N556add			71.40	
# N534	Percutaneous radio frequency posterior dorsal root rhizotomy - any number of levels.....			379.45	8

SPINAL SURGICAL PROCEDURES

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 N562add		255.00	
# 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	714.00	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.

SPINAL SURGICAL PROCEDURES

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 myelomeningocele (one surgeon).....	7	765.00	9	
Repair of myelomeningocele (two surgeons)					
# N537	- neurosurgeon.....		510.00	9	
# N538	- reconstructive surgeon.....		632.40		
# N565	Repair of lipomeningocele including release of tethered cord	8	1020.00	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:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900552_e.htm#BK9

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:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/940114_e.htm#P95_6023

RECORDS:

Please refer to Sections 18 and 19 of Regulation 114/94 made under the *Medicine Act*, 1991.

For a complete text version of Section 18 and 19 please refer to:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/940114_e.htm#P95_6023

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 and Long-Term Care 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 and Long-Term Care *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 and Long-Term Care Offices for participants in the inter-provincial reciprocal medical billing system. The Ministry of Health and Long-Term Care also accepts billings for these services on various magnetic media types. Further details can be obtained from any Ministry of Health and Long-Term Care office.

BENEFITS OUTSIDE CANADA

Prior approval from the Ministry of Health and Long-Term Care 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. Surgery to alleviate significant physical symptoms, which have not responded to a minimum of six months active treatment, or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is an insured service.
2. 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 Mental Health Facility (as designated by *The Mental Hospitals 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.
3. In establishing this policy, it has been recognized that
 - a. Peer acceptance in our society often is influenced disproportionately by facial appearance.
 - b. Children are especially susceptible to emotional trauma caused by physical appearances.
4. 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.
5. 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.
6. Within the context of this policy, the word "trauma" includes trauma due to treatment such as surgery, radiation, etc.
7. The phrase "reasonable period of convalescence" should be considered as two years. Independent consideration will be given to the questionable cases.
8. Prior authorization from the Ministry of Health and Long-Term Care 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.
9. Suitable documentation, with the exception of photographs, may be requested in some cases before prior authorization can be considered.
10. 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 and Long-Term Care. No prior authorization is required.
11. 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 and Long-Term Care 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 and Long-Term Care 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 and Long-Term Care 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 and Long-Term Care 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 and Long-Term Care is required.
- iii. Prior authorization from the Ministry of Health and Long Term Care 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 and Long-Term Care 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 and Long-Term Care 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 and Long-Term Care is required. A computer-generated visual field report and interpretative report must accompany the request for prior authorization.

8. Warts

- a. Removal or treatment of warts is not an insured service subject to (b) and (c) below.
- b. Removal or treatment of warts by any listed procedure is an insured service in the case of plantar warts, perianal and genital warts and all warts in immunocompromised patients. Prior authorization is not required.
- 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.

APPENDIX D

SURFACE PATHOLOGY

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 and Long-Term Care 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 and Long-Term Care 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.

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 and Long-Term Care 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.

APPENDIX D

SUB-SURFACE PATHOLOGY

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 and Long-Term Care:
 - 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 and Long-Term Care:
 - 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.

APPENDIX D

SUB-SURFACE PATHOLOGY

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 and Long-Term Care 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 and Long-Term Care 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 and Long-Term Care 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 MOHLTC:
 - i. where there is significant associated symptomatology related to the pannus;
 - ii. where the pannus extends to a level below the pubis symphysis; and
 - iii. where the patient's weight has been stable for a minimum of 6 months 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 pain, chronic skin breakdown, and recurrent cellulitis and/or ulcers.]

17. Sex-Reassignment Surgery

Sex-reassignment surgical procedures listed in this section are insured services when prior authorization has been obtained from the MOHLTC.

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 MOHLTC.
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

SUB-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, metoidioplasty, 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 months of hormone therapy (unless hormones are contraindicated);
 - iii. Has completed twelve (12) continuous months 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 months 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 months of hormone therapy with no breast enlargement (unless hormones are contraindicated).

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 MOHLTC.

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 http://www.health.gov.on.ca/en/public/programs/ohip/outofcountry/prior_approval.aspx 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 and Long-Term Care 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 and Long-Term Care, acting as paying agent on behalf of the Ministry of Community and Social Services (MCSS), 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 Activities of Daily Living Index (completion of amalgamated forms for initial ODSP application)	100.00
K051	Health Status Report (completed separately) for initial ODSP application	80.00
K052	Activities of Daily Living Index (completed separately) for initial ODSP application	20.00
K057	Medical Form Part A for Medical Review process	35.00
K058	Medical Form Part B including both Health Status Report and Activities of Daily Living Index for Medical Review process.....	125.00
K059	Health Status Report of Part B (completed separately) for Medical Review process	100.00
K060	Activities of Daily Living Index of Part B (completed separately) for Medical Review process.....	25.00
K054	Mandatory Special Necessities Benefit Request Form	25.00
K055	Application for Special Diet Allowance.....	20.00
K056	Application for Pregnancy/Breast-feeding Nutritional Allowance.....	20.00

MCSS ONTARIO WORKS PROGRAM (OW)

K053	A Limitation to Participation Form.....	15.00
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Note:

The MCSS 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. Form 4, Form 5 and Request for Supplementary Information are obsolete and will not be accepted by MCSS. Inquiries regarding MCSS forms may be directed to the local MCSS office.

PERIODIC OCULO-VISUAL ASSESSMENT

K065	Eye examination rendered to patients between the ages 20 and 64 who are recipients of income support under the <i>Ontario Disability Support Program Act</i> , 1997	48.90
K066	Eye examination rendered to patients between the ages 20 and 64 who are recipients of income assistance or benefits under the <i>Ontario Works Act</i> , 1997	48.90

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 the first claim for either service or a major eye examination is or has been submitted for a service rendered by an optometrist or physician.
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.

K061	Taking of blood samples in a hospital setting at the request of a police officer	30.00
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Cortical evoked audiometry, multiple frequency (minimum of 4 frequencies in each ear) as required by WSIB:

G153	- technical component.....	9.75
G154	- professional component.....	40.30

APPENDIX F

NOT ALLOCATED

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:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/940114_e.htm#P151_11852

For a complete text version of Section 37.1, of the *Health Insurance Act*, please refer to:

http://www.e-laws.gov.on.ca/DBLaws/statutes/english/90h06_e.htm#BK77

APPENDIX G

NOT ALLOCATED

APPENDIX H

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]	12	14
>120-135 [>2h – 2h 15m]	14	17
>135-150 [>2h 15m – 2h 30m]	16	20
>150-165 [>2h 30m – 2h 45m]	19	23
>165-180 [>2h 45m – 3h]	22	26
>180-195 [>3h – 3h 15m]	25	29
>195-210 [>3h 15m – 3h 30m]	28	32
>210-225 [>3h 30m – 3h 45m]	31	35
>225-240 [>3h 45m – 4h]	34	38
>240-255 [>4h – 4h 15m]	37	41
>255-270 [>4h 15m – 4h 30m]	40	44
>270-285 [>4h 30m – 4h 45m]	43	47
>285-300 [>4h 45m – 5h]	46	50
>300-315 [>5h – 5h 15m]	49	53
>315-330 [>5h 15m – 5h 30m]	52	56
>330-345 [>5h 30m – 5h 45m]	55	59
>345-360 [>5h 45m – 6h]	58	62
>360-375 [>6h – 6h 15m]	61	65
>375-390 [>6h 15m – 6h 30m]	64	68
>390-405 [>6h 30m – 6h 45m]	67	71
>405-420 [>6h 45m – 7h]	70	74
>420-435 [>7h – 7h 15m]	73	77
>435-450 [>7h 15m – 7h 30m]	76	80
>450-465 [>7h 30m – 7h 45m]	79	83
>465-480 [>7h 45m – 8h]	82	86
>480-495 [>8h – 8h 15m]	85	89
>495-510 [>8h 15m – 8h 30m]	88	92

APPENDIX H

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 FOBT Positive/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
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

APPENDIX Q

Code	Description	Fee	Eligible Models
After Hours Fees			
Q017A	HIV After Hours Fees	30%	HIV

Code	Description	Fee	Eligible Models
Chronic Disease Management			
Q042A	Smoking Cessation Counselling Fee (2 / year)	7.50	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

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	Bill at \$0.00	FHN, FHO

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses			
Q150A	FOBT Distribution and Counselling Fee (Once per patient every two years)	7.00	All primary care physicians in Ontario including physicians participating in Patient Enrolment Models

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses			
Q152A	FOBT Completion Fee (Once per patient every two years)	5.00	<p>All primary care physicians in Ontario including FHG and CCM physicians who do not meet the minimum roster size.</p> <p>Physicians participating in Patient Enrollment Models who are eligible for Preventive Care Bonus Payment are not eligible to bill this fee code.</p>

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) Pap Smear - 60% (\$220)	Bill at \$0.00	FHN, FHO, RNPG, 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) Pap Smear - 65% (\$440)	Bill at \$0.00	FHN, FHO, RNPG, 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) Pap Smear - 70% (\$660)	Bill at \$0.00	FHN, FHO, RNPG, 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) Pap Smear - 75% (\$1320)	Bill at \$0.00	FHN, FHO, RNPG, 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) Pap Smear - 80% (\$2200)	Bill at \$0.00	FHN, FHO, RNPG, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q110A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 55% (\$220)	Bill at \$0.00	FHN, FHO, RNPG, 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	FHN, FHO, RNPG, 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	FHN, FHO, 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	FHN, FHO, 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	FHN, FHO, 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
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	FHN, FHO, 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	FHN, FHO, 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	FHN, FHO, 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	FHN, FHO, 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	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q123A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 70% (\$4000)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

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A002	62.20				A5
A003	77.20				A2
A004	38.35				A2
A005	77.20				A1
A006	45.90				A1
A007	33.70				A5
A008	13.05				A6
A013	47.50				A45
A014	31.45				A45
A015	106.80				A45
A016	52.15				A45
A020	49.95				A54
A023	38.70				A53
A024	21.90				A53
A025	72.15				A53
A026	44.45				A53
A027	147.30				A53
A033	44.40				A64
A034	24.10				A64
A035	90.30				A64
A036	60.00				A64
A043	58.25				A89
A044	30.00				A89
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A050	144.75				A51
A051	70.90				A51
A053	79.85				A51
A054	61.25				A51
A055	125.60				A51
A056	84.20				A51
A058	38.05				A51
A063	42.55				A97
A064	24.05				A97
A065	83.10				A97
A066	51.70				A97
A070	185.00				A71
A071	70.90				A72
A073	79.85				A72
A074	61.25				A72
A075	175.00				A71
A076	105.25				A72
A078	38.05				A72
A083	41.55				A110
A084	26.55				A110
A085	81.10				A110

