

Schedule of Benefits

Physician Services Under the Health Insurance Act

(February 14, 2025 (effective March 3, 2025))

Ministry of Health

[Commentary:

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

GENERAL PREAMBLE

INTRODUCTION

[Commentary:

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

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

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

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

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

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

GENERAL PREAMBLE

DEFINITIONS

GENERAL DEFINITIONS

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

A. Age Definitions

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

B. Time Definitions

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

C. Other Definitions

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

GENERAL PREAMBLE

DEFINITIONS

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>

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.]

GENERAL PREAMBLE

DEFINITIONS

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

[Commentary:

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

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

[Commentary:

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

GENERAL PREAMBLE

DEFINITIONS

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

patient's representative the legal representative of a patient

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

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

[Commentary:

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

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

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

Schedule Schedule of Benefits for Physician Services

specialist a physician who holds one of the following:

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

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

GENERAL PREAMBLE

DEFINITIONS

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

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

[Commentary:

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

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

[Commentary:

A *transferal* occurs, for example, where the first physician is leaving temporarily on *holidays* 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 *MOH* and the *OMA*, additions, deletions, fee changes, or other modifications to the Schedule, are made by the *MOH* following consultation and/or negotiation with the *OMA*. Physicians who wish to have modifications to the Schedule considered should submit any proposals to the Physician Payment Committee (PPC) through the appropriate clinical section of the *OMA*.

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

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

[Commentary: Medical Research]

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

[Commentary: Medical Records]

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

- 1.an insured service was provided;
- 2.the service for which the account is submitted is the service that was rendered; and
- 3.the service was medically necessary.

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

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

[Commentary:

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

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

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

GENERAL PREAMBLE

GENERAL INFORMATION

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

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

[Commentary:

Any additional assessment is *not eligible for payment.*]

Use of Codes, Prefixes and Suffixes

[Commentary:

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

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

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

suffix A if the physician performs the procedure;

suffix B if the physician assisted at the surgery; and

suffix C if the physician administered the anaesthetic.

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

Diagnostic Services Rendered at a Hospital

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

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

[Commentary:

1. For those diagnostic services which have both technical and *professional 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*.

Payment for Diagnostic and Therapeutic Services Rendered at a Hospital

The *technical component* of a diagnostic and therapeutic service listed below and rendered in a hospital is payable at 94.68% of the listed fee in the column headed "T".

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

Technical Component Requirements

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

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

[Commentary:

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

GENERAL PREAMBLE

GENERAL INFORMATION

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

Consultation and Assessment Codes

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

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

[Commentary:

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

Independent Consideration (IC)

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

GENERAL PREAMBLE

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

[Commentary:

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

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

Most services include as a constituent element of the service the provision of the premises, equipment, supplies, and personnel used in the performance of the common and *specific elements* of the service. This is not, however, the case for services denoted by codes marked with the prefix “#”, and for services that are divided into *professional and technical 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 Integrated Community Health Services Centre (*ICHSC*), the premises, equipment, supplies, and personnel are funded under the facility costs set out in the *Integrated Community Health Services Centres Act, 2023*.

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

COMMON ELEMENTS OF INSURED SERVICES

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

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

- A. Being available to provide follow-up insured services to the patient and arranging for coverage when not available.
- B. Making arrangements for appointment(s) for the insured service.
- C. Travelling to and from the place(s) where any element(s) of the service is (are) performed.

[Commentary:

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

GENERAL PREAMBLE

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

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

Appropriate sources include but are not limited to:

1. patient and *patient's representative*
2. patient charts and records
3. investigational data
4. physicians, pharmacists, and other health professionals
5. suppliers and manufacturers of drugs and devices
6. relevant literature and research data.

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

F. Keeping and maintaining appropriate medical records.

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

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

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

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

K. Except for services denoted by codes marked with the prefix "#", or for services that are divided into *professional and technical 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:

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

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

[Commentary:

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

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

The following are additional requirements for a consultation:

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

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

GENERAL PREAMBLE

CONSULTATIONS

[Commentary:

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

Payment rules:

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

See the Table below.

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

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

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

GENERAL PREAMBLE

CONSULTATIONS

- a. consultations are in excess of the above limits;
- b. the payment requirements of a repeat consultation are not met; or
- c. the consultation is requested by a Medical Trainee.

Note:

1. The above limits are applicable to all consultations, including time-based and age-specific consultation services (e.g. special, extended and comprehensive consultations) but not repeat consultations.
2. In the preoperative preparation of a patient undergoing the following low risk elective surgical procedures under local anaesthesia and/or I.V. sedation, a preoperative consultation by any physician is *only eligible for payment* where the medical record demonstrates the consultation is medically necessary.
 - a. cataract surgery;
 - b. colonoscopy;
 - c. cystoscopy;
 - d. carpal tunnel surgery; or
 - e. arthroscopic surgery.

[Commentary:

Such medically necessary consultations would be very uncommon.]

GENERAL PREAMBLE

CONSULTATIONS

REPEAT CONSULTATION

Definition/Required elements of service:

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

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

LIMITED CONSULTATION

Definition/Required elements of service:

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

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

EMERGENCY 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.]

GENERAL PREAMBLE

CONSULTATIONS

Claims submission instruction:

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

GENERAL PREAMBLE

ASSESSMENTS

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

GENERAL ASSESSMENT

Definition/Required elements of service:

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

Payment rules:

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

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

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

PERIODIC HEALTH VISIT

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

Payment rules:

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

[Commentary:

Periodic health visits in excess of the limit are not insured.]

Claims submission instruction:

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

No diagnostic code is required unless otherwise specifically listed.

GENERAL PREAMBLE

ASSESSMENTS

Family Practice & Practice in General

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

Paediatrics

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

GENERAL RE-ASSESSMENT

Definition/Required elements of service:

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

Payment rules:

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

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 GP40, admission assessments are deemed to be a specific re-assessment or medical specific re-assessment under either of the following circumstances:

1. for those procedures prefixed with a "Z" or noted as an *IOP*, by a surgical *specialist* who has assessed the patient prior to admission in respect of the same illness; or
2. for those patients who have been assessed by a physician and subsequently admitted to the hospital for the same illness by the same physician.]

Payment rules:

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

GENERAL PREAMBLE

ASSESSMENTS

COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT

Definition/ Required elements of service:

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

Payment rules:

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

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

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 inpatients 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:

Diagnostic Code	Description
042	AIDS
043	AIDS-related complex
044	Other human immunodeficiency virus infection
250	Diabetes mellitus, including complications
286	Coagulation defects (e.g. haemophilia, other factor deficiencies)
282	Hereditary hemolytic anemia (e.g., thalassemia, sickle-cell anemia)
287	Purpura, thrombocytopenia, other haemorrhagic conditions
290	Senile dementia, presenile dementia
299	<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 A4 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 25.25

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, 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:

GENERAL PREAMBLE

ASSESSMENTS

Service	Minimum time required in delivery of service before detention is payable
minor, partial, multiple systems assessment, level 1 and level 2 paediatric assessment, intermediate assessment, focused practice assessment or subsequent hospital visit	30 minutes
specific or general re-assessment	40 minutes
consultation, repeat consultation, specific or general assessment, complex dermatology assessment, complex endocrine neoplastic disease assessment, complex neuromuscular assessment, complex psychiatry assessment, complex respiratory assessment, enhanced 18 month well baby visit, midwife or aboriginal midwife-requested anaesthesia assessment, midwife or aboriginal midwife-requested assessment, midwife or aboriginal midwife-requested genetic assessment 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 or aboriginal 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 or aboriginal 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 or aboriginal 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.

GENERAL PREAMBLE

ASSESSMENTS

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
------	--	-------

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.

GENERAL PREAMBLE

ASSESSMENTS

Payment rules:

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

[Commentary:

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

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

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.]

GENERAL PREAMBLE

ASSESSMENTS

Medical record requirements:

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

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

Claims submission instructions:

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

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*.

GENERAL PREAMBLE

ASSESSMENTS

Follow-up E-ASSESSMENT

Definition/ Required elements of service:

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

[Commentary:

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

Payment rules:

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

- 1.one (1) service per patient per day, same physician;
- 2.four (4) services per patient same physician per *12 month period*; and
- 3.one thousand (1000) services per physician per *12 month period*.

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).]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency 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 paragraphs 2 and 3, or when a patient is referred from one physician to another (see Claims submission instruction below), subsequent visits are limited to one per patient, per day for the first 5 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. Pediatric subsequent visits (C262) are limited to one per patient, per day for the duration of the admission.
4. When a physician is already in the hospital and assesses one of his/her own patients or patients transferred to his/her care, the service constitutes a subsequent visit. If a physician assesses another physician’s patient on an emergency basis, the General Listings (“A” prefix) apply.

Claims submission instruction:

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

[Commentary:

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

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 GP46.]

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 GP44.]

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%

E084 Saturday, Sunday or *Holiday* subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982Add 45%

Payment rules:

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

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

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

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

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

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

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

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

[Commentary:

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

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

3.E083 or E084 are *not eligible for payment* with C121 additional visits for intercurrent illness.]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

F. Concurrent Care

Definition/Required elements of service:

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

Payment rules:

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

G. Supportive Care

Definition:

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

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

Payment rules:

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

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 inpatients, 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 A12, A13 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), collection of cervical cancer screening specimen(s) (G365, G394, E430, E431), intravenous (G379), and laboratory test codes (G001, G002, G481, G004, G005, G009, G010, G011, G012, G014).
- 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.

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

[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

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:

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

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

2. Except for in-patient individual psychotherapy by a psychiatrist or in-patient individual psychiatric care for which the time can be consecutive or non-consecutive, for all other services in this section the time units must be calculated based upon consecutive time spent rendering the service.
3. Psychotherapy performed outside a hospital, psychiatric care, primary mental health care, or hypnotherapy rendered the same day as a consultation or other assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

[Commentary:

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.