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A086	47.95				A110
A093	44.40				A49
A094	24.10				A49
A095	90.30				A49
A096	60.00				A49
A100	76.90				A5
A110	48.90				A6
A112	48.90				A6
A113	89.85				A86
A115	51.10				A7, A93
A120	18.85				A62, A78
A130	300.70				A78
A131	70.90				A78
A133	79.85				A78
A134	61.25				A78
A135	157.00				A78
A136	105.25				A78
A138	38.05				A78
A150	300.70				A57
A151	70.90				A57
A153	79.85				A57
A154	61.25				A57
A155	157.00				A57
A156	105.25				A57
A158	38.05				A57
A160	300.70				A84
A161	70.90				A84
A163	79.85				A84
A164	61.25				A84
A165	157.00				A84
A166	105.25				A84
A168	38.05				A84
A173	44.40				A127
A174	24.10				A127
A175	90.30				A127
A176	60.00				A127
A180	300.70				A86
A181	71.90				A86
A183	78.80				A86
A184	62.10				A86
A185	176.35				A86
A186	84.95				A86
A188	37.65				A86
A190	300.70				A111
A191	212.65				A111
A192	212.65				A111
A193	79.85				A111

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A194	38.05				A111
A195	199.40				A111
A196	105.25				A111
A197	212.65				A111
A198	212.65				A111
A203	47.45				A91
A204	26.35				A91
A205	101.70				A91
A206	54.10				A91
A215	47.50				A45
A220	300.70				A67
A221	38.05				A67
A223	395.65				A67
A225	165.00				A67
A226	105.25				A67
A230	25.00				A93
A231	120.00				A92
A233	57.70				A92
A234	28.95				A92
A235	82.30				A92
A236	45.85				A92
A237	56.60				A92
A239	56.60				A92
A243	41.10				A99
A244	24.55				A99
A245	77.90				A99
A246	48.60				A99
A250	120.00				A93
A251	120.00				A95
A252	240.00				A94
A253	82.30				A95
A254	120.00				A94
A255	105.25				A57
A256	144.75				A95
A260	300.70				A100
A261	21.50				A101
A262	42.15				A101
A263	77.70				A101
A264	59.45				A101
A265	167.00				A100
A266	91.35				A101
A268	62.40				A101
A275	105.25				A76
A283	55.55				A81
A284	30.60				A81
A285	102.00				A81
A286	71.20				A81

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A310	65.00				A105
A311	70.90				A105
A313	74.00				A105
A315	172.85				A105
A316	91.35				A105
A318	38.05				A105
A325	105.25				A67
A330	89.50				A118
A331	17.75				A118
A332	199.70				A118
A335	50.00				A117
A338	17.75				A118
A340	59.55				A119
A341	68.90				A119
A343	77.55				A119
A345	152.40				A119
A346	99.30				A119
A348	37.05				A119
A353	45.00				A126
A354	26.00				A126
A355	80.00				A126
A356	55.75				A126
A365	223.20				A117
A375	105.25				A72
A385	84.95				A86
A395	105.25				A111
A400	240.55				A51
A405	84.20				A51
A411	70.90				A62
A413	79.85				A62
A414	61.25				A62
A415	157.00				A62
A416	105.25				A62
A418	38.05				A62
A425	300.70				A105
A435	105.25				A78
A441	70.90				A82
A443	79.85				A82
A444	61.25				A82
A445	157.00				A82
A446	105.25				A82
A448	38.05				A82
A460	300.70				A76
A461	70.90				A76
A463	79.85				A76
A464	61.25				A76
A465	157.00				A76

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A466	105.25				A76
A468	38.05				A76
A470	300.70				A120
A471	70.90				A120
A473	79.85				A120
A474	61.25				A120
A475	157.00				A120
A476	105.25				A120
A478	38.05				A120
A480	89.85				A122
A481	70.90				A122
A483	79.85				A122
A484	61.25				A122
A485	157.00				A122
A486	105.25				A122
A488	38.05				A122
A510	89.85				A106
A511	89.85				A106
A515	91.35				A105
A525	105.25				A50
A545	105.25				A62
A565	91.35				A101
A570	89.85				A120
A575	105.25				A120
A585	64.70				A81
A586	71.20				A81
A590	300.70				A122
A595	105.25				A122
A600	300.70				A47
A601	70.90				A47
A603	79.85				A47
A604	61.25				A47
A605	157.00				A47
A606	105.25				A47
A608	38.05				A47
A611	70.90				A75
A613	79.85				A75
A614	61.25				A75
A615	157.00				A75
A616	105.25				A75
A618	38.05				A75
A621	70.90				A50
A623	79.85				A50
A624	61.25				A50
A625	157.00				A50
A626	105.25				A50
A628	38.05				A50

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A636	57.25				A90
A638	35.35				A90
A643	44.40				A66
A644	24.10				A66
A645	90.30				A66
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A655	105.25				A75
A661	68.80				A101
A662	395.65				A100
A665	91.35				A101
A667	395.65				A100
A675	105.25				A47
A680	144.75				A42
A695	395.65				A111
A735	33.70				A90
A745	99.30				A119
A760	89.85				A57
A765	165.50				A47, A50, A57, A62, A75, A76, A78, A82, A84, A119, A120, A122
A770	395.65				A71
A771	20.60				A5
A775	300.70				A71
A777	33.70				A5
A795	300.70				A111
A800	165.00				A68
A801	300.70				A68
A802	395.65				A68
A813	101.70				A8
A815	186.95				A8
A816	106.80				A8
A835	180.00				A90
A845	105.25				A82
A865	105.25				A84
A888	33.70				A2
A895	232.70				A111
A900	45.15				A3
A901	45.15				A3
A902	45.15				A3
A903	65.05				A4
A904	33.70				A4
A905	65.90				A1
A911	144.75				A1
A912	217.15				A1
A917	33.70				A6
A920	161.15				K4
A921	33.70				K5

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A927	33.70				A6
A933	79.90				A4
A935	160.00				A49, A64, A66, A89, A91, A92, A97, A99, A110, A126, A127
A937	33.70				A6
A945	144.75				A1
A947	33.70				A6
A957	33.70				A6
A960	36.40				GP51
A962	36.40				GP51
A963	36.40				GP51
A964	36.40				GP51
A967	33.70				A6
A990	20.00				GP51
A994	60.00				GP51
A996	100.00				GP51
A998	75.00				GP51

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B961	36.40				GP50
B962	36.40				GP50
B963	36.40				GP50
B964	36.40				GP50
B966	36.40				GP51
B986	36.40				GP52
B987	110.00				GP52
B988	82.50				GP52
B990	27.50				GP50
B992	44.00				GP50
B993	82.50				GP50
B994	66.00				GP50
B996	110.00				GP50
B997	110.00				GP51
B998	82.50				GP51

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C003	77.20				A9
C004	38.35				A9
C005	77.20				A9
C006	45.90				A9
C007	31.00				A9
C008	31.00				A9
C009	31.00				A9
C010	18.85				A9
C012	31.00				A46
C013	47.50				A45
C014	28.00				A45
C015	106.80				A45
C016	52.15				A45
C017	31.00				A46
C018	31.00				A46
C019	31.00				A46
C020	49.95				A55
C022	31.00				A55
C023	38.70				A55
C024	25.40				A55
C025	147.30				A55
C026	44.45				A55
C027	31.00				A55
C028	31.00				A55
C029	31.00				A55
C032	31.00				A64
C033	44.40				A64
C034	25.95				A64
C035	90.30				A64
C036	60.00				A64
C037	31.00				A64
C038	31.00				A64
C039	31.00				A64
C042	31.00				A89
C043	58.25				A89
C044	30.00				A89
C045	121.10				A89
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C048	31.00				A89
C049	31.00				A89
C050	144.75				A51
C051	70.90				A51
C052	31.00				A52
C053	79.85				A51
C054	61.25				A51

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C056	84.20				A51
C057	31.00				A52
C058	31.00				A52
C059	31.00				A52
C062	31.00				A97
C063	42.55				A97
C064	25.50				A97
C065	83.10				A97
C066	51.70				A97
C067	31.00				A97
C068	31.00				A97
C069	31.00				A97
C071	70.90				A73
C072	31.00				A73
C073	79.85				A73
C074	61.25				A73
C075	185.00				A73
C076	105.25				A73
C077	31.00				A73
C078	31.00				A73
C079	31.00				A73
C082	31.00				A110
C083	41.55				A110
C084	27.80				A110
C085	81.10				A110
C086	47.95				A110
C087	31.00				A110
C088	31.00				A110
C089	31.00				A110
C092	31.00				A49
C093	44.40				A49
C094	25.95				A49
C095	90.30				A49
C096	60.00				A49
C097	31.00				A49
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C103	36.40				GP66
C104	36.40				GP66
C105	60.00				GP66
C106	75.00				GP66
C107	100.00				GP66
C108	75.00				GP66
C109	60.00				GP66

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C113	89.85				A87
C121	31.00				A9, A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A83, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
C122	58.80				A9, A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A82, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
C123	58.80				A9, A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A82, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
C124	58.80				A9, A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A82, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
C130	300.70				A79
C131	70.90				A79
C132	31.00				A79
C133	79.85				A79
C134	61.25				A79
C135	157.00				A79
C136	105.25				A79
C137	31.00				A79
C138	31.00				A79
C139	31.00				A79
C142	58.80				A9, A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A83, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
C143	58.80				A9, A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A83, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
C150	300.70				A60
C151	70.90				A60
C152	31.00				A60
C153	79.85				A60
C154	61.25				A60
C155	157.00				A60
C156	105.25				A60
C157	31.00				A60
C158	31.00				A60
C159	31.00				A60
C160	300.70				A84
C161	70.90				A84
C162	31.00				A85
C163	79.85				A84
C164	61.25				A84

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C172	31.00				A127
C173	44.40				A127
C174	25.95				A127
C175	90.30				A127
C176	60.00				A127
C177	31.00				A127
C178	31.00				A127
C179	31.00				A127
C180	300.70				A87
C181	71.90				A87
C182	31.00				A87
C183	78.80				A87
C184	62.10				A87
C185	176.35				A87
C186	84.95				A87
C187	31.00				A87
C188	31.00				A87
C189	31.00				A87
C190	300.70				A113
C192	31.00				A113
C193	79.85				A113
C194	61.25				A113
C196	105.25				A113
C197	31.00				A113
C198	31.00				A113
C199	31.00				A113
C202	31.00				A91
C203	47.45				A91
C204	29.65				A91
C205	101.70				A91
C206	54.10				A91
C207	31.00				A91
C208	31.00				A91
C209	31.00				A91
C215	47.50				A45
C220	300.70				A70
C222	31.00				A70
C223	395.65				A70
C225	165.00				A70
C226	105.25				A70
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C229	31.00				A70

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C233	57.70				A96
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C235	82.30				A96
C236	45.85				A96
C237	31.00				A96
C238	31.00				A96
C239	31.00				A96
C242	31.00				A99
C243	41.10				A99
C244	27.50				A99
C245	77.90				A99
C246	48.60				A99
C247	31.00				A99
C248	31.00				A99
C249	31.00				A99
C250	120.00				A96
C255	105.25				A60
C260	300.70				A103
C262	31.00				A103
C263	77.70				A103
C264	59.45				A103
C265	167.00				A103
C266	91.35				A103
C267	31.00				A103
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C269	31.00				A103
C275	105.25				A76
C283	55.55				A81
C285	102.00				A81
C286	71.20				A81
C288	30.10				A81
C311	70.90				A107
C312	31.00				A107
C313	74.00				A107
C314	65.00				A107
C315	182.85				A107
C316	91.35				A107
C317	31.00				A107
C318	31.00				A107
C319	31.00				A107
C325	105.25				A70
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C335	50.00				A118
C341	68.90				A119

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C345	152.40				A119
C346	99.30				A119
C347	31.00				A119
C348	31.00				A119
C349	31.00				A119
C352	31.00				A126
C353	45.00				A126
C354	26.00				A126
C355	80.00				A126
C356	55.75				A126
C357	31.00				A126
C358	31.00				A126
C359	31.00				A126
C365	223.20				A118
C375	105.25				A73
C385	84.95				A87
C395	105.25				A113
C400	240.55				A51
C405	84.20				A51
C411	70.90				A62
C412	31.00				A63
C413	79.85				A62
C414	61.25				A62
C415	157.00				A62
C416	105.25				A62
C417	31.00				A63
C418	31.00				A63
C419	31.00				A63
C425	300.70				A107
C435	105.25				A79
C441	70.90				A82
C442	31.00				A82
C443	79.85				A82
C444	61.25				A82
C445	157.00				A82
C446	105.25				A82
C447	31.00				A82
C448	31.00				A83
C449	31.00				A82
C460	300.70				A76
C461	70.90				A76
C462	31.00				A77
C463	79.85				A76
C464	61.25				A76

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C468	31.00				A77
C469	31.00				A77
C470	300.70				A121
C471	70.90				A121
C472	31.00				A121
C473	79.85				A121
C474	61.25				A121
C475	157.00				A121
C476	105.25				A121
C477	31.00				A121
C478	31.00				A121
C479	31.00				A121
C480	89.85				A125
C481	70.90				A125
C482	31.00				A125
C483	79.85				A125
C484	61.25				A125
C485	157.00				A125
C486	105.25				A125
C487	31.00				A125
C488	31.00				A125
C489	31.00				A125
C510	89.85				A107
C511	89.85				A107
C515	91.35				A107
C525	105.25				A50
C545	105.25				A62
C565	91.35				A103
C570	89.85				A121
C575	105.25				A121
C585	64.70				A81
C586	71.20				A81
C590	300.70				A125
C595	105.25				A125
C600	300.70				A48
C601	70.90				A48
C602	31.00				A48
C603	79.85				A48
C604	61.25				A48
C605	157.00				A48
C606	105.25				A48
C607	31.00				A48
C608	31.00				A48
C609	31.00				A48

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C612	31.00				A75
C613	79.85				A75
C614	61.25				A75
C615	157.00				A75
C616	105.25				A75
C617	31.00				A75
C618	31.00				A75
C619	31.00				A75
C621	70.90				A50
C622	31.00				A50
C623	79.85				A50
C624	61.25				A50
C625	157.00				A50
C626	105.25				A50
C627	31.00				A50
C628	31.00				A50
C629	31.00				A50
C635	82.40				A90
C636	57.25				A90
C642	31.00				A66
C643	44.40				A66
C644	25.95				A66
C645	90.30				A66
C646	60.00				A66
C647	31.00				A66
C648	31.00				A66
C649	31.00				A66
C655	105.25				A75
C661	68.80				A103
C662	395.65				A103
C665	91.35				A103
C667	395.65				A103
C675	105.25				A48
C680	144.75				A42
C695	395.65				A113
C735	33.70				A90
C745	99.30				A119
C760	89.85				A60
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C770	395.65				A73
C771	20.60				A9
C775	300.70				A73
C777	33.70				A9
C795	300.70				A113
C800	165.00				A70

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C802	395.65				A70
C813	101.70				A9
C815	186.95				A9
C816	106.80				A9
C835	180.00				A90
C845	105.25				A82
C865	105.25				A84
C882	31.00				A9
C895	232.70				A113
C903	65.05				A9
C904	33.70				A9
C905	65.90				A9
C911	144.75				A9
C912	217.15				A9
C933	79.90				A9
C935	160.00				A49, A64, A66, A89, A91, A96, A97, A99, A110, A126, A127
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C961	36.40				GP49
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C982	31.00				A46, A48, A49, A50, A52, A55, A60, A63, A64, A66, A73, A75, A77, A79, A83, A85, A87, A89, A91, A96, A97, A99, A103, A107, A110, A113, A119, A121, A125, A126, A127
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C987	75.00				GP49
C988B	76.40				GP56
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C990	20.00				GP49
C991	20.00				GP49
C992	40.00				GP49
C993	40.00				GP49
C994	60.00				GP49
C995	60.00				GP49
C996	100.00				GP49
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D007	128.05				N12
D008	241.30				N12
D009	84.45				N16
D010	252.45				N16
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D026	147.60				N49
D027	57.50				N49
D028	300.00				N49
D029	151.25				N49
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D032	163.35				N49
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D038	207.90				N40
D039	309.00				N40
D040	62.20				N40
D041	290.55				N40
D042	268.25				N34
D043	406.45				N34
D046	967.90				N34
D047	1451.45				N34
D052	612.45				N34
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E105	424.35				Y1
E106	640.00				Y1
E107	496.00				Y1
E108	131.25				Y1
E109	677.50				Y7
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E118	308.30				Y2
E119	542.00				Y2
E121	740.00				Y2
E122	590.00				Y2
E123	161.75				Y2
E124	740.00				Y2
E125	750.00				Y6
E126	1245.00				Y6
E127	166.45				Y3
E128	496.00				Y2
E130	308.30				Y3
E131	161.75				Y3
E132	550.00				Y3
E133	182.75				Y3
E134	205.55				Y3
E135	505.45				Y3
E136	290.00				Y3
E137	161.75				Y4
E138	450.00				Y4
E139	161.75				Y4
E140	397.75				Y4
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E144	450.00				Y4
E145	350.00				Y4
E146	400.00				Y4
E147	90.00				Y5
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E149	90.00				Y5
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E160	190.30				Y7
E161	250.00				Y6
E162	542.00				Y6
E163	514.80				Y7
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E165	590.00				Y7
E166	450.00				Y7
E167	640.00				Y7
E168	308.30				Y7
E169	542.00				Y7
E170	575.85				Y7
E171	1005.00				Y7
E172	200.00				Y7
E173	594.70				N29
E174	667.00				N29
E176	325.00				Y7
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E178	222.65				Y7
E179	296.90				Y7
E180	411.20				Y7
E181	640.00				Y7
E190	150.00				Y8
E191	161.75				Y8
E192	313.15				Y8
E193	393.00				Y8
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E196	290.00				Y8
E197	310.00				Y8
E198	300.00				Y8
E199	225.00				Y8
E200	82.80				Y9
E201	205.55				Y9
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E223	484.35				Y9
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E313	362.55				Y13
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E317	139.95				Y12
E318	92.40				Y12
E319	345.30				Y14
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E332	548.45				Y15
E333	406.55				Y14
E335	637.15				Y15
E336	345.15				Y14
E337	468.85				Y14
E339	661.55				Y15
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E379	510.00				Z6, Z7, Z8, Z10
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E767	138.15				T2
E768	236.70				T2
E769	260.05				T3
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E781	49.90				T7
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E952	175.00				Y6
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E968	511.90				N24
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G108	20.20				J80
G111			50.75		J13
G112				75.00	J13
G115	46.30				J11
G117	170.00				J60
G118	130.00				J55
G119	190.00				J60
G120				7.00	J16
G121			12.55		J16
G123	17.10				J64
G125	100.00				J55
G126				7.00	J16
G127			12.55		J16
G138				71.65	J67
G140			40.15		J67
G141				19.15	J79
G143			36.00		J79
G144				19.15	J79
G146			36.00		J79
G147				12.30	J75
G149			17.60		J75
G150				19.20	J75
G152			30.10		J75
G153			9.75		AF1
G154				40.30	AF1
G166				10.45	J36
G167			6.60		J36
G174			46.75		J13
G175	21.85				J12
G176	334.25				J10
G177	416.80				J10

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CODE	\$	T	P	P1	Page
G178	352.05				J11
G179	111.20				J11
G180				16.95	J15
G181			11.55		J15
G185	184.95				J4
G190	184.95				J5
G191	12.40				J80
G192	73.65				J92
G193	43.85				J92
G194	8.35				J92
G195	17.00				J5
G196	17.00				J5
G197				0.19	J5
G198	2.39				J4
G199	40.00				J5
G200	8.65				J4
G201	1.60				J4
G202	4.45				J4
G203	1.60				J4
G204	12.40				J4
G205	13.15				J4
G206	2.39				J4
G207	14.15				J4
G208	15.00				J4
G209			0.69		J5
G210	190.75				J28
G211	38.35				J23
G212	9.75				J4
G213	13.80				J5
G214	54.65				J63
G217	200.00				J61
G218	54.65				J64
G219	34.20				J64
G220	34.20				J64
G221	16.95				J64
G222	55.00				J55
G223	17.10				J64
G224	15.55				J56
G225	34.20				J64
G226	82.45				J64
G227	54.65				J64
G228	34.10				J64
G229	54.65				J64
G230	54.65				J64
G231	34.10				J64
G232	150.00				J61
G233	200.00				J61