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Payment rules:

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

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

[Commentary:

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

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 GP29 for further information.]

Payment rules:

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

A. Individual Counselling

Definition:

Individual counselling is counselling rendered to a single patient.

B. Group Counselling

Definition:

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

Payment rules:

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

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

- 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.

GENERAL PREAMBLE

DELEGATED PROCEDURE

COMMON PROCEDURAL DESCRIPTION	APPLICABLE FEE CODES	CURRENT PAGE #
Venipuncture	G480, G482, G489	J7
Injections and immunizations	G372, G373, G538, G590, G593, G840, G841, G842, G843, G844, G845, G846, G847, G848	J55
Ultraviolet light therapy	G470	J37
Administration of oral polio vaccine	G462	J55
Simple office laboratory procedures	G001, G002, G004, G005, G009, G010, G011, G012, G014, G481	J68
Ear syringing, curetting or debridement	G420	J98
B.C.G. inoculation	G369	J54
Simple Spirometry and Flow Volume Loop	J301, J324, J304, J327	H4
Casts	Z198-Z209, Z211, Z213, Z216, Z873	N7

[Commentary:

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

GENERAL PREAMBLE

AGE-BASED FEE PREMIUMS

1. Despite any other provision in this Schedule, the amount payable for the following services to an insured person who falls into the age group described in the Age Group column of the following Age Premium Table is increased by the percentage specified in Percentage Increase column opposite the Age Group:
 - a. A consultation, limited consultation or repeat consultation rendered by a *specialist*, as those services are defined in this *Schedule*.
 - b. A surgical procedure listed in Parts K to Z inclusive of this *Schedule*.
 - c. Basic and time unit surgical assistant services listed in Parts K to Z inclusive of this *Schedule*.
 - d. Clinical Procedures associated with Diagnostic Radiological Examinations.
 - e. A specific assessment or a partial assessment rendered by a specialist in ophthalmology (23) (A233 or A234).

age premium table

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

2. Despite any other provision in this *Schedule*, the amount payable for the following services to an insured person who is at least 65 years of age, as those services are defined in this *Schedule*, is increased by 15 per cent:
 - a. A general assessment (A003, C003, C903, W102, W109 or W903);
 - b. A general re-assessment (A004, C004, W004);
 - c. An intermediate assessment (A007);
 - d. A focused practice assessment (A917, A927, A937, A947, A957 or A967);
 - e. A periodic health visit (K132).
 - f. Comprehensive assessment and care (H102, H122, H132, H152)
 - g. A multiple systems assessment (H103, H123, H133, H153)

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 GP75.]

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

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 MOH.

LIMITS FOR EMERGENCY DEPARTMENT PHYSICIAN

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

- a. who on a day when the physician is scheduled to work in a hospital emergency department specifically for the purpose of rendering services to patients who attend the emergency department for physician services,
 - i. is requested by the emergency department to attend at a time when the physician is not otherwise scheduled to work in the emergency department; and
 - ii. who is not at the hospital at the time the emergency department request for attendance is made; or
- b. is on-call on a scheduled basis specifically to be available to a hospital emergency department to render services to patients who attend the emergency department for physician services and who is not at the hospital at the time the emergency department request for attendance is made.

[Commentary:

Emergency 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 GP66, to make a special visit to the hospital emergency department.

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

- 2.** If the Emergency Department Physician is at the hospital at the time the emergency department request for attendance is made, the appropriate H prefix code may be eligible for payment.
- 3.** If the Emergency Department Physician is called to a hospital ward on a non-elective basis, the General Listings ("A" prefix) apply and "C" prefix first person seen/additional person seen special visit premium may be eligible for payment.]

Note:

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

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

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

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00 - 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 K960 (max. 2 per time period)	\$36.40 K961 (max. 2 per time period)	\$36.40 K962 (max. 2 per time period)	\$36.40 K963 (max. 6 per time period)	\$36.40 K964 (no max. per time period)
First Person Seen	\$20.00 K990 (max. 10 (total of first and additional person seen) per time period)	\$40.00 K992 (max. 10 (total of first and additional person seen) per time period)	\$60.00 K994 (max. 10 (total of first and additional person seen) per time period)	\$75.00 K998 (max. 20 (total of first and additional person seen) per time period)	\$100.00 K996 (no max. per time period)
Additional Person(s) seen	\$20.00 K991 (max. 10 (total of first and additional person seen) per time period)	\$40.00 K993 (max. 10 (total of first and additional person seen) per time period)	\$60.00 K995 (max. 10 (total of first and additional person seen) per time period)	\$75.00 K999 (max. 20 (total of first and additional person seen) per time period)	\$100.00 K997 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE II

Hospital Out-Patient Department

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 U960 (max. 2 per time period)	\$36.40 U961 (max. 2 per time period)	\$36.40 U962 (max. 2 per time period)	\$36.40 U963 (max. 6 per time period)	\$36.40 U964 (no max. per time period)
First person seen	\$20.00 U990 (max. 10 (total of first and additional person seen) per time period)	\$40.00 U992 (max. 10 (total of first and additional person seen) per time period)	\$60.00 U994 (max. 10 (total of first and additional person seen) per time period)	\$75.00 U998 (max. 20 (total of first and additional person seen) per time period)	\$100.00 U996 (no max. per time period)
Additional person(s) seen	\$20.00 U991 (max. 10 (total of first and additional person seen) per time period)	\$40.00 U993 (max. 10 (total of first and additional person seen) per time period)	\$60.00 U995 (max. 10 (total of first and additional person seen) per time period)	\$75.00 U999 (max. 20 (total of first and additional person seen) per time period)	\$100.00 U997 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE III

Hospital In-Patient

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 C960 (max. 2 per time period)	\$36.40 C961 (max. 2 per time period)	\$36.40 C962 (max. 2 per time period)	\$36.40 C963 (max. 6 per time period)	\$36.40 C964 (no max. per time period)
First person seen	\$20.00 C990 (max. 10 (total of first and additional person seen) per time period)	\$40.00 C992 (max. 10 (total of first and additional person seen) per time period)	\$60.00 C994 (max. 10 (total of first and additional person seen) per time period)	\$75.00 C986 (max. 20 (total of first and additional person seen) per time period)	\$100.00 C996 (no max. per time period)
Additional person(s) seen	\$20.00 C991 (max. 10 (total of first and additional person seen) per time period)	\$40.00 C993 (max. 10 (total of first and additional person seen) per time period)	\$60.00 C995 (max. 10 (total of first and additional person seen) per time period)	\$75.00 C987 (max. 20 (total of first and additional person seen) per time period)	\$100.00 C997 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE IV

Long-Term Care Institution

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 W960 (max. 2 per time period)	\$36.40 W961 (max. 2 per time period)	\$36.40 W962 (max. 2 per time period)	\$36.40 W963 (max. 6 per time period)	\$36.40 W964 (no max. per time period)
First person seen	\$20.00 W990 (max. 10 (total of first and additional person seen) per time period)	\$40.00 W992 (max. 10 (total of first and additional person seen) per time period)	\$60.00 W994 (max. 10 (total of first and additional person seen) per time period)	\$75.00 W998 (max. 20 (total of first and additional person seen) per time period)	\$100.00 W996 (no max. per time period)
Additional person(s) seen	\$20.00 W991 (max. 10 (total of first and additional person seen) per time period)	\$40.00 W993 (max. 10 (total of first and additional person seen) per time period)	\$60.00 W995 (max. 10 (total of first and additional person seen) per time period)	\$75.00 W999 (max. 20 (total of first and additional person seen) per time period)	\$100.00 W997 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE V

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

Premium	Weekdays Daytime (07:00- 17:00)	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 H960 (max. 2 per time period)	\$36.40 H962 (max. 2 per time period)	\$36.40 H963 (max. 4 per time period)	\$36.40 H964 (no max. per time period)
First person seen	\$20.00 H980 (max. 5 (total of first and additional person seen) per time period)	\$60.00 H984 (max. 5 (total of first and additional person seen) per time period)	\$75.00 H988 (max. 10 (total of first and additional person seen) per time period)	\$100.00 H986 (no max. per time period)
Additional person(s) seen	\$20.00 H981 (max. 5 (total of first and additional person seen) per time period)	\$60.00 H985 (max. 5 (total of first and additional person seen) per time period)	\$75.00 H989 (max. 10 (total of first and additional person seen) per time period)	\$100.00 H987 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE VI

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

Premium	Weekdays Daytime (07:00- 17:00) Non- elective	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours Non- elective	Evenings (17:00- 24:00) Monday through Friday Non- elective	Sat., Sun. and Holidays (07:00- 24:00) Non- elective	Nights (00:00- 07:00) Non- elective	Elective home visit
Travel Premium	\$36.40 B960 (max. 2 per time period)	\$36.40 B961 (max. 2 per time period)	\$36.40 B962 (max. 2 per time period)	\$36.40 B963 (max. 6 per time period)	\$36.40 B964 (no max. per time period)	\$36.40 B960 (max. 2 per time period)
First person seen	\$27.50 B990 (max. 10 (total of first and additional person seen) per time period)	\$44.00 B992 (max. 10 (total of first and additional person seen) per time period)	\$66.00 B994 (max. 10 (total of first and additional person seen) per time period)	\$82.50 B993 (max. 20 (total of first and additional person seen) per time period)	\$110.00 B996 (no max. per time period)	\$27.50 B990 (max. 10 (total of first and additional person seen) per time period)

Note:

1. The maximum number of services per physician per day for B960 is 2, for any combination of non-elective and elective visits.
2. The maximum number of services per physician per day for B990 is 10, for any combination of non-elective and elective visits.
3. Special visit to patient's *home* premiums are *only eligible for payment* for first patient seen, regardless of number of patients seen during one visit to a *home* or to one or more living units in a multiple resident dwelling. A multiple resident dwelling is a single location that shares a common external building entrance or lobby e.g. apartment block, rest or retirement *home*, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility or group *home*.