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CODE	\$	T	P	P1	Page
G234	55.10				J61
G235	34.10				J64
G236	150.00				J61
G238	34.10				J64
G239	127.60				J60
G240	82.45				J64
G241	54.65				J64
G242	82.45				J64
G243	54.65				J63
G244	81.95				J63
G245	180.00				J60
G246	150.00				J60
G247	30.10				J56
G248	55.00				J55
G249	231.65				J10
G250	75.10				J64
G251				27.05	J35
G254	34.70				J36
G256	34.10				J64
G257	77.25				J64
G258	44.25				J64
G259	383.30				J10
G260	80.00				J55
G261	331.05				J10
G262	212.45				J9
G263	97.40				J9
G264	34.10				J63
G265	17.10				J63
G266	278.85				J65
G267	270.05				J65
G268	31.25				J7
G269	31.25				J7
G270	23.90				J7
G271	12.75				J7
G272					J8
G275	205.45				J8
G276	15.35				J8
G277	82.00				J8
G278	41.80				J8
G279	80.00				J56, J64
G280	186.90				J8
G281	7.70				J45
G282	19.90				J7
G283				11.30	J15
G284			8.80		J15
G285	32.90				J8
G286	32.90				J8

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CODE	\$	T	P	P1	Page
G287	82.00				J8
G288	200.00				J11
G289	110.95				J8
G290	41.80				J8
G291	19.85				J63
G292	10.00				J63
G294	184.75				J30
G295	246.45				J30
G296	110.95				J8
G297	118.70				J9
G298	78.95				J9
G299	110.95				J8
G300	110.95				J8
G301	122.40				J8
G303	51.25				J23
G305	122.40				J8
G306	110.95				J8
G307				9.55	J15
G308			8.80		J15
G309	45.55				J7
G310			6.60		J12
G311			1.92		J15
G312	15.40				J30
G313				4.45	J12
G314	112.00				J11
G315			43.50		J13
G317				27.80	J15
G319				62.65	J13
G320				4.30	J15
G321				47.65	J15
G322	9.60				J36
G323	158.60				J30
G324	102.95				J30
G325	317.25				J30
G327	77.30				J30
G328	39.80				J42
G329	20.25				J42
G330	219.50				J31
G331	197.55				J31
G332				122.25	J36
G334	4.05				J37
G336	17.65				J30
G337	16.95				J33
G338	24.90				J33
G340	45.45				J33
G341	16.95				J33
G342	31.05				J33

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CODE	\$	T	P	P1	Page
G344	42.30				J34
G345	75.00				J45
G347	96.35				J53
G348	96.35				J53
G349	45.30				J36
G350				76.05	J35
G351				31.85	J35
G352	9.60				J36
G353				28.75	J35
G354				38.50	J35
G355	9.60				J36
G356	33.80				J36
G357	19.55				J36
G358	24.90				J33
G359	105.15				J45
G362	6.25				J37
G363	22.00				J37
G364	17.60				J37
G365	6.75				J37
G366	148.50				J11
G369	5.30				J42
G370	20.25				J42
G371	19.90				J42
G372	3.89				J43
G373	6.75				J43
G374	54.30				J61
G375	8.85				J43
G376	10.20				J44
G377	13.30				J43
G378	25.50				J37
G379	6.15				J44
G380	27.05				J44
G381	54.25				J45
G382	13.30				J45
G383					J43
G384	8.85				J43
G385	4.55				J43
G387	125.00				J44
G388	20.50				J46
G389	13.90				J44
G390	262.40				J45
G391	28.35				J21, J22
G394	6.75				J37
G395	56.80				J22
G396	24.90				J42
G398	61.30				J38
G399	44.15				J37

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CODE	\$	T	P	P1	Page
G400	223.10				J25
G401	146.45				J25
G402	58.60				J25
G403	21.15				J77
G404	61.00				J85
G405	193.45				J25
G406	101.55				J25
G407	67.60				J25
G408	121.45				J53
G409	60.70				J53
G410	68.40				J65
G411	192.10				J53
G412	242.90				J53
G413	170.85				J65
G414			24.40		J66
G415				23.15	J66
G417	15.90				J65
G418				50.00	J66
G419	20.60				J65
G420	11.25				J77
G421	27.70				J70
G422	34.20				J64
G423	90.30				J70
G424	201.00				J70
G425				44.40	J71
G426	9.70				J70
G427	9.60				J70
G428				6.85	J71
G429	42.45				J70
G430	86.05				J70
G431	41.60				J70
G432				26.95	J71
G433				9.90	J71
G435	5.10				J70
G436				14.50	J71
G437				22.90	J71
G438				22.15	J71
G439				75.00	J71
G440			10.30		J79
G441			17.90		J79
G442			3.25		J79
G443			7.80		J79
G444				7.00	J71
G448			21.70		J79
G450				5.70	J79
G451			18.55		J80
G453	41.60				J70

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CODE	\$	T	P	P1	Page
G454	16.80				J80
G455			27.40		J83
G456				99.90	J83
G457				61.95	J83
G458	191.70				J84
G460	330.00				J76
G461	500.00				J76
G462	1.65				J43
G463	90.30				J70
G466			18.40		J83
G470	7.85				J29
G471			27.40		J84
G473				191.00	J84
G475	23.75				J92
G476	5.40				J92
G477				5.40	J92
G478	80.30				J85
G479	92.60				J85
G480	9.90				J7
G481	1.32				J52
G482	7.35				J7
G483	9.70				J7
G485	45.45				J84
G486	28.50				J84
G487	28.50				J84
G488	18.80				J84
G489	3.54				J7
G490	42.30				J34
G493	6.25				J33
G494	10.20				J33
G495	42.30				J33
G497	49.80				J33
G498	10.20				J34
G499	49.80				J34
G500	31.80				J33
G501	6.25				J34
G509	80.40				J9
G510	21.00				J44
G511	17.75				J81
G512	62.75				J82
G513	42.30				J34
G514	10.60				J33
G515	46.30				J34
G516				36.90	J35
G517	10.05				J16
G518				11.20	J16
G519			10.35		J16

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CODE	\$	T	P	P1	Page
G520	21.20				J33
G521	110.55				J21
G522	36.35				J21
G523	55.20				J21
G524				75.00	J71
G525				5.85	J79
G526				15.70	J79
G529				1.86	J79
G530				5.95	J79
G533				18.30	J80
G536	77.85				J44
G537	26.05				J44
G538	4.50				J43
G540			9.05		J66
G541			39.00		J66
G542			23.10		J66
G543				60.00	J66
G544			8.30		J66
G545				14.70	J66
G546				30.45	J66
G547	185.70				J65
G548	278.85				J65
G549	157.85				J65
G551	170.85				J65
G554			46.30		J66
G555				47.75	J66
G556	136.40				J28
G557	325.40				J25
G558	213.50				J25
G559	85.35				J25
G570			112.60		J18
G571				96.20	J18
G574			16.05		J19
G575				13.95	J19
G579	11.35				J20
G580	45.00				J20
G581				25.00	J19
G582			127.85		J18
G583				110.15	J18
G585			126.75		J19
G590	4.50				J43
G592	1.65				J43
G600	358.00				J26
G601	178.95				J26
G602	89.40				J26
G603	536.95				J26
G604	536.95				J26

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G610	245.65				J26
G611	122.80				J26
G620	155.20				J26
G621	77.60				J26
G647			112.65		J14
G648			164.00		J14
G649				122.25	J14
G650				47.90	J14
G651			23.90		J14
G652			32.70		J14
G653				34.10	J14
G654			22.80		J14
G655			15.60		J14
G656				51.15	J14
G657				68.20	J14
G658				75.45	J14
G659				95.85	J14
G660				8.65	J15
G661			4.00		J15
G682			47.80		J14
G683			65.40		J14
G684			71.65		J14
G685			98.10		J14
G686			45.60		J14
G687			31.20		J14
G688			68.40		J14
G689			46.85		J14
G690				122.25	J15
G692			168.45		J15
G700	5.10				J3
G790	223.10				J69
G791	146.45				J69
G792	58.60				J69
G800	83.80				J27
G801	41.90				J27
G802	83.80				J27
G804	71.85				J27
G805	35.90				J27
G807	35.75				J28
G810	4.80				J72
G811	4.80				J72
G812	4.80				J72
G813	5.10				J72
G814	25.00				J74
G815			36.00		J80
G816				104.45	J80
G818	35.00				J73

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G820	35.00				J73
G821	35.00				J73
G822	25.00				J73
G823	35.00				J73
G840	4.50				J43
G841	4.50				J43
G842	4.50				J43
G843	4.50				J43
G844	4.50				J43
G845	4.50				J43
G846	4.50				J43
G847	4.50				J43
G848	4.50				J43
G850			20.40		J71
G851			30.55		J71
G852			33.15		J71
G853			21.95		J71
G854			6.40		J71
G855			6.30		J71
G856			9.05		J71
G857			4.40		J71
G858			13.30		J71
G860	127.20				J32
G861	127.20				J32
G862	127.20				J32
G863	127.20				J32
G864	127.20				J32
G865	127.20				J32
G866	68.80				J32
G870	120.00				J41
G871	120.00				J41
G872	120.00				J41
G873	120.00				J41
G874	50.00				J41
G875	40.00				J41
G876	10.00				J41
G877	18.85				J41
G878	28.10				J41
G879	18.85				J41
G880	28.10				J41
G900	12.70				J92
G910	80.00				J59
G911	80.00				J59
G912	80.00				J59
G913	20.00				J59
G914	56.00				J59
G915	14.00				J59

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CODE	\$	T	P	P1	Page
G916	75.00				J59
G917	160.00				J59
G918	74.20				J60
G919	400.00				J60
G920	80.00				J61
G921	12.50				J61