[Commentary:

1. Special visit premiums listed in Table VI above are *not eligible for payment* with A007 or A001 when rendered in a patient's *home*. See page A2.
2. For A007 or A001 rendered in a patient's *home*, travelling to and from the *home* is included as a common element of the insured service. See page GP13 of this Schedule.]

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE VII

Palliative Care Home Visit

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 B966 (no max. per time period)	\$36.40 B966 (no max. per time period)	\$36.40 B966 (no max. per time period)	\$36.40 B966 (no max. per time period)	\$36.40 B966 (no max. per time period)
First person seen	\$82.50 B998 (no max. per time period)	\$82.50 B998 (no max. per time period)	\$82.50 B998 (no max. per time period)	\$82.50 B998 (no max. per time period)	\$110.00 B997 (no max. per time period)

SPECIAL VISIT PREMIUM TABLE VIII

Physician Office

Premium	Weekdays Daytime (07:00- 17:00)	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00-07:00)
Travel Premium	\$36.40 A960 (max. 1 per time period)	\$36.40 A962 (max. 1 per time period)	\$36.40 A963 (max. 1 per time period)	\$36.40 A964 (no max. per time period)
First person seen	\$20.00 A990 (max. 1 per time period)	\$60.00 A994 (max. 1 per time period)	\$75.00 A998 (max. 1 per time period)	\$100.00 A996 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE IX

Other (non-professional setting not listed)

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 Q960 (max. 1 per time period)	\$36.40 Q961 (max. 1 per time period)	\$36.40 Q962 (max. 1 per time period)	\$36.40 Q963 (max. 1 per time period)	\$36.40 Q964 (no max. per time period)
First person seen	\$20.00 Q990 (max. 1 per time period)	\$40.00 Q992 (max. 1 per time period)	\$60.00 Q994 (max. 1 per time period)	\$75.00 Q998 (max. 1 per time period)	\$100.00 Q996 (no max. per time period)

SPECIAL VISIT PREMIUM TABLE X

Geriatric Home Visit

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 B986 (no max. per time period)	\$36.40 B986 (no max. per time period)	\$36.40 B986 (no max. per time period)	\$36.40 B986 (no max. per time period)	\$36.40 B986 (no max. per time period)
First person seen	\$82.50 B988 (no max. per time period)	\$82.50 B988 (no max. per time period)	\$82.50 B988 (no max. per time period)	\$82.50 B988 (no max. per time period)	\$110.00 B987 (no max. per time period)

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

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

Obstetrical Delivery with Sacrifice of Office Hours

Weekdays Daytime (07:00- 17:00)	Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
\$0.00	\$76.40 C989 (max. 1 per time period)	\$0.00	\$0.00	\$0.00

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

[Commentary:

1. A physician who supervises a medical trainee who renders an insured service is eligible to be paid for the insured service as if the supervising physician performed the service personally, subject to any terms, conditions and limitations found in this section.
2. The sole purpose of the terms and conditions described in this section is to define when a service is payable by OHIP. These terms and conditions do not alter the College of Physicians and Surgeons of Ontario Professional Responsibilities in Postgraduate Medical Education requirements or any requirements of the institutions responsible for postgraduate medical education.]

Note:

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

DEFINITIONS:

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

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

Supervision is only performed:

- a. in person, by telephone, or videoconference, the method being consistent with the acuity of the service being rendered by the Medical Trainee as well as the Medical Trainee's level of competence;
- b. when the service is provided within a setting approved by the educational institution where the Medical Trainee is registered; and
- c. when the service is within the scope and oversight of the postgraduate medical training program in which the Medical Trainee is registered.

[Commentary:

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

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

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

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

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

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

[Commentary:

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

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

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

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

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

Payment Rules

A. GENERAL

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

[Commentary:

In the scenario described above the Resident is not performing the service as a Medical Trainee. In this scenario, the Resident would bill OHIP for the service provided.]

3. Where a Clinical Fellow with an OHIP billing number is providing insured services independently and outside their training program, the insured service is *not eligible for payment* to a Supervising Physician as there is no Supervision provided.

[Commentary:

In the scenario described above the Clinical Fellow is not performing the services as a Medical Trainee. In this scenario, the Clinical Fellow would bill OHIP for the services provided. For example, an orthopedic surgeon may be enrolled in a sarcoma surgery clinical fellowship but has privileges as a general orthopedic surgeon and may perform, and be eligible for payment, for rendering a service such as an open reduction of a fracture that is not being supervised by a Supervising Physician.]

4. Special Visit premiums are *not eligible for payment* to the Supervising Physician unless the Supervising Physician personally satisfies the payment requirements for a special visit premium.
5. The following services are *not eligible for payment* to the Supervising Physician when rendered by a Medical Trainee:
 - a. Case Conferences;
 - b. Multidisciplinary Cancer Conferences;
 - c. Provider-to-provider services, including:
 - i. Telephone Consultations;
 - ii. E-Consultations; and
 - iii. E-Assessments.
 - d. Virtual Care Services when provided to hospital inpatients or patients in an emergency department.

B. PROCEDURE SERVICES

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

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

2. A Procedure rendered by a Clinical Fellow is *only eligible for payment* to the Supervising Physician when the Supervising Physician:
 - a. is aware the Clinical Fellow will render the service; and
 - b. is available to personally attend the patient when requested by the Clinical Fellow or other health care professional in a timely manner consistent with the acuity of the clinical scenario.

Note:

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

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

[Commentary:

1. The Supervising Physician should submit a claim as the operating surgeon in this situation ("A" suffix).
2. The Clinical Fellow should submit a claim as the assistant ("B" suffix).]

C. TIME-BASED SERVICES

1. A Time-Based Service rendered by a Medical Trainee is *only eligible for payment* to the Supervising Physician when the Supervising Physician is aware the Medical Trainee will render the service.
2. The number of time units payable is the time spent by the Medical Trainee providing the service to the patient subject to limits set out below:

Note:

1. Any time taken in discussion with the Medical Trainee about the case is *not eligible for payment*.
2. The maximum number of time units payable for a Time-Based service rendered by the Medical Trainee(s) to an individual patient is two units.
3. The maximum number of time units payable for a Time-Based service rendered by the Medical Trainee(s) to a group of two or more patients is four units.

[Commentary:

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

D. NUMBER OF MEDICAL TRAINEES

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

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

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

Note:

1. Maximum number of services rendered concurrently include all services rendered by both the Medical Trainee(s) and the Supervising Physician.
2. With respect to the maximum number of services eligible for payment in Specialized Clinics located at a Quaternary hospital, the following is applicable:
 - a. The maximums are applicable only for clinics that have been approved by the MOH.
 - b. In the absence of MOH approval, the other maximums pertaining to the type and location of insured services rendered by the Supervising Physician and Medical Trainee(s) are applicable.
3. The above maximums refer to Time-Based Services rendered to individual patients. In circumstances where Time-Based Services are rendered to groups of two or more patients, the group session is considered to be a service provided to one patient.

[Commentary:

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

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

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

E. Forms

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

F. Medical Record Requirements

1. A service is *only eligible for payment* to the Supervising Physician when the medical record of the patient(s) identifies the following information at the time of the provision of the service:
 - a. The Supervising Physician;
 - b. The Medical Trainee and level of training;
 - c. The description of the insured service performed by the Medical Trainee;
 - d. Patient consent to the Supervision of services of a Medical Trainee; and
 - e. Where the service rendered is a Time-Based service, the Supervising Physician has at a minimum, reviewed the nature and outcome of the service and the patient record(s), with the Medical Trainee.
2. In addition to the requirements in 1 above, the Supervising Physician must have:
 - a. signed off on the service rendered by the Medical Trainee in the patient's medical record; or
 - b. where the Supervising Physician was not immediately available to sign off on the service rendered by the Medical Trainee, the Medical Trainee has written the date and time a discussion occurred with the Supervising Physician regarding the provision of the service in the patient's medical record.

[Commentary:

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

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

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

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

SPECIFIC ELEMENTS

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

- A. Preparing or supervising the preparation of the patient for the procedure.
- B. Performing the procedure by any method, or assisting another physician in the performance of the procedure(s), assisting with the carrying out of all recovery room procedures and the transfer of the patient to the recovery room, and any ongoing monitoring and detention rendered during the immediate post-operative and recovery period, when indicated.
- C. Making arrangements for any related assessments, procedures, or therapy, (including obtaining any specimens from the patient) and/or interpreting results.
- D. When medically indicated, monitoring the condition of the patient for post-procedure follow-up until the first post-operative visit.
- E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.
- F. Providing premises, equipment, supplies, and personnel for services identified with prefix # for any aspect(s) of A, C, D, and E that is (are) performed in a place other than the place in which the surgical procedure is performed.

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

CALCULATION OF FEE PAYABLE: BASIC UNITS AND TIME UNITS

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

Assistant Unit Fee	\$12.51
---------------------------------	----------------

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*.

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

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

- a. time spent by the physician in direct contact with the patient in the operating room prior to scrub time to assist with patient preparation; and
- b. time spent by the physician assisting at the patient's surgery starting with scrub time and ending when the physician is no longer required to be in attendance with that patient.

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

During the first hour or less.....	1 unit
After the first hour	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 GP65.]