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H001	52.20				A10
H002	32.75				A10
H003	16.25				A10
H007	61.65				A10
H055	97.60				A56
H065	74.25				A12
H100	19.65				A13
H101	15.00				A12
H102	37.20				A12
H103	35.65				A12
H104	15.00				A12
H105	26.25				A12
H112	34.20				A12
H113	19.80				A12
H121	29.80				A12
H122	73.90				A12
H123	65.95				A12
H124	29.80				A12
H131	18.70				A12
H132	46.30				A12
H133	42.40				A12
H134	18.70				A12
H151	25.50				A12
H152	63.30				A12
H153	56.95				A12
H154	25.50				A12
H261	57.90				A104
H262	61.00				A104
H263	17.75				A104
H267	63.45				A104
H312	39.00				A109
H313	76.95				A109
H317	39.00				A109
H319	39.00				A109
H400	72.80				GP69
H401	72.80				GP69
H402	72.80				GP69
H403	72.80				GP69
H404	72.80				GP69
H405	72.80				GP69
H406	72.80				GP69
H407	72.80				GP69
H408	72.80				GP69
H960	36.40				GP50
H962	36.40				GP50
H963	36.40				GP50
H964	36.40				GP50

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H980	20.00				GP50
H981	20.00				GP50
H984	60.00				GP50
H985	60.00				GP50
H986	100.00				GP50
H987	100.00				GP50
H988	75.00				GP50
H989	75.00				GP50

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J001	29.55				E3
J002	27.00				E3
J003	68.00				E3
J004	70.35				E3
J005	45.40				E3
J006	105.30				E3
J007					E4
J008	56.70				E3
J009	33.50				E3
J010	105.30				E4
J011	93.40				E4
J012					E4
J013	105.30				E4
J014	38.05				E2
J018	45.40				E4
J020	23.85				E4
J021	121.40				E2
J022	60.15				E2
J023	29.55				E2
J024	89.90				E3
J025	398.15				E2
J026	61.50				E2
J027	76.55				E2
J028	29.55				E4
J029	59.95				E4
J030	54.05				E3
J031	89.90				E2
J032	111.50				E2
J033	111.50				E2
J034	89.90				E2
J035	29.55				E2
J036	26.95				E3
J037	70.35				E4
J038	21.75				E4
J039	121.95				E4
J040	105.30				E2
J041	295.25				E4
J042	82.20				E3
J043	40.65				E3
J044	135.00				E3
J045	122.10				E4
J046	223.75				E4
J047	49.35				E2
J048	311.05				E2
J049	437.30				E3
J050	297.30				E3
J051	94.60				E4

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CODE	\$	T	P	P1	Page
J052	99.90				E4
J053	45.35				E3
J055	223.75				E4
J056	582.45				E2
J057	787.35				E4
J058	101.55				E2
J059	101.55				E4
J060	29.55				E4
J061	223.75				E4
J062	223.75				E4
J063	259.55				E4
J064	72.65				E4
J065	20.50				E4
J066	438.10				E2
J067	38.20				E2
J068	44.25				E3
J069	515.70				E4
J102		22.40		28.50	G3
J103		43.95		38.05	G3
J105		47.30		23.70	G3
J107		21.75		18.85	G3
J108		22.80		19.70	G3
J122		47.20		23.70	G3
J125		48.75		24.55	G4
J127		23.70		13.10	G10
J128		32.10		17.55	G4
J135		48.75		26.55	G4
J138		48.75		26.55	G6
J149		47.30		36.85	G11
J151				19.65	G11
J157		32.10		17.55	G5
J158		32.10		17.55	G5
J159		48.75		26.55	G5
J160		48.75		26.55	G5
J161		32.10		16.25	G6
J162		48.75		26.55	G6
J163		32.10		17.55	G6
J164		24.40		12.30	G6
J165		99.95		33.15	G6
J166		41.45		22.10	G5
J167		32.10		30.00	G5
J168		39.00		20.85	G5
J169		33.15		16.35	G5
J180		35.15		18.90	G10
J182		25.50		14.95	G10
J183		47.30		23.80	G10
J186				32.50	G7

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CODE	\$	T	P	P1	Page
J187				32.50	G7
J188				22.90	G7
J189				23.65	G7
J190		42.65		17.10	G7
J193		22.05		14.30	G7
J196		8.00		10.10	G9
J197		6.85		7.80	G9
J198		7.40		9.90	G7
J199		6.85		7.80	G9
J200		20.40		21.40	G9
J201		55.05		24.65	G7
J202		28.50		16.60	G7
J203		24.10		5.50	G9
J204		13.20		5.50	G9
J205		22.05		14.20	G7
J206		22.05		14.20	G8
J207		22.05		14.20	G8
J290				30.60	G10
J301			9.30	7.85	H3
J303		16.20		16.05	H4
J304			18.55	10.75	H3
J305		51.95		48.15	H4
J306		16.20		16.05	H4
J307		17.50		17.85	H4
J308		19.90		14.60	H4
J310		21.40		18.00	H4
J311		16.30		17.55	H4
J313		11.25		4.70	H4
J315		62.45		50.75	H4
J316		90.00		65.40	H4
J318		3.79			H4
J319		11.25			H4
J320		27.55		12.85	H4
J322		5.30		6.45	H5
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J324			2.81	4.20	H3
J327			2.81	6.45	H3
J330		33.35		24.50	H4
J331		27.55		16.05	H4
J332		17.60		10.80	H5
J333		48.25		34.70	H5
J334		30.55		16.05	H5
J335		51.85		30.95	H5
J336		30.55		16.05	H5
J340		2.81		3.43	H4
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J804	16.10			15.90	B3
J806	95.10			41.70	B3
J807	217.55			38.10	B3
J808	80.10			20.90	B3
J809	43.50			23.65	B3
J810	88.25			37.90	B3
J811	95.10			43.25	B3
J812	48.15			20.90	B3
J813	135.15			62.50	B3
J814	48.15			33.00	B3
J815	131.70			38.70	B3
J816	385.90			38.70	B4
J817	28.65			17.50	B4
J818	64.15			38.70	B4
J819	43.50			23.65	B8
J820	234.70			53.10	B4
J821	44.65			11.40	B5
J823	48.15			9.70	B5
J824	57.30			9.95	B5
J825	82.45			9.75	B5
J826	61.90			9.95	B5
J827	118.90			38.70	B5
J829	103.10			38.70	B5
J830	87.00			38.70	B5
J831	114.50			38.70	B5
J832	80.10			38.70	B5
J833	96.25			38.70	B5
J834	96.25			31.30	B6
J835	131.70			55.50	B6
J836	33.25			38.70	B6
J837	40.15			9.95	B6
J838	40.15			9.95	B6
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J843		48.15		11.40	B7
J847		400.95		26.50	B7
J848		102.60		21.25	B7
J849		148.25		27.10	B7
J850		103.70		47.70	B8
J851		84.85		38.70	B8
J852		177.55		51.70	B8
J853		123.70		38.70	B8
J857		120.25		43.95	B9
J858		90.40		38.70	B9
J859		85.90		34.60	B9
J860		171.85		47.70	B9
J861		112.20		52.60	B10
J862		75.60		54.90	B10
J863		99.95		38.70	B11
J864		97.35		41.25	B10
J865		187.95		38.70	B10
J866		43.50		23.65	B3, B10
J867		57.30		22.30	B3
J868		451.30		44.60	B4
J869		555.35		44.45	B4
J870		14.65		10.30	B4
J871		103.10		38.70	B4
J872		240.60		44.45	B4
J873		137.70		14.25	B5
J874		61.90		9.70	B5
J875		253.10		31.00	B5
J876		56.70		38.70	B5
J877		40.15		38.70	B5
J878		143.20		38.70	B5
J879		66.30		38.70	B5
J880		44.85		17.10	B6
J881		113.70		47.70	B7
J882		84.85		38.70	B7
J883		364.30		46.75	B7
J884		320.80		38.70	B7
J885		308.20		43.95	B9
J886		88.55		42.70	B9
J887		107.70		34.60	B9
J889		370.75		97.50	J91
J890		370.75		97.50	J91
J893		68.95		49.90	J91
J894		68.95		49.90	J91
J895		370.75		97.50	J90
J896		370.75		97.50	J88

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J899		185.40			J88
J990		370.75			J88

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K005	62.75				A15
K006	62.75				A17
K007	62.75				A17
K008	62.75				A19
K010	10.00				A17
K012	15.80				A17
K013	62.75				A15
K014	62.75				A15
K015	62.75				A15
K016	74.05				A35, A67
K017	43.60				A6
K018	308.70				A39
K019	31.40				A17
K020	20.90				A17
K021	243.50				A39
K022	62.75				A34
K023	62.75				A34
K024	13.00				A17
K025	11.05				A17
K026	54.70				A39
K027	21.85				A39
K028	62.75				A35
K029	62.75				A35
K030	39.20				A36
K031	102.50				A39
K032	62.75				A40
K033	38.15				A15
K034	36.00				A41
K035	36.25				A40
K036	10.25				A41
K037	62.75				A34
K038	45.15				A41
K039	33.45				A39
K040	62.75				A15
K041	38.80				A15
K044	62.75				A69
K045	75.00				A58, A78, A101
K046	115.00				A59, A78
K050	100.00				AF1
K051	80.00				AF1
K052	20.00				AF1
K053	15.00				AF1
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K056	20.00				AF1
K057	35.00				AF1
K058	125.00				AF1
K059	100.00				AF1
K060	25.00				AF1
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K066	48.90				AF1
K070	31.75				A40
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K077	35.45				A72
K090	100.00				A37
K091	25.00				A38
K101	42.10				GP21
K102	20.20				GP21
K111	126.40				GP21
K112	25.05				GP21
K119	100.00				A101
K121	31.35				A24
K122	80.30				A102
K123	91.10				A102
K124	31.35				A27
K130	77.20				A6
K131	50.00				A6
K132	77.20				A6
K140	31.40				A16
K141	20.90				A16
K142	15.80				A16
K143	13.00				A16
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K189	200.00				A114
K190	84.15				A116
K191	105.10				A116
K192	80.30				A116
K193	95.45				A116
K194	14.60				A116
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K200	21.00				A116
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K207	12.85				A116
K208	40.15				A116
K209	26.75				A116
K210	42.10				A116
K211	28.05				A116
K222	74.70				A69
K223	37.65				A69
K224	37.65				A69
K267	41.60				A101
K269	77.20				A101
K313	8.10				A109
K399	29.05				A41
K480	31.35				A124
K481	75.00				A123
K620	85.00				A115
K623	104.80				A17, A115
K624	129.05				A17, A115
K629	38.25				A17, A115
K630	105.10				A112
K680	62.75				A43
K682	45.00				A43
K683	38.00				A43
K684	6.00				A43
K700	31.35				A24
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K732	31.35				A31
K733	40.45				A31
K734	31.35				A29
K735	40.45				A29
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K737	40.45				A31