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

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.....	67.05
C983B Saturdays, Sundays or Holidays, daytime and evenings (07:00h -24:00h), first patient seen	85.60
C999B Nights (00:00h - 07:00h), first patient seen	117.65

Payment rules:

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

[Commentary:

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

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

SPECIAL VISIT PREMIUM TABLE - SURGICAL ASSISTANT SERVICES

Surgical Assistant Services

Weekdays Daytime (07:00- 17:00)	Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
\$0.00	\$76.40 C988B (max. 1 per time period)	\$67.05 C998B (max. 2 per time period)	\$85.60 C983B (max. 6 per time period)	\$117.65 C999B (no max. per time period)

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, M112, M117, M134, M142, P042, P051, P052, P056, P059, R008, R009, R013, R014, R015, R016, R055, R056, R064, R065, R067, R069, R134, R135, R136, R140, R182, R240, R241, R244, R326, R327, R334, R393, R438, R440, R441, R483, R487, R545, R553, R568, R593, R594, R617, R645, R701, R702, R704, R712, R713, R714, R715, R718, R726, R727, R728, R729, 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, S079, 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

[Commentary:

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

SURGICAL ASSISTANT STANDBY

Definition/Required elements of service:

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

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.

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

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 GP15);
- b. the anaesthetic procedure; and
- c. post-anaesthetic follow-up.

Note:

1. With the exception of the listings in the "Consultations and Visits" section, all references to an anaesthesiologist in this Schedule are references to any physician providing anaesthetic services.
2. As defined in the General Preamble (see 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

\$15.49

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

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

- a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units listed in the column headed with "Anae" opposite the service that describes the major procedure; or
- b. where the basic units are listed as IC, or where no basic units are listed, the amount payable is calculated by adding the appropriate time units to the basic units listed for a comparable procedure (taking into account the region, modifying conditions, or techniques).

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

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

Claims submission instruction:

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

[Commentary:

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

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 GP66, to make a special visit to the hospital to administer an anaesthetic for a case that commences:

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

C998C Evenings (17:00h - 24:00h) Monday to Friday; or for non-elective surgery with sacrifice of office hours - Weekdays	60.00
C985C Saturdays, Sundays or Holidays daytime and evenings (07:00h - 24:00h)	75.00
C999C Nights (00:00h - 07:00h).....	100.00

Payment rules:

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

[Commentary:

- 1.The specific requirements for special visits are found in pages GP65 to GP77.
- 2.These premiums are payable in addition to the E400 and E401 premiums.]

SPECIAL VISIT PREMIUM TABLE - ANAESTHESIA SERVICES

Anaesthesia Services

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

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

CANCELLED SURGERY - ANAESTHESIA SERVICES

Payment rules:

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

[Commentary:

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

SECOND ANAESTHESIOLOGIST

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

REPLACEMENT ANAESTHESIOLOGIST

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

- a. the amount payable to the first anaesthesiologist is calculated by adding the listed procedural basic units plus time units for the time the first anaesthesiologist is in attendance;
- b. except in the case of continuous conduction anaesthesia, the service provided by the replacement anaesthesiologist constitutes E005C based on the actual number of time units and 6 basic units.

Note:

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

[Commentary:

1. Each anaesthesiologist must indicate, as part of the medical record, his/her starting and finishing times.
2. For continuous conduction anaesthesia, the replacement anaesthesiologist submits claims using the applicable continuous conduction anaesthesia fee code.]

OBSTETRICS – CONTINUOUS CONDUCTION ANAESTHESIA

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

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

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

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

[Commentary:

1. As these services fall under the definition of *general anaesthesia*, the *specific elements* for *general anaesthesia* apply to P014C, P016C and E100C.
2. For additional information on obstetrical anaesthesia services, see page K9 of the Schedule.]

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

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

Note:

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

1. greater than 70 ml/kg of red blood cells are transfused for a patient with a weight up to 50 kg; or
2. 10 or more units of red blood cells are transfused for a patient with a weight exceeding 50 kg.

[Commentary:

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

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

Payment rules:

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

[Commentary:

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

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

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 GP97 are not payable with E030C.

E031C General anaesthesia or deep sedation 4 basic units

Note:

Extra units listed on GP97 are not payable with E031C.

[Commentary:

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

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

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

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

Ocular Surgery, Cystoscopy, and Examination Under Anaesthesia

E023C Anaesthesia service for E137, E138, E139, E140, E141, E143,
E144, E145, E146, E186, E187, E149, Z432, Z606, or Z607
..... 6 basic units, plus time units.

Colonoscopy and Sigmoidoscopy

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

[Commentary:

1. Deep sedation, *general anaesthesia* or regional anaesthesia, performed by an anaesthesiologist, are examples of anaesthesia that may be rendered for E023C and E032C.
2. Anaesthesia extra units listed on GP97 are eligible for payment with E023C and E032C.
3. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment.*]

Note:

For the purposes of anaesthesia services the following definitions apply:

1. **Procedural Sedation** is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
2. **Deep Sedation** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
3. **General Anaesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

ANAESTHESIA ADMINISTERED BY SAME PHYSICIAN PERFORMING A PROCEDURE

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

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

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

[Commentary:

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

GENERAL PREAMBLE

SUPPORTIVE CARE/MONITORING BY SURGICAL ASSISTANT OR ANAESTHESIOLOGIST

SPECIFIC ELEMENTS

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

- A.** Being in constant attendance at a surgical procedure for the sole purpose of monitoring the condition of the patient (including appropriate physical examination and inquiry) and being immediately available to provide, and including the provision of, special supportive care to the patient.
- B.** Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:
 - 1. the service; and
 - 2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).
- C.** Providing premises, equipment, supplies, and personnel for any aspect(s) of the *specific elements* of the service that is(are) performed at a place other than the place in which the attendance occurs.

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

CALCULATION OF FEE PAYABLE

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

	Asst	Anae
E003 Supportive care/Monitoring	6	4

Payment rules:

- 1. For E003B, the assistants' premiums apply as for assistants' services.
- 2. Anaesthesia extra units listed on GP97 are *not eligible for payment* with E003C.
- 3. E003B is *not eligible for payment* for second assistant services.

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).]

INTERNAL MEDICINE OFFICE ASSESSMENT PREMIUM

The Internal Medicine Office Assessment Premium is payable automatically to an eligible physician subject to the definitions and rules described below.

Definitions:

"Qualifying services" means A133, A134, A131, and A138.

"*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.

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 the qualifying services in the following circumstances:

1. The physician is practicing solely as a general internist and has submitted all claims using the specialty designation of Internal Medicine (13) in the qualifying year.

HOSPITALIST PREMIUM

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

Definitions:

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

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

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

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

GENERAL PREAMBLE

OTHER PREMIUMS

Payment rules:

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

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

AFTER HOURS PROCEDURE PREMIUMS

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

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

Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations, Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures:

G060, G061, G062, G065, G066, G067, G068, G082, G083, G085, G090, G099, G117, G118, G119, G125, G176, G177, G178, G179, G211, G224, G246, G248, G249, G260, G261, G262, G263, G268, G269, G275, G277, G279, G280, G282, G287, G288, G290, G297, G298, G303, G309, G322, G323, G324, G330, G331, G336, G347, G348, G349, G356, G376, G379, G380, G509, J001 to J068, and X112 when required for intussusception

and;

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

Emergency Department Physician

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

Physician – other than an Emergency Department Physician

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

Payment rules:

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

[Commentary:

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

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 GP65) in the hospital during the time periods set out below for the purpose of interpreting the results of a diagnostic service, performing a procedure, rendering a diagnostic radiology or nuclear medicine consultation or to conclude that a procedure is not medically indicated, a special visit premium is eligible for payment payable in addition to the appropriate diagnostic radiology or nuclear medicine consultation, interpretation, or procedural fee, or by itself if the decision is made not to perform the procedure.

Payment rules:

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

[Commentary:

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

SPECIAL VISIT PREMIUM TABLE - NON ELECTIVE DIAGNOSTIC SERVICES

Non-elective Diagnostic Services

Premium	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	\$36.40 C102 (max. 2 per time period)	\$36.40 C103 (max. 6 per time period)	\$36.40 C104 (no max. per time period)
First person seen	\$60.00 C109 (max. 2 per time period)	\$75.00 C108 (max. 6 per time period)	\$100.00 C110 (no max. per time period)
Additional person(s) seen	\$60.00 C105 (max. 2 per time period)	\$75.00 C106 (max. 6 per time period)	\$100.00 C107 (no max. per time period)

GENERAL PREAMBLE

OTHER PREMIUMS

[Commentary:

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

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 provider within three hours of the completion of the CT/MRI study.

Note:

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

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

GENERAL PREAMBLE

OTHER PREMIUMS

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

Medical record requirements:

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

1. The time of the request and the time of the transmission of the interpretation; and
2. A description of any factors referred to in the note above.

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 Holidays (07:00- 24:00)	Nights (00:00- 07:00)
\$60.00 E406 (max. 2 per time period)	\$75.00 E407 (max. 6 per time period)	\$100.00 E408 (no max. per time period)

TRAUMA PREMIUM

Definition/Required elements of service:

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

- a. rendered either on the day of the trauma or within 24 hours of the trauma; and
- b. for trauma patients age 16 or more who have an Injury Severity Score (ISS) of greater than 15, or for patients less than age 16 who have an Injury Severity Score of greater than 12.

E420 Trauma premium add 50%

Payment rules:

1. The premium is applicable to the following services and units;
 - a. services listed in the Consultation and Visits Section (Section A of the Schedule);
 - b. services listed in the Obstetrics Section (Section K of the Schedule);
 - c. services listed in the Surgical Procedures section (Section M through Z of the Schedule);
 - d. the following resuscitative services: G395, G391, G521, G522 and G523.
 - e. basic and time units provided by surgical assistants; or
 - f. basic and time units provided by anaesthesiologists.
2. The premium is payable only for the services for which the medical record lists the ISS score.

Claims submission instruction:

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

[Commentary:

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

GENERAL PREAMBLE

EMERGENCY DEPARTMENT ALTERNATIVE FUNDING AGREEMENTS

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

- a. a second on-call physician who either does or does not participate in the ED AFA and who can submit fee-for-service claims under the hospital's ED AFA second on-call group number;
- b. general practitioner experts ('GP Experts') who, in accordance with the ED AFA, are entitled to submit fee-for-service claims under the hospital's ED AFA GP Expert group number; or
- c. the patient's general/family physician only for services payable as A100 - General/Family Physician Emergency Department Assessment.