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K888	84.70				A18
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K960	36.40				GP48
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K963	36.40				GP48
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K990	20.00				GP48
K991	20.00				GP48
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L802	44.45				J50
L803	73.95				J50
L804	14.30				J49
L805	79.00				J49
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L807	4.95				J50
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L810	22.05				J49
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L812	4.60				J49
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L816	97.95				J50
L817	6.05				J50
L819	13.60				J49
L820	6.05				J49
L822	77.20				J49
L823	38.25				J49
L824	24.70				J49
L825	12.80				J49
L826	11.85				J50
L827	5.30				J50
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L830	11.85				J50
L831	49.35				J50
L832	23.70				J50
L833	140.75				J49
L834	11.85				J50
L835	11.85				J50
L836	24.70				J50
L837	15.60				J50
L838	19.80				J50
L841	11.85				J50
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L847	65.15				J50
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M015	306.85				P2
M016	358.70				P2
M017	39.60				P2
M018	306.85				P2
M020	360.45				P2
M021	123.70				P2
M023	360.45				P3
M027	297.25				P2
M028	73.80				P2
M030	1082.30				P2
M031	254.15				P2
M032	432.45				P2
M033	254.15				P2
M054	123.70				P4
M055	247.35				P3
M056	971.75				P3
M058	460.20				P3
M059	460.20				P3
M061	355.65				P3
M063	716.25				P3
M064	612.65				P3
M067	345.15				P3
M080	182.10				P5
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M083	350.00				P4
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M085	395.05				P5
M086	822.45				P4
M089	234.60				P5
M090	642.45				P5
M099	918.60				P7
M100	654.30				P7
M101	868.15				P7
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M142	1400.00				P10
M143	1285.00				P10
M144	1285.00				P10
M145	818.45				P10
M149	525.00				P10
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N103	1562.90				X1
N104	1100.00				X2
N105	2140.15				X1
N106	1622.50				X1
N107	1456.95				X2
N108	1229.55				X2
N109	1878.35				X3
N110	2184.20				X3
N111	1879.00				X6
N112	1360.00				X6
N113	774.90				X3
N114	1742.45				X6
N115	578.85				X3
N116	2243.45				X6
N117	1416.50				X3
N118	952.05				X2
N119	901.25				X3
N120	481.90				X2
N121	1711.40				X1
N122	2140.15				X2
N123	538.40				X3
N124	1551.20				X3
N125	2140.15				X2
N126	1442.95				X3
N127	518.85				X3
N128	798.80				X3
N129	1110.00				X3
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N139	634.90				X4
N140	773.15				X4
N143	559.60				X4
N144	863.25				X4
N148	1040.65				X4
N149	968.50				X4
N150	1065.45				X4
N151	1726.80				X1
N152	1575.80				X1
N153	2345.00				X1
N154	2140.15				X1
N155	1532.10				X1
N156	1229.55				X1
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N158	968.50				X2
N159	1065.05				X2
N160	426.95				X2
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N163	614.70				X5
N164	696.35				X5
N165	430.75				X5
N166	345.35				X5
N167	952.55				X5
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N169	461.10				X5
N174	420.30				X5
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N190	215.35				N14, X8
N200	638.05				X4
N201	855.80				X5
N202	540.95				X5
N203	408.30				X5
N206	430.75				X5
N207	563.50				X5
N208	918.15				X5
N211	1116.60				X5
N212	1045.45				X5
N213	1116.60				X5
N218	1178.35				X1
N223	798.80				X4
N230	737.00				X5
N245	420.70				X5
N246	289.70				X5
N249	777.80				X5
N258	504.95				X4
N259	481.90				X4
N265	348.30				X4
N266	727.80				X4
N267	1232.35				X4
N269	292.25				X4
N282	1000.00				X8
N283	389.05				X8
N284	408.00				P8
N285	256.15				N7, N32, N39, X8
N286	317.85				X8
N287	500.00				X8
N288	927.55				X8
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N502	1530.00				Z2
N503	1836.00				Z2
N504	1122.00				Z2
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N506	1224.00				Z2
N507	1734.00				Z2
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N511	800.70				Z5
N512	1004.70				Z5
N513	867.00				Z6
N514	408.00				Z7
N515	1020.00				Z7
N516	510.00				Z4
N517	1224.00				Z4
N518	765.00				Z4
N519	612.00				Z7
N520	1514.70				Z5
N521	357.00				Z5
N522	535.50				Z5
N523	1530.00				Z13
N524	1208.70				Z5
N525	1734.00				Z3
N526	2040.00				Z3
N527	469.20				Z13
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N529	1020.00				Z13
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N531	306.00				Z13
N532	1224.00				Z7
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N535	510.00				Z15
N536	765.00				Z15
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N538	632.40				Z15
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N541	255.00				Z11
N542	357.00				Z14
N543	586.50				Z14
N544	433.50				Z14
N545	295.80				Z14
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N551	229.50				Z12
N552	382.50				Z12
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N554	484.50				Z9
N555	510.00				Z13
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N557	1224.00				Z14
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N559	1122.00				Z4
N560	1530.00				Z9
N561	1765.75				Z9
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N563	510.00				Z13
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N567	1020.00				Z15
N568	306.00				Z11
N569	1442.95				Z2
N570	569.15				Z8
N571	255.00				Z5
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N573	1020.00				Z8
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N575	765.00				Z5
N576	255.00				Z5
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P007	55.15				K7
P008	33.70				K7
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R711	741.55				Q5
R712	525.75				Q5
R713	635.45				Q5
R714	525.75				Q5
R715	755.80				Q6
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R729	717.25				Q8
R730	798.80				Q8
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S403	356.70				T2
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S412	467.00				T2
S413	467.00				T2
S415	522.50				T2
S416	875.00				T2
S420	673.10				T2
S422	679.25				T2
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S467	437.20				T5
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S478	215.80				T8
S481	260.65				T8
S482	381.60				T8
S483	552.30				T8
S484	657.75				T9
S485	984.65				T9
S488	215.80				T9
S490	733.50				T8
S491	657.75				T9
S512	330.90				T9
S513	657.75				T9
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S541	260.85				T10
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S556	552.30				T11
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S561	657.75				T4
S562	482.40				T4
S564	325.95				T11
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S571	383.50				U1
S572	662.45				U1
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S574	170.65				U1
S575	437.20				U1
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S595	170.65				U2
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S602	170.65				U3
S611	205.35				U3
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S647	600.75				U7
S650	600.75				U7
S651	1008.35				U7
S652	431.20				U7
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S654	411.20				U7
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S704	431.45				V2
S706	112.00				V2
S707	92.30				V2
S708					V2
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S710	680.65				V8
S712	115.00				V3
S714	431.45				V10
S715	123.70				V3
S716	164.00				V4
S717	303.40				V4
S718	349.00				V4
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S720	349.00				V4
S721	349.00				V4
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S723	272.40				V4
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S725	257.05				V4
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S727	884.85				V10
S728	429.10				V5
S729	560.95				V4
S730	330.50				V5
S731	557.95				V5
S732	429.65				V5
S733	429.65				V5
S735	306.85				V9
S736	359.55				V9
S738	306.85				V9

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S741	155.70				V9
S742	349.00				V3
S743	616.60				V9
S744	173.15				V6
S745	306.85				V10
S747	306.85				V10
S748	686.70				V5
S749	528.75				V5
S750	797.45				V10
S751	528.75				V5
S752	112.40				V7
S754	92.30				V7
S756	112.40				V7
S757	463.00				V8
S758	616.60				V8
S759	523.55				V8
S760	349.00				V4
S761	431.45				V4
S762	801.10				V8
S763	893.55				V8
S764	383.90				V7
S765	173.55				V6
S766	321.90				V6
S767	321.90				V6
S768	93.00				V7
S770	245.40				V7
S772	218.65				V7
S774	142.50				V7
S775	431.45				V8
S776	431.20				V8
S777	349.00				V8
S778	349.00				V8
S779	349.00				V8
S780	257.05				V10
S781	431.20				V8
S782	410.40				V10
S783	257.05				V7
S784	306.85				V9
S785	189.85				V7
S786	82.25				W1
S787	213.15				W1
S788	777.30				W1
S789	618.25				W1
S790	525.15				W1
S792	685.00				W2

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S795	605.45				W2
S796	687.60				W2
S797	615.10				W2
S798	646.30				W2
S799	1032.70				W2
S800	871.80				W2
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S812	453.70				V4
S813	453.70				V4
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S816	463.00				V8
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U023	29.00				A53
U025	44.45				A53
U026	21.90				A53
U231	15.00				A92
U233	43.30				A92
U235	45.85				A92
U236	28.95				A92
U960	36.40				GP48
U961	36.40				GP48
U962	36.40				GP48
U963	36.40				GP48
U964	36.40				GP48
U990	20.00				GP48
U991	20.00				GP48
U992	40.00				GP48
U993	40.00				GP48
U994	60.00				GP48
U995	60.00				GP48
U996	100.00				GP48
U997	100.00				GP48
U998	75.00				GP48
U999	75.00				GP48
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W008	21.20				A14
W010	108.85				A14, A74
W021	21.20				A55
W022	32.20				A55
W023	32.20				A55
W025	147.30				A55
W026	44.45				A55
W028	21.20				A55
W031	21.20				A65
W032	32.20				A65
W033	32.20				A65
W035	90.30				A65
W036	60.00				A65
W038	21.20				A65
W045	107.00				A89
W046	51.45				A89
W050	144.75				A52
W051	21.20				A52
W052	32.20				A52
W053	32.20				A52
W054	20.60				A52
W055	125.60				A52
W056	84.20				A52
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W061	21.20				A98
W062	32.20				A98
W063	32.20				A98
W065	83.10				A98
W066	51.70				A98
W068	21.20				A98
W071	21.20				A74
W072	32.20				A74
W073	32.20				A74
W074	20.60				A74
W075	185.00				A74
W076	105.25				A74
W078	21.20				A74
W085	81.10				A110
W086	47.95				A110
W095	90.30				A49
W096	60.00				A49
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W104	20.60				A14