GENERAL PREAMBLE

DIAGNOSTIC PROCEDURES ORDERED BY PERSONS OTHER THAN PHYSICIANS

Midwives and Aboriginal Midwives

Diagnostic ultrasound for normal, complicated or high-risk pregnancy (but not for the postpartum period) rendered in an *ICHSC* or hospital is insured when referred by a midwife or aboriginal midwife.

Nurse Practitioners

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

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

Oral and Maxillofacial Surgeons

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

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

GENERAL PREAMBLE

NOT ALLOCATED

INDEX

OHIP LISTED SPECIALTIES

CONSULTATIONS AND VISITS

SPECIALTY	PAGE
Family Practice & Practice in General (00)	A1
Virtual Care Services	A62
Anaesthesia (01).....	A72
Cardiology (60)	A75
Cardiac Surgery (09).....	A77
Clinical Immunology (62)	A79
Community Medicine (05).....	A81
Critical Care Medicine (11)	A85
Dermatology (02)	A87
Emergency Medicine (12)	A92
Endocrinology & Metabolism (15)	A93
Gastroenterology (41).....	A99
General Surgery (03)	A102
General Thoracic Surgery (64)	A104
Genetics (22)	A106
Geriatrics (07)	A112
Haematology (61)	A117
Infectious Disease (46)	A119
Internal and Occupational Medicine (13)	A122
Laboratory Medicine (28)	A125
Medical Oncology (44)	A126
Nephrology (16)	A128
Neurology (18)	A132
Neurosurgery (04).....	A136
Nuclear Medicine (63).....	A138
Obstetrics and Gynaecology (20)	A140
Ophthalmology (23)	A142
Orthopaedic Surgery (06)	A151
Otolaryngology (24)	A153
Paediatrics (26).....	A155
Physical Medicine & Rehabilitation (31).....	A161
Plastic Surgery (08)	A167
Psychiatry (19)	A169
Diagnostic Radiology (33).....	A178
Radiation Oncology (34)	A181
Respiratory Disease (47)	A183
Rheumatology (48)	A186
Urology (35)	A192
Vascular Surgery (17)	A194

INDEX

OHIP LISTED SPECIALTIES

NOT ALLOCATED

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

GENERAL LISTINGS

A005 Consultation..... 87.90

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..... 150.70

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 226.05

Payment rules:

1. For A911 and A912, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
2. No other consultation, assessment, visit or counselling service is eligible for payment when rendered the same day as one of A911 or A912 to the same patient by the same physician.

[Commentary:

1. A911 and A912 must satisfy all the elements of a consultation (see page GP16).
2. 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..... 159.20

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..... 73.25

A006 Repeat consultation..... 45.90

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

A003 General assessment.....	87.35
------------------------------	-------

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
----------------------------------	-------

Note:

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

A001 Minor assessment.....	23.75
----------------------------	-------

A007 Intermediate assessment or well baby care	37.95
--	-------

A002 Enhanced 18 month well baby visit (see General Preamble GP34).....	62.20
---	-------

Note:

1. Special visit premiums listed in Table VI on page GP75 of this Schedule are not eligible for payment with A007 or A001 when rendered in a patient's home.
2. For A007 or A001 rendered in a patient's home, travelling to and from the home is included as a common element of the insured service. See page GP13 of this Schedule.
3. See the Definitions section of this Schedule for the definition of home.

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
---------------------------	-------

[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	45.25
------------------	-------

K130 adolescent	77.20
-----------------------	-------

K131 adult age 18 to 64 inclusive	56.95
---	-------

K132 adult 65 years of age and older	80.95
--	-------

Note:

For definitions and payment rules - see General Preamble GP21.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[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.]

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.....	37.95
--	-------

[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)

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..... 54.50

Payment rules:

1. A complex house call assessment is *only eligible for payment* for the first person seen during a single visit to the same location.
2. A900 is *not eligible for payment* unless the patient is a frail elderly patient or a housebound patient.

Note:

1. For the purposes of A900, a frail elderly patient is a patient who is 65 years of age or over who has one or more of the following:
 - a. Complex medical management needs, that may include polypharmacy;
 - b. Cognitive impairment (e.g. dementia or delirium);
 - c. Age-related reduced mobility or falls; or
 - d. Unexplained functional decline not otherwise specified.
2. For the purposes of A900, a housebound patient is a patient who meets all the following criteria:
 - a. The person has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
 - b. Transportation and other strategies to remedy the access difficulties have been considered but are not available or not appropriate in the person's circumstances; and
 - c. The person's care and support requirements can be effectively and appropriately delivered at home.

[Commentary:

1. A900 is payable when rendered in the patient's home or an assisted living or retirement residence.
2. A900 is not payable when rendered in a long-term care home.]

Medical record requirements:

Complex house call assessment is not payable if the medical record does not:

1. Demonstrate that an intermediate assessment was rendered; and
2. Demonstrate that the patient was a frail elderly or housebound patient.

House call assessment - Pronouncement of death in the home

A house call assessment - Pronouncement of death in the *home* is the service rendered when a physician pronounces a patient dead in a *home*. This service includes completion of the death certificate and counselling of any relatives which may be rendered during the same visit.

A902 House call assessment - Pronouncement of death in the home 54.50

Claims submission instructions:

Submit the claim using the diagnostic code for the underlying cause of death as recorded on the death certificate.

Note:

For special visit premiums, please see pages GP65 to GP78 of the General Preamble.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

On-call admission assessment

On-call admission assessment is the first hospital in-patient admission general assessment per patient per 30-day period if:

- a. the physician is a general practitioner or family physician participating in the hospital's on-call roster whether or not the physician is on-call the day the service is rendered;
- b. the admission is non-elective; and
- c. the physician is the *most responsible physician* with respect to subsequent in-patient care.

The amount payable for any additional on-call admission assessment rendered by the same physician to the same patient in the same 30-day period is reduced to the amount payable for a general re-assessment.

A933 On-call admission assessment 79.90

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

Payment rules:

No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instructions:

For claims payment purposes, the hospital master number associated with the emergency department must be submitted on the claim.

[Commentary:

1. Services described as A100 rendered in an emergency department not funded under an ED-AFA may be payable under other existing fee schedule codes.
2. In the event the patient is subsequently admitted to hospital, and the general/family physician remains the *MRP* for the patient, the General/Family Physician emergency department assessment constitutes the admission assessment. see General Preamble GP41 for additional information.]

Certification of death

Certification of death is payable to the physician who personally completes the death certificate on a patient who has been pronounced dead by another physician, medical resident or other authorized health professional. Claims submitted for this service must include the diagnostic code for the underlying cause of death as recorded on the death certificate. The service *may include* any counselling of relatives that is rendered at the same visit. Certification of death rendered in conjunction with A902 or A777/C777 is an insured service payable at nil.

A771 Certification of death 20.60

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

A777 Intermediate assessment - Pronouncement of death (see General Preamble GP27).....	37.95
--	-------

Certification of stillbirth

Certification of stillbirth is payable to the physician who personally completes the Medical Certificate of Stillbirth. The service may include any counselling of family members that is rendered at the same visit.

A772 Certification of stillbirth.....	20.60
---------------------------------------	-------

Claims submission instructions:

For claims payment purposes, the Health Card Number of the patient experiencing the stillbirth must be submitted on the claim.

Periodic health visit for adults with Intellectual and Developmental Disabilities (IDD)

Definition/Required elements of service:

A periodic health visit for adults with IDD is a service performed on an adult with IDD that consists of an intermediate assessment, appropriate history, physical examination, health screening and relevant counselling, and a coordinated care and management plan consistent with the current Canadian consensus guidelines on the primary care of adults with IDD.

The service must include:

- a. Evaluation for and identification of any need for special accommodations in clinical settings as well as other health care access issues,
- b. Proactive review of the patient's genetic and psychosocial risks,
- c. Review of any chronic diseases,
- d. Review of systems,
- e. An in-person physical examination that includes, at a minimum:
 - i. Measurement of vital signs including weight or waist circumference,
 - ii. Screening for abnormalities in hearing, vision, and dentition,
 - iii. Screening examination of musculoskeletal and neurological systems,
 - iv. Survey examination of skin,
 - v. Detailed examination of any part(s), region(s) or system(s) needed to make a diagnosis, and/or rule out disease as a contributing factor
- f. Documentation of a coordinated care and management plan,
- g. Written communication of the care and management plan to the patient and their guardian, legal representative or other caregiver

K133 Periodic health visit for adults with Intellectual and Developmental Disabilities (IDD).....	160.00
---	--------

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

- 1.K133 is limited to one per patient per *12 month period*.
- 2.Only one of K133, K131, or K132 is eligible for payment per patient per physician per *12 month period*.
- 3.This service can be provided over multiple distinct time periods, however, a minimum of 50 minutes total time spent in direct contact with the patient is required. Start and stop times must be recorded for each time period related to the service. For payment purposes, the service date on the claim must be the date on which all requirements for the service have been completed. No other services are eligible for payment for time periods used to meet the time requirements of this service.
- 4.While some aspects of K133 may be provided virtually, a minimum of 26 minutes must be provided through direct physical encounter(s).
- 5.K133 is only payable when the patient has one of the following conditions (listed with ministry diagnostic codes):
 - a.Autism spectrum disorder (299)
 - b.Intellectual disability or Fetal Alcohol Syndrome (319)
 - c.Cerebral palsy (343)
 - d.Spina bifida, with or without hydrocephalus, meningocele, meningomyelocele (741)
 - e.Chromosomal anomalies such as Down's syndrome, Fragile X syndrome, other autosomal anomalies (758)

Claims submission instructions:

A diagnostic code listed above that corresponds to the patient's condition must accompany the claim for payment purposes.

[Commentary:

Guidelines relating to coordinated care and management plans can be found at: <https://www.cfp.ca/content/cfp/64/4/254.full.pdf>]

Focused practice assessment (FPA)

FPA is an assessment rendered by a GP/FP physician, unless otherwise specified, with additional training and/or experience in sport medicine, allergy, pain management, sleep medicine, addiction medicine (including methadone) or care of the elderly (age 65 or older). The assessment must satisfy, at a minimum, all of the requirements of an intermediate assessment.

A917 Sport medicine FPA.....	37.95
A927 Allergy FPA.....	37.95
A937 Pain management FPA.....	37.95
A947 Sleep medicine FPA.....	37.95
A957 Addiction medicine FPA.....	37.95
A967 Care of the elderly FPA.....	37.95

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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

3.A957 may also be billed by a *specialist* with additional training and/or experience in addiction medicine (including methadone).

[Commentary:

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

Periodic oculo-visual assessment

see General Preamble GP28 for definitions and conditions

A110 aged 19 years and below	48.90
A112 aged 65 years and above	48.90

Identification of patient for a major eye examination

Identification of patient for a major eye examination, is the service of determining that a patient aged 20 to 64 inclusive has a medical condition (other than diabetes mellitus, glaucoma, cataract, retinal disease, amblyopia, visual field defects, corneal disease, strabismus, recurrent uveitis or optic pathway disease) requiring a major eye examination and providing such a patient with a completed requisition.

E077 - identification of patient for a major eye examination.. add	10.25
--	-------

Note:

- 1.This service is limited to a maximum of one every four fiscal years by the same physician for the same patient unless the patient seeks a major eye examination from 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.

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 *nurse practitioner*
- 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

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

- iv. retinal disease
- v. amblyopia
- vi. visual field defects
- vii. corneal disease
- viii. strabismus
- ix. recurrent uveitis
- x. optic pathway disease; or

- b. The patient must have a valid "request for eye examination requisition" completed by another physician or by a *nurse practitioner*
- 2. This service is limited to one per patient per consecutive *12 month period* regardless of whether 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.]

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA)

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) is an assessment of a mother or newborn provided by a physician upon the written request of a midwife or aboriginal midwife because of the complex, obscure or serious nature of the patient's problem and is payable to a family physician or obstetrician for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient's permanent medical record. The MAMRA must include the common and specific elements of a general or specific assessment and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or aboriginal midwife and in writing to both the midwife or aboriginal midwife and the patient's primary care physician, if applicable. Maximum one per patient per physician per pregnancy.

A813 Midwife or Aboriginal Midwife-Requested Assessment
(MAMRA).....

111.70

Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA)

Midwife or Aboriginal Midwife-Requested Special Assessment must include constituent elements of A813 and is payable in any setting:

- a. to a paediatrician for an urgent or emergency assessment of a newborn; or

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

- 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 or Aboriginal Midwife-Requested Special Assessment
(MAMRSA)

186.95

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C005	Consultation.....	87.90
C911	Special family and general practice consultation - subject to the same conditions as A911	150.70
C912	Comprehensive family and general practice consultation - subject to the same conditions as A912	226.05
C945	Special palliative care consultation - subject to the same conditions as A945	159.20
C905	Limited consultation	74.25
C006	Repeat consultation	45.90
C003	General assessment.....	87.35
C004	General re-assessment	38.35
C813	Midwife or Aboriginal Midwife-Requested Assessment - subject to the same conditions as A813	111.70
C815	Midwife or Aboriginal Midwife-Requested Special Assessment - subject to the same conditions as A815	186.95
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	37.95
C771	Certification of death - subject to the same conditions as A771	20.60
C772	Certification of death - subject to the same conditions as A772	20.60

Subsequent visits

C002	- first five weeks	per visit	34.10
C007	- sixth to thirteenth week inclusive (maximum 3 per patient per week).....	per visit	34.10
C009	- after thirteenth week (maximum 6 per patient per month)	per visit	34.10

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122 - day following the hospital admission assessment.....	61.15
C123 - second day following the hospital assessment	61.15
C124 - day of discharge	61.15

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

See General Preamble GP46 for terms and conditions.

C142 - first subsequent visit by the MRP following transfer from an Intensive Care Area.....	61.15
C143 - second subsequent visit by the MRP following transfer from an Intensive Care Area.....	61.15
C121 Additional visits due to intercurrent illness (see General Preamble GP43)..... per visit	34.10
C008 Concurrent care per visit	34.10
C010 Supportive care per visit	34.10
C882 Palliative care (see General Preamble GP50)..... per visit	34.10

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
--	-------

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
---	-------

Low birth weight baby care (uncomplicated)

H002 - initial visit (per baby).....	34.10
H003 - subsequent visit..... per visit	16.90

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

EMERGENCY DEPARTMENT PHYSICIAN

Note:

See General Preamble GP50 for definitions and conditions for Emergency Department Physician.

In-patient interim admission orders

In-patient interim admission orders is payable to an Emergency Department Physician who is on-call or on duty in the emergency department or Hospital Urgent Care Clinic for writing in-patient interim admission orders pending admission of a “non-elective” patient by a different *most responsible physician* (see General Preamble GP4).

Comprehensive assessment and care

Comprehensive assessment and care is a service rendered in an emergency department or Hospital Urgent Care Clinic that requires a full history (including systems review, past history, medication review and social/domestic evaluation), a full physical examination, concomitant treatment, and intermittent attendance on the patient over many hours as warranted by the patient’s condition and ongoing evaluation of response to treatment.

It also includes the following as indicated:

- a. interpretation of any laboratory and/or radiological investigation; and
- b. any necessary liaison with the following: the family physician, family, other institution (e.g. nursing *home*), and other agencies (e.g. *Home Care*, VON, CAS, police, or detoxification centre).

[Commentary:

Re-assessments, where required, are payable in addition to this service if the criteria described in the *Schedule* are met.]

Multiple systems assessment

A multiple systems assessment is an assessment rendered in an emergency department or Hospital Urgent Care Clinic that includes a detailed history and examination of more than one system, part or region.

Re-assessment

A re-assessment is an assessment rendered in an emergency department or Hospital Urgent Care Clinic at least two hours after the original assessment or re-assessment (including appropriate investigation and treatment), which indicates that further care and/or investigation is required and performed.

Payment rules:

1. This service is *not eligible for payment* under any of the following circumstances:
 - a. for discharge assessments;
 - b. when the patient is admitted by the Emergency Department Physician; or
 - c. when the reassessment leads directly to a *referral* for consultation.
2. This service is limited to three per patient per day and two per physician per patient per day. Services in excess of these limits are *not eligible for payment*.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

H065 Consultation in Emergency Medicine	81.25
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	43.05
H103 Multiple systems assessment.....	40.00
H101 Minor assessment.....	17.10
H104 Re-assessment.....	17.10

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

H132 Comprehensive assessment and care	52.55
H133 Multiple systems assessment.....	47.45
H131 Minor assessment.....	20.95
H134 Re-assessment.....	20.95

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

H152 Comprehensive assessment and care	66.15
H153 Multiple systems assessment.....	58.90
H151 Minor assessment.....	26.35
H154 Re-assessment.....	26.35

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

H122 Comprehensive assessment and care	76.95
H123 Multiple systems assessment.....	68.00
H121 Minor assessment.....	30.70
H124 Re-assessment.....	30.70

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)	35.15
H113 - daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays	20.35

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 GP50 for the definition of an “Emergency Department Physician”.
- 2.Current standards and minimum requirements for training and experience for Emergency Department investigative ultrasound may be found at the Canadian Emergency Ultrasound Society website at the following internet link: [http://www.ceus.ca.\]](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 inpatients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W105 Consultation	87.75
W911 Special family and general practice consultation - subject to the same conditions as A911	150.70
W912 Comprehensive family and general practice consultation - subject to the same conditions as A912	226.05
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	37.95
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 GP49)

Chronic care or convalescent hospital

W002 - first 4 subsequent visits per patient per month	34.10
W001 - additional subsequent visits (maximum 4 per patient per month).....	34.10
W882 - palliative care (see General Preamble GP50)	34.10

Nursing *home* or *home* for the aged

W003 - first 2 subsequent visits per patient per month	34.10
W008 - additional subsequent visits (maximum 2 per patient per month).....	34.10
W872 - palliative care (see General Preamble GP50)	34.10

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

W121 Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	34.10
<i>Monthly Management of a Nursing Home or Home for the Aged Patient</i>		
W010 Monthly management fee (per patient per month) (see General Preamble GP51 to GP52)		115.25

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 GP7, GP54 to GP61 for definitions and time-keeping requirements.

K005 Individual care.....	per unit	70.10
---------------------------	----------	-------

Counselling

Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

Individual care

K013 - first three units of K013 and K040 combined per patient per provider per 12 month period	per unit	70.10
K033 - additional units per patient per provider per 12 month period	per unit	49.35

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	70.10
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	50.20
K014 Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons	per unit	70.10
K015 Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons	per unit	70.10

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	35.10
K141	- 3 patients	per unit	23.35
K142	- 4 patients	per unit	17.65
K143	- 5 patients	per unit	14.55
K144	- 6 to 12 patients	per unit	12.35

[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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.
2. The service is *only eligible for payment* when:
 - a. the appointment is pre-scheduled; and
 - b. each patient regularly visits the physician or another physician in the same physician group for management of their chronic disease.
3. Chronic disease shared appointment rendered the same day as an additional assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 GP54.