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W109	70.50				A14
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W130	300.70				A80
W131	21.20				A80
W132	32.20				A80
W133	32.20				A80
W134	20.60				A80
W138	21.20				A80
W150	300.70				A61
W151	21.20				A61
W152	32.20				A61
W153	32.20				A61
W154	20.60				A61
W155	157.00				A61
W156	105.25				A61
W158	21.20				A61
W160	300.70				A85
W161	21.20				A85
W162	32.20				A85
W163	32.20				A85
W164	20.60				A85
W165	157.00				A85
W166	105.25				A85
W168	21.20				A85
W171	21.20				A128
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W173	32.20				A128
W175	90.30				A128
W176	60.00				A128
W178	21.20				A128
W180	300.70				A88
W181	21.20				A88
W182	32.20				A88
W183	32.20				A88
W184	20.60				A88
W185	176.35				A88
W186	84.95				A88
W188	21.20				A88
W190	300.70				A113
W196	105.25				A113
W220	300.70				A70
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W224	32.20				A70
W225	165.00				A70
W226	105.25				A70
W228	21.20				A70
W231	120.00				A96
W232	69.35				A80
W234	20.60				A80
W235	157.00				A80
W236	105.25				A80
W237	30.70				A80
W239	65.05				A80
W252	69.35				A61
W254	20.60				A61
W255	105.25				A61
W257	30.70				A61
W259	65.05				A61
W260	300.70				A104
W261	21.20				A104
W262	32.20				A104
W265	167.00				A104
W266	82.90				A104
W269	30.70				A104
W272	69.35				A74
W274	20.60				A74
W275	105.25				A77
W277	30.70				A74
W279	65.05				A74
W292	69.35				A77
W294	20.60				A77
W297	30.70				A77
W299	65.05				A77
W305	101.70				A91
W306	54.10				A91
W310	91.35				A108
W311	21.20				A108
W312	32.20				A108
W313	32.20				A108
W314	20.60				A108
W318	21.20				A108
W325	105.25				A70
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W402	69.35				A52
W404	20.60				A52
W405	84.20				A52
W407	30.70				A52
W409	65.05				A52
W419	65.05				A108
W425	300.70				A108
W435	105.25				A80
W441	21.20				A83
W442	32.20				A83
W443	32.20				A83
W444	20.60				A83
W445	157.00				A83
W446	105.25				A83
W448	21.20				A83
W460	300.70				A77
W461	21.20				A77
W462	32.20				A77
W463	32.20				A77
W464	20.60				A77
W465	157.00				A77
W466	105.25				A77
W468	21.20				A77
W510	89.85				A108
W511	89.85				A108
W512	69.35				A108
W514	20.60				A108
W515	182.85				A108
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W517	30.70				A108
W535	82.30				A96
W536	45.85				A96
W562	69.35				A104
W564	20.60				A104
W565	91.35				A104
W567	30.70				A104
W645	90.30				A66
W646	60.00				A66
W662	395.65				A104
W667	395.65				A104
W695	395.65				A113
W760	89.85				A61
W765	167.00				A61, A77, A80, A83, A85
W770	395.65				A74

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W777	33.70				A14
W795	300.70				A113
W842	69.35				A83
W844	20.60				A83
W845	105.25				A83
W847	30.70				A83
W849	65.05				A83
W862	69.35				A85
W864	20.60				A85
W865	105.25				A85
W867	30.70				A85
W869	65.05				A85
W872	32.20				A14
W882	32.20				A14
W895	232.70				A113
W903	65.05				A14
W904	33.70				A14
W911	144.75				A14
W912	217.15				A14
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W961	36.40				GP49
W962	36.40				GP49
W963	36.40				GP49
W964	36.40				GP49
W972	32.20				A52, A55, A61, A65, A70, A74, A77, A80, A83, A85, A88, A98, A108, A128
W982	32.20				A52, A55, A61, A65, A70, A74, A77, A80, A83, A85, A88, A98, A104, A108, A128
W990	20.00				GP49
W991	20.00				GP49
W992	40.00				GP49
W993	40.00				GP49
W994	60.00				GP49
W995	60.00				GP49
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W997	100.00				GP49
W998	75.00				GP49
W999	75.00				GP49

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X004		21.70		10.30	D4
X005		14.90		6.40	D4
X006		21.70		10.35	D4
X007		21.70		10.35	D4
X008		21.70		10.35	D4
X009		37.25		16.40	D4
X010		28.65		14.25	D4
X011		21.70		10.35	D4
X012		29.90		13.25	D4
X016		14.85		9.05	D4
X017		15.30		20.40	D4
X018		16.85		9.05	D4
X019		13.75		7.95	D4
X020		13.75		7.95	D4
X025		25.90		7.95	D5
X027		23.65		7.95	D5
X028		25.90		7.95	D5
X031		29.70		13.35	D5
X032		53.55		20.75	D5
X033		21.70		10.15	D5
X034		23.95		6.40	D5
X035		21.70		10.35	D5
X036		14.90		6.40	D5
X037		27.75		9.20	D5
X038		31.90		10.35	D5
X039		17.95		7.85	D9
X040		17.95		7.85	D9
X045		14.90		6.40	D6
X046		21.70		10.35	D6
X047		17.95		7.95	D6
X048		17.95		7.95	D6
X049		17.95		7.95	D6
X050		14.90		6.40	D6
X051		14.90		6.40	D6
X052		14.90		6.40	D6
X053		14.90		6.40	D6
X054		14.90		6.40	D6
X055		21.70		13.05	D6
X056		11.50		4.70	D6
X057		14.90		6.40	D8
X058		21.70		10.65	D8
X060		23.75		7.65	D7
X063		14.90		6.40	D7
X064		21.70		10.35	D7
X065		14.90		6.40	D7

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X067		14.90		6.40	D7
X068		14.90		6.40	D7
X069		14.90		6.40	D7
X072		11.50		4.70	D7
X080		7.45		3.30	D8
X081		7.45		3.30	D8
X090		14.90		6.40	D9
X091		21.90		10.75	D9
X092		28.15		12.45	D9
X096		14.90		6.40	D9
X100		14.90		6.40	D9
X101		22.80		9.20	D9
X103		60.95		58.40	D10
X104		48.50		46.40	D10
X105		29.50		36.90	D10
X106		29.50		36.90	D10
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X108		46.30		38.15	D10
X109		59.10		49.80	D10
X110		39.35		32.95	D10
X111		26.40		21.80	D10
X112		48.40		29.40	D10
X113		61.30		49.80	D10
X114		29.95		11.60	D10
X116		21.70		9.90	D10
X117		21.70		11.10	D10
X120		39.80		11.60	D10
X121				83.15	D14
X122		29.50		23.15	D14
X123		21.70		9.00	D10
X124				108.30	D17
X125				86.60	D17
X126				108.30	D19
X127				75.85	D20
X128				108.30	D20
X129		21.70		9.00	D11
X130		49.65		22.75	D11
X131		5.75		4.75	D11
X132		48.90		34.00	D14
X133		79.90		51.05	D14
X134		17.95		6.80	D11
X135		27.50		13.80	D11
X136		17.95		6.80	D11
X137		23.85		8.40	D11
X138		21.70		9.00	D11
X139		21.70		11.10	D11

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X142		42.85		40.15	D15
X145		42.85		40.15	D15
X146		55.20		48.00	D15
X147		29.80		11.35	D12
X148		55.20		48.00	D15
X149		42.85		40.15	D15
X150		25.45		15.85	D21
X151		48.40		34.85	D21
X152		42.85		40.15	D15
X153		55.20		48.00	D15
X154		15.95		4.70	D21
X155		55.20		48.00	D15
X156		26.25		27.50	D14
X158		28.95		23.00	D14
X159		38.40		34.60	D14
X160		48.90		34.00	D14
X161		78.60		69.65	D14
X162		59.20		23.10	D14
X163		29.60		11.60	D21
X164		28.95		23.00	D21
X165				11.35	D21
X166					D21
X167		21.50		11.45	D21
X168				42.50	D20
X169		39.90		11.35	D21
X170		28.95		23.00	D21
X171		49.00		23.05	D21
X172		28.05		16.90	D21
X173		34.95		27.30	D21
X174		29.80		15.50	D14
X175		39.35		30.90	D14
X176		29.80		11.35	D21
X177		15.60		9.20	D21
X178		37.15		27.00	D21
X179		29.60		15.85	D14
X180		38.95		31.35	D14
X181		59.65		30.90	D14
X182		79.30		37.45	D14
X183		48.40		34.70	D21
X184		28.05		16.90	D21
X185		37.15		27.00	D21
X188				75.85	D17
X189		7.30		23.75	D13
X190		17.75		6.90	D21
X191		21.70		9.00	D11

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X193		14.50		11.60	D21
X194		5.95		5.20	D21
X195		9.25		14.20	D13
X196		9.25		14.20	D13
X197		9.25		14.20	D13
X198		59.10		22.60	D14
X199		59.10		22.60	D14
X200		36.70		45.55	D14
X201		5.95		5.20	D21
X202		33.40		10.75	D5
X203		40.35		13.25	D5
X204		29.90		10.65	D5
X205		33.40		10.75	D5
X206		40.35		13.35	D5
X207		31.05		10.65	D5
X208		28.95		13.05	D5
X209		22.90		8.90	D6
X210		29.60		13.05	D6
X211		25.60		10.90	D6
X212		25.60		10.65	D6
X213		25.80		10.65	D6
X214		22.75		9.30	D6
X215		22.90		9.05	D6
X216		30.85		11.65	D6
X217		22.90		9.05	D6
X218		22.90		9.05	D6
X219		22.90		9.05	D6
X220		27.65		15.70	D6
X221		14.90		6.40	D6
X223		22.20		9.05	D7
X224		22.90		9.05	D7
X225		30.85		11.65	D7
X226		22.90		9.05	D7
X227		22.90		9.05	D7
X228		22.90		9.05	D7
X229		22.90		9.05	D7
X230		14.90		9.05	D7
X231				86.60	D19
X232				97.50	D19
X233				108.30	D19
X234				235.30	D19
X235				147.50	D18
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X305	170.85				C4
X306	85.50				C4

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X312	680.45				C3
X313	811.15				C4
X322	71.30				C5
X323	223.65				C5
X324	223.65				C5
X325	69.80				C5
X326	85.30				C6
X327	77.80				C6
X328	45.35				C6
X329	70.55				C6
X330	54.00				C6
X332	36.45				C6
X334	111.90				C5
X335	75.90				C6
X336	75.90				C6
X400				43.25	D17
X401				64.95	D17
X402				64.95	D17
X403				86.60	D17
X404				97.50	D17
X405				75.85	D17
X406				64.95	D17
X407				75.85	D17
X408				86.60	D17
X409				86.60	D19
X410				97.50	D19
X412				43.25	D20
X413				64.95	D20
X415				86.60	D20
X416				97.50	D20
X417				32.70	D20
X421				73.35	F2
X425				36.70	F2
X431				73.35	F2
X435				36.70	F2
X441				73.35	F2
X445				36.70	F2
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X451				73.35	F2
X455				36.70	F2
X461				73.35	F3
X465				36.70	F3
X471				62.80	F3
X475				31.45	F3

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X488				108.80	F3
X489				54.35	F3
X490				59.50	F3
X492				29.85	F3
X493				68.45	F3
X495				34.15	F3
X496				101.65	F3
X498				50.65	F3
X499				32.70	F3

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Z081	30.00				M7
Z082	45.00				M7
Z083	60.00				M7
Z084	60.00				M7
Z085	90.00				M7
Z094	75.45				M17
Z095	37.70				M17
Z096	80.00				M3
Z097	160.00				M3
Z100					M1
Z101	25.75				M1
Z102	44.35				M1
Z103	44.35				M1
Z104	20.10				M1
Z105	66.00				M1
Z106	44.35				M1
Z107	108.00				M1
Z108	72.00				M1
Z110	17.45				M16
Z111	15.35				S1
Z112	50.90				S1
Z113	29.60				M1
Z114	25.25				M1
Z115	88.80				M1
Z116	29.60				M1
Z117	11.65				M5
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Z124	78.00				M3
Z125	32.00				M3
Z126	45.00				M3
Z127	60.00				M3
Z128	33.10				M16
Z129	35.70				M16
Z130	62.75				M16
Z131	82.65				M16
Z132	304.10				M17
Z135	195.95				M19
Z137	23.05				M17
Z138	195.85				M17
Z139	37.20				M18
Z140	33.00				M18
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Z149	50.00				M3
Z150	65.55				M3
Z151	98.55				M3
Z152					M3
Z154	35.90				M10
Z155					M1
Z156	20.00				M2
Z157	26.50				M2
Z158	44.25				M2
Z159	10.55				M2
Z160	15.85				M2
Z161	26.20				M2
Z162	20.00				M2
Z163	26.50				M2
Z164	44.25				M2
Z165					M2
Z172	66.60				M1
Z173	30.35				M1
Z174	40.80				M1
Z175	35.90				M10
Z176	20.00				M10
Z177	71.30				M10
Z179	50.40				M10
Z180	106.25				M8
Z181	53.10				M8
Z182	255.05				M19
Z187	92.30				M10
Z188	92.30				M10
Z189	92.30				M11
Z190	101.45				M10
Z191	77.30				M10
Z192	154.95				M10
Z196	377.65				M13
Z197	49.20				N36
Z198	10.25				N5
Z199	14.90				N5
Z200	14.90				N5
Z201	10.25				N5
Z202	14.90				N5
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Z204	10.25				N5
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Z212	89.70				N32
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Z216	10.25				N5
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Z220	89.70				N19
Z221	49.20				N7
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Z225	72.35				N14
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Z229	49.20				N47
Z230	89.70				N7
Z231	73.70				N11
Z232	49.20				N33
Z233	97.35				N33
Z234	281.25				N22
Z235	19.45				N45
Z237	49.20				N40
Z238	72.35				N40
Z239	133.00				N25
Z240	204.80				N25
Z242	193.00				N22, N35, N39, N41, N44
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Z247	49.20				N11
Z248	72.35				N11
Z249	99.15				N11
Z250	193.00				N3
Z251	49.20				N14, N41
Z252	39.00				N32
Z253	394.80				N25
Z254	507.45				N25
Z255	394.80				N25
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Z261	450.50				N25
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Z264	154.00				N27
Z265	230.65				N27
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Z280	72.35				N3
Z281	145.70				N3
Z290	63.95				N32
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Z301	55.60				P1
Z302	55.60				P1
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Z306	55.60				P1
Z308	55.60				P1
Z309	18.30				P1
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Z317	112.05				P1
Z318	133.30				P4
Z319	43.15				P3
Z320	25.85				P5
Z321	61.30				P5
Z322	106.45				P5
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Z330	490.00				P8
Z331	32.45				P9
Z332	59.15				P9
Z333	317.20				P8
Z334	304.60				P9
Z335	228.40				P9
Z336	59.15				P9
Z337	133.10				P9
Z338	202.80				P10
Z339	182.90				P9
Z340	137.85				P9
Z341	69.80				P9
Z342	112.55				P6
Z343	202.35				P5
Z344	45.95				P7
Z345	18.60				P7
Z346	22.35				P7
Z347	300.00				P8
Z348	605.85				P8
Z349	23.25				P9
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Z360	474.65				P6
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Z362	200.00				P9
Z399	92.50				S6
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Z401	131.70				Q5
Z402	117.30				Q9
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Z404	100.45				R1
Z405	186.90				R2
Z406	247.75				R2
Z407	108.05				R2
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Z411	62.95				R2
Z412	110.75				Q4
Z413	31.25				R2
Z414	23.10				Q5
Z415	339.45				Q4
Z422	210.55				J11
Z423	690.25				J10
Z424	297.15				J11
Z425	506.75				R1
Z426	62.55				R1
Z427	330.45				R2
Z428	598.50				Q4
Z429	299.25				Q3
Z430					J6
Z431	64.25				J11
Z432	54.10				J6
Z433	146.45				Q3
Z434	471.60				J9
Z435	154.10				Q3
Z436	166.55				Q3
Z437	92.45				J8
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Z440	210.55				J8
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Z445	323.75				Q3
Z446	168.00				J7
Z447	74.05				J7
Z448	487.90				J9
Z449	415.15				J9
Z450	102.55				J30
Z451	152.40				J30
Z452	93.60				J30
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Z456	168.00				J7
Z457	48.90				J7
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Z460	377.55				J9
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Z492	51.95				S13
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Z500	30.65				S3
Z501	35.50				S1
Z502	71.00				S1
Z503	35.40				S4
Z504	61.15				S4
Z505	37.20				S7
Z506	50.90				S1
Z510	91.10				S1
Z511	43.15				S3
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Z515	68.25				S6
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Z522	51.25				S3
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Z524	271.05				S1
Z525	110.85				S8
Z526	73.60				S9
Z527	82.90				S9
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Z535	36.80				S20
Z536	44.55				S20
Z537	97.05				S1
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Z544	34.90				S21
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Z546	34.60				S22
Z547	99.75				S9
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Z555	51.95				S14
Z558	300.25				S24
Z560	92.10				S13
Z561	213.15				S24
Z562	116.20				S24
Z563	48.00				S28
Z564	73.60				S28
Z565	99.60				S22
Z566	39.10				S22
Z569	122.05				S29
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Z575	27.05				S22
Z576	35.90				S22
Z577	122.05				S26
Z578	93.00				R2
Z580	57.70				S13
Z582	105.40				V7
Z583	131.40				V7
Z584	185.15				S13
Z585	131.40				V7
Z586	349.00				V7
Z587	200.00				V7
Z590	31.30				S28
Z591	57.65				S28
Z592	49.40				S20
Z593	55.25				S24
Z594	288.30				S29
Z595	54.05				S29
Z596	314.20				S25
Z597	90.10				E4
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Z603	16.25				T8
Z604	31.60				T10
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Z606	71.00				T7
Z607	35.50				T7
Z608	58.65				T8
Z609	31.60				T10
Z610	25.65				T8
Z611	8.55				T8
Z612	250.00				T11
Z615	59.75				T11
Z616	23.55				T10
Z617	35.50				T10
Z618	77.70				T10
Z619	52.70				T11
Z620	41.65				T11
Z621	13.65				T11
Z622	5.65				T11
Z623	95.10				T3
Z624	105.25				T3
Z625	52.70				T3
Z626	95.95				T3
Z627	167.85				T3
Z628	125.65				T3
Z629	153.35				T3
Z630	314.20				T2
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Z701	32.60				U1
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Z703	55.15				U2
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Z705	83.35				U2
Z706	120.80				U2
Z707	55.15				U3
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Z722	26.85				V3
Z723	92.30				V3
Z724	8.55				V6
Z725	50.90				V6
Z726	38.00				W1
Z727	71.30				W1
Z728	92.30				V3
Z729	38.35				V6
Z730	25.50				V6
Z731	50.90				V6
Z732	17.30				V6
Z733	11.05				V2
Z734	58.00				K9
Z735	50.90				V5
Z736	26.85				V2
Z737	215.80				V9
Z738	216.10				P7
Z740	75.00				M18
Z741	273.15				P7
Z742	106.45				P8
Z743	307.80				Q2
Z744	123.05				Q3
Z745	53.20				Q14
Z746	74.25				Q14
Z747	74.25				Q14
Z748	148.60				Q14
Z749	72.55				S13
Z750	82.35				S17
Z751	127.95				Q3
Z752	82.35				S20
Z753	24.25				S20
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Z758	97.65				S22
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Z769	115.10				V2
Z770	34.05				V7
Z771	38.00				W1
Z772	81.45				W2
Z773	165.40				K9
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Z781	39.00				Q3
Z782	82.55				Q3
Z783	97.35				N3, N14, N41
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Z787	50.90				V6
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Z801	51.50				X5
Z802	81.65				X3
Z803	53.10				X4
Z804	67.60				J65
Z805	75.10				J65
Z807	266.60				X4
Z808	317.85				X4
Z809	370.50				X5
Z811	54.10				X1
Z812	279.55				X3
Z813	453.60				X3
Z815	200.00				X4
Z816	241.00				X8
Z818	215.35				X3
Z819	215.35				X3
Z820	317.85				X3
Z821	53.10				X5
Z823	307.40				X3, X8
Z824	266.60				X3
Z825	408.95				X3
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Z852	74.20				Y2
Z853	74.20				Y2
Z854	60.00				Y8
Z855	225.00				Y8
Z856	150.00				Y8
Z857	26.60				Y8
Z858	65.70				Y8
Z860	26.60				Y8
Z861	26.60				Y10
Z862	52.40				Y11
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Z906	66.50				Y12
Z907	27.40				Y14
Z908	50.90				Y14
Z909	25.85				Y12
Z912	42.15				Y14
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