Note:

Psychotherapy outside hospital and hypnotherapy may not be claimed as such when provided in conjunction with a consultation or other assessments rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K007	Individual care	per unit	70.10
Group - per member - first 12 units per day			
K019	- 2 people.....	per unit	35.10
K020	- 3 people.....	per unit	23.35
K012	- 4 people.....	per unit	17.65
K024	- 5 people.....	per unit	14.55
K025	- 6 to 12 people.....	per unit	12.35
K010	- additional units per member (maximum 6 units per patient per day)	per unit	11.20
Family			
K004	- 2 or more family members in attendance at the same time	per unit	76.10

Hypnotherapy

Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K006	Individual care*	per unit	70.10
------	------------------------	----------	-------

Note:

* May not be claimed in conjunction with delivery as the service is included in the obstetrical fees.

Certification of mental illness

See General Preamble GP34 for definitions and conditions.

Form 1

Application for psychiatric assessment in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K623	Application for psychiatric assessment	117.05
------	--	--------

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	144.15
------	--	--------

K629	All other re-certification(s) of involuntary admission including completion of appropriate forms.....	42.70
------	---	-------

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Note:

- 1.**A completed Form 1 Application by a Physician For Psychiatric Assessment retained on the patient's medical record is sufficient documentation to indicate that a consultation for involuntary psychiatric treatment has been requested by the referring physician.
- 2.**Consultations or assessments claimed in addition to certification or re-certification same day are payable at nil.
- 3.**Certification of incompetence (financial) including assessment to determine incompetence is not an insured service (see Appendix A).

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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for Definitions and time-keeping requirements. A single all-inclusive claim for CTO Initiation or CTO Renewal is submitted once per patient per physician per initiation or renewal in any six *month* period on an Independent Consideration basis. A single all-inclusive claim for CTO Supervision is submitted once per patient per *month* on an Independent Consideration basis. The form provided by the MOH for elapsed times must be completed and submitted with each claim and a copy retained on the patient's permanent medical record. The total number of allowable units rendered per claim shall be determined by adding the actual elapsed time of each insured activity rounded to the nearest minute, dividing by 30 and rounding to the nearest whole unit. In the absence of a claim in accordance with these requirements, the amount payable for CTO services is nil.

K887	CTO initiation including completion of the CTO form and all preceding CTO services directly related to CTO initiation.. per unit	94.55
K888	CTO supervision including all associated CTO services except those related to initiation or renewal.....	per unit	94.55
K889	CTO renewal including completion of the CTO form and all preceding CTO services directly related to CTO renewal per unit	94.55

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 $\frac{1}{2}$ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K002 Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act	per unit	70.10
---	----------	-------

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	70.10
--	----------	-------

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	70.10
--	----------	-------

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 Ontario Health.

K708 MCC Participant, per patient.....	32.45
K709 MCC Chairperson, per patient.....	41.85
K710 MCC Radiologist Participant, per patient.....	32.45
K711 MCC Nuclear Medicine Participant for patients requiring PET scan, per patient.....	32.45

Payment rules:

- 1.K708, K709, K710, and K711 are *only eligible for payment* in circumstances where:
 - a.the MCC meets the minimum standards, including attendance requirements, established by Ontario Health; and
 - b.the MCC is pre-scheduled.
- 2.K708, K709, K710, and K711 are eligible for payment for each patient discussed where the total time of discussion for all patients meets the minimum time requirements described in the table below, otherwise the number of patients for K708, K709, K710, and K711 are payable will be adjusted to correspond to the overall time of discussion.
- 3.K708, K710, and K711 are *only eligible for payment* if the physician is actively participating in the case conference, and their participation is documented in the record.
- 4.K708, K710, and K711 are each limited to a maximum of 5 services per patient per day, any physician.
- 5.K708, K710, and K711 are each limited to a maximum of 8 services, per physician, per day.
- 6.Only K708 or K709 or K710 or K711 is eligible for payment to the same physician, same day.
- 7.K709 is limited to a maximum of 8 services per physician, per day.
- 8.Any other insured service rendered during a MCC is *not eligible for payment*.
- 9.K708, K709, K710, and K711 are *not eligible for payment* where a physician receives payment, other than by fee-for-service under this *Schedule*, for the preparation and/or participation in a MCC.
- 10.K708 and K709 are *not eligible for payment* to physicians from the following specialties: Radiation Oncology (34), Diagnostic Radiology (33) and Laboratory Medicine (28).
- 11.K710 is *only eligible for payment* to physicians from Diagnostic Radiology (33).
- 12.K711 is *only eligible for payment* to physicians from Nuclear Medicine (63).

Medical record requirements:

- 1.identification of the patient and physician participants;
- 2.total time of discussion for all patients discussed; and
- 3.the outcome or decision of the case conference related to each of the patients discussed.

[Commentary:

- 1.The 2006 Multidisciplinary Cancer Conference standards can be found at the Ontario Health website at the following internet link: <https://www.cancercareontario.ca/en/content/multidisciplinary-cancer-conference-standards>
- 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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

3. One common medical record in the patient's chart for the MCC that indicates the physician participants (including listing the time the service commenced and terminated and individual attendance times for each participant if different) would satisfy the medical record requirements for billing purposes.]

[Commentary:

1. The time spent per patient does not have to be 10 minutes. For example, if the physician participates in discussion about three patients and patient A is discussed for 5 minutes, patient B is discussed for 15 minutes and patient C for 10 minutes, the total time of discussion is 30 minutes and a claim may be submitted for each of the three patients. The time spent at the MCC should be recorded as 30 minutes.
2. If the physician participates in a discussion about four patients and the total time of discussion is 20 minutes the physician should only submit a claim for two patients.
3. A physician can only be either a chairperson, participant or radiologist participant on any given day.]

Number of Patients Discussed	Minimum Total Time of Discussion
1 patient	10 minutes
2 patients	20 minutes
3 patients	30 minutes
4 patients	40 minutes
5 patients	50 minutes
6 patients	60 minutes
7 patients	70 minutes
8 patients	80 minutes

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 J40).
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 32.45

Payment rules:

- 1.K121 is eligible for payment for a case conference regarding a hospital in-patient at an acute care hospital, chronic care hospital, or rehabilitation hospital. K121 is *not eligible for payment* for a resident in a long term care institution.
- 2.K121 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.
- 3.A maximum of 8 units of K121 are payable per physician, per patient, per day.
- 4.K121 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.
- 5.Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K121.

[Commentary:

- 1.For case conferences regarding out-patients, see K700, K701, K702, K703, K704 and K707 for applicable services.
- 2.For case conferences regarding an in-patient in a long term care institution, see K124.]

Palliative care out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a *palliative care* out-patient case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a *palliative care* out-patient.

K700 Palliative care out-patient case conference per unit 32.45

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 32.45

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, regarding an *adult* out-patient.

K701 Mental health out-patient case conference per unit 32.45

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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 32.45

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 32.45

Payment rules:

- 1.K703 is *not eligible for payment* with any other case conference or telephone consultation service for the same patient on the same day.
- 2.K703 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.
- 3.A maximum of 8 units of K703 are payable per physician, per patient, per day.
- 4.K703 is *only eligible for payment* to:
 - a.a *specialist* in Geriatrics (07); or
 - b.a physician with an exemption to access bonus impact in Care of the Elderly from the MOH.

[Commentary:

- 1.For case conferences regarding an in-patient in an acute care hospital, chronic care hospital or rehabilitation hospital, see K121.
- 2.For case conferences regarding an in-patient in a long term care institution, see K124.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 32.45

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 32.45

Payment rules:

- 1.K124 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.
- 2.A maximum of 8 units of K124 are payable per physician, per patient, per day.
- 3.K124 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.
- 4.Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K124.

[Commentary:

- 1.For case conferences regarding out-patients, see K700, K701, K702, K703, K704, and K707 for applicable services.
- 2.For case conferences regarding an in-patient in an acute care hospital, chronic care hospital or rehabilitation hospital, see K121.]

Long-term care – High risk patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a Long-term care – High risk patient case conference is participation by a physician and at least 2 other participants that include physicians, employees of 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 32.45

Payment rules:

- 1.K705 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.
- 2.A maximum of 8 units of K705 are payable per physician, per patient, per day.
- 3.K705 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.
- 4.Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K705.

Note:

- 1.In circumstances where the physician other than the physician most responsible for the care of the patient participates in the case conference, K705 is only eligible for payment when the physician's participation is for directing the care of the individual patient.
- 2.For the purposes of K705, a high risk patient is a patient identified by staff in the long term institution with clinical instability based on a change in the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for Nursing Homes.

[Commentary:

- 1.For case conferences regarding out-patients, see K700, K701, K702, K703, K704, and K707 for applicable services.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 MOH.

K706 Convalescent care program case conference 32.45

Payment rules:

- 1.K706 is limited to a maximum of 8 services per patient, per physician, per *12 month period*.
- 2.A maximum of 4 units of K706 are payable per physician, per patient, per day.
- 3.Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K706.

[Commentary:

- 1.For case conferences regarding out-patients, see K700, K701, K702, K703, K704 and K707 for applicable services.
- 2.For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.
- 3.For case conferences regarding an in-patient in a long term care institution, see K705 or K124.]

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	32.45
K731 Physician to physician telephone consultation - Consultant physician	41.85

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

K734 Physician to physician telephone consultation - Referring physician	32.45
K735 Physician to physician telephone consultation - Consultant physician	41.85

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[Commentary:

Referring and consultant physicians participating in physician to physician telephone consultations while on duty in an emergency department or a hospital urgent care clinic should submit claims using K734 and K735. K730 and K731 should not be claimed in these circumstances.]

Payment rules:

- 1.A maximum of one K730 or K734 service is eligible for payment per patient per day.
- 2.A maximum of one K731 or K735 service is eligible for payment per patient per day.
- 3.This service is *only eligible for payment* for a physician to physician telephone consultation service:
 - a.that includes a minimum of 10 minutes of patient-related discussion for any given patient
 - b.where the referring physician/nurse practitioner and consultant physician are physically present in Ontario at the time of the service
- 4.This service is *not eligible for payment* to the referring or consultant physicians in the following circumstances:
 - a.when the purpose of the telephone discussion is to arrange for transfer of the patient's care to any physician;
 - b.when rendered in whole or in part to arrange for a consultation, assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s);
 - c.when rendered primarily to discuss results of diagnostic investigation(s); or
 - d.when a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician to physician telephone consultation for the same patient.
- 5.In circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for participation in the telephone consultation, this service is *not eligible for payment* to that physician.

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	32.45
K733	CritiCall telephone consultation - Consultant physician.....	41.85
E150	CritiCall review of complex neurosurgical imaging, to K733...	44.00

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

K736	CritiCall telephone consultation - Referring physician	32.45
K737	CritiCall telephone consultation - Consultant physician.....	41.85

[Commentary:

Referring and consultant physicians participating in Criticall telephone consultations while on duty in an emergency department or a hospital urgent care clinic should submit claims using K736 and K737. K732 and K733 should not be claimed in these circumstances.]

Payment rules:

- 1.A maximum of 2 K732 or K736 services (any combination) are eligible for payment per patient, per day.
- 2.A maximum of 1 K733 or K737 service is eligible for payment per physician, per patient, per day.
- 3.A maximum of 1 E150 service is eligible for payment per physician, per patient, per day.
- 4.A maximum of 3 K733 or K737 services (any combination) are eligible for payment per patient, per day.
- 5.These services are *only eligible for payment* for a CritiCall telephone consultation service that fulfills all of the following criteria:

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

- a.the telephone consultation service is arranged by, and subject to the requirements of CritiCall Ontario; and
 - b.the referring physician/nurse practitioner and patient are physically present in Ontario at the time of the telephone consultation.
- 6.E150 is *only eligible for payment*
- a.to specialists in Neurosurgery (04);
 - b.for review of all complex neurosurgical imaging provided by the referring physician/nurse practitioner which is defined as at least one brain and/or spinal CT, MRI or angiography; and,
 - c.when the analysis of the complex neurosurgical imaging provided by the physician claiming E150 is documented in the patient permanent medical record.
- 7.E150 is *not eligible for payment* when the consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day for the same patient.
- 8.In circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for participation in the telephone consultation, these services are *not eligible for payment* to that physician.

Medical record requirements:

CritiCall telephone consultation is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

- 1.the telephone consultation was arranged by CritiCall Ontario;
- 2.identification of the patient by name and health number;
- 3.identification of the referring 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;

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

- 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 GP37). K738 is *not eligible for payment* where existing data is already available in the primary care physician's records for submission to the *specialist*.
- Medical record requirements:**
- Physician/nurse practitioner to physician e-consultation is *only eligible for payment* if all of the following elements are included in the medical record of the patient for a physician who submits a claim for the service:
- 1.patient's name and health number;
 - 2.name of the referring 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 GP58. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for HIV Primary Care, the HIV Primary Care service is included (in addition to the *common elements*) as a specific element of the other insured service. Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

K022 HIV primary care per unit 70.10

Fibromyalgia/myalgic encephalomyelitis care

Fibromyalgia/myalgic encephalomyelitis care is the provision of care to patients with fibromyalgia or myalgic encephalomyelitis. The service includes the common and *specific elements* of all insured services listed under "Family Practice & Practice In General" in the "Consultations and Visits" section of the *Schedule*.

K037 Fibromyalgia/myalgic encephalomyelitis care per unit 70.10

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 GP7, GP55 for definitions and time-keeping requirements.
2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K037 to the same patient by the same physician.

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 74.70

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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 GP7, GP55 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 GP7, GP55 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 GP7, GP55 for definitions and time keeping requirements.

K028	STD management	per unit	70.10
------	----------------------	----------	-------

Payment rules:

1. K028 is *not eligible for payment* when rendered with any consultation, assessment or visit by the same physician on the same day.
2. K028 is limited to a maximum of two units per patient per physician per day and four units per patient, per physician, per year.

Insulin therapy support (ITS)

ITS is a time-based all-inclusive visit fee per patient per day for the purpose of providing assessment, support and counselling to patients on intensive insulin therapy requiring at least 3 injections per day or using an infusion pump. The service includes any combination of common and *specific elements* of any insured service listed under "Family Practice & Practice In General" in the "Consultations and Visits" section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP58. ITS rendered same patient same day as any other consultation or visit by the same physician is an insured service payable at nil. Unit means $\frac{1}{2}$ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements. Maximum 6 units per patient, per physician, per year.

K029	Insulin therapy support (ITS)	per unit	70.10
------	-------------------------------------	----------	-------

[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 40.55

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
--	--------

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
---	-------

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 15.55

Payment rules:

1. E079 is *only eligible for payment* when rendered in conjunction with one of the following services: A001, A003, A004, A005, A006, A007, A008, A905, K005, K007, K013, K017, K130, K131, K132, 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

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.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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.....	326.00
K021 - male.....	257.15

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
--	--------

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..... 70.10

[Commentary:

Examples of neurocognitive assessment batteries which would be acceptable are the short form of the Behavioral Neurology Assessment (BNA) or the Dementia Rating Scale (DRS). The Mini-Mental State Examination ("Folstein") test is not considered acceptable for this purpose.]

Extended specific neurocognitive assessment

An extended specific neurocognitive assessment is an assessment of neurocognitive function *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 46 minutes (consecutive or non-consecutive) must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and
- c. the start and stop time(s) must be recorded in the patient's medical record.

K042 Extended specific neurocognitive assessment..... 140.20

Payment rules:

1.K042 is *only eligible for payment* to specialists in one of the following: Geriatrics (07), Neurology (18), and Psychiatry (19).

2.Only one of K032 or K042 is eligible for payment to the same physician, same day.

[Commentary:

Examples of extended neurocognitive assessment batteries which would be acceptable, where the minimum time requirement has been met, are the Montreal Cognitive Assessment (MOCA), Toronto Cognitive Assessment (TorCA), Frontal Assessment battery.]

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

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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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
---	-------

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.]

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 70.10

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 GP7, GP55 for definitions and time-keeping requirements.
- 2.No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K680 to the same patient by the same physician.
- 3.K680 is *not eligible for payment* for management of smoking cessation.

Medical record requirements:

Start and stop times must be recorded in the patient's permanent medical record or payment will be adjusted to reflect the service documented in the medical record.

[Commentary:

See K039 – smoking cessation.]

Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP)

Definition/Required elements of service:

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 or otherwise, on matters related to the service, regardless of identity of person initiating discussion; and
- c.All discussions in respect of the patient's opioid dependency, except where the discussion is payable as a separate service.

K682 Opioid Agonist Maintenance Program monthly management fee - intensive, per month	45.00
K683 Opioid Agonist Maintenance Program monthly management fee - maintenance, per month	38.00
K684 - Opioid Agonist Maintenance Program - team premium, per month, to K682 or K683 add	6.00

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Definitions:

- a.** Required services are:
 - i. a consultation, assessment or visit from the Consultation and Visits section of this *Schedule*; or
 - ii. a K-prefix time-based service excluding group services and case conferences.
- b.** OAMP - intensive, is the service for management of an OAMP patient receiving an opioid agonist where the physician renders at least two (2) required services in the *month*.
- c.** OAMP - maintenance, is the service for management of an OAMP patient receiving an opioid agonist where the physician renders one required service in the *month*.
- d.** OAMP - team premium, is the service for management of an OAMP patient receiving an opioid agonist where:
 - i. the physician most responsible for the OAMP management of the patient provides one of K682 or K683 in the *month* and supervises members of the OAMP management team;
 - ii. the OAMP management team consists of the physician most responsible for the OAMP treatment and at least two other non-physician members who have successfully completed a training program in addiction medicine that includes opioid agonist management;
 - iii. the OAMP management team members provides at least one in-person therapeutic encounter with the patient in the *month* for which the service is payable; and
 - iv. the therapeutic encounter is not primarily for the purpose of urine testing or the provision of a prescription.
- e.** A service primarily for the purpose of providing a prescription does not constitute a required service and does not count towards the minimum requirements of K682 or K683.

Payment rules:

- 1.** K682, K683 and K684 are *only eligible for payment* to the physician most responsible for the patient's OAMP for the applicable *month*.
- 2.** K684 is *only eligible for payment* when all required patient encounters are documented in the medical record.
- 3.** K682 is limited to a maximum of six services per patient per *12 month period*.
- 4.** A maximum of one of K682 or K683 is eligible for payment per patient per *month* any physician.
- 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*.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[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 MOH and the Ontario Medical Association on or before December 31, 2012.]

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

DEFINITIONS:

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

Comprehensive Virtual Care Service means a Virtual Care Service rendered where an Existing/Ongoing Patient-Physician Relationship exists, and in the physicians' professional opinion in accordance with accepted professional standards and practice, the person's care and support requirements can be effectively and appropriately delivered by Video or Telephone.

Existing/Ongoing Patient-Physician Relationship means:

1. Where a physician is providing a Virtual Care Service to a patient where there has been at least one insured service with a direct physical encounter between the patient and that physician (Family and General Practice Physician or *specialist*) in the preceding 24-months; or
2. Where a physician is providing a Virtual Care Service to a patient who has signed the *MOH*'s Patient Enrollment and Consent to Release Personal Health Information form and is enrolled to that physician or another physician within the same group (who is signatory/locum to a *MOH* alternate funding plan agreement); or
3. Where a *specialist* or GP Focused Practice Physician is providing a consultation by Video set out in Appendix J – Section 1, or has provided any such consultation in the preceding 24-months to that patient; or

[Commentary]:

Where the visit leading to the referral for consultation has occurred virtually, it would be expected that the referring physician has an established relationship with the patient and that the clinical issue leading to the referral has been assessed in-person within the previous 12-months.]

[Commentary]:

A consultation billed as an insured service under K083 or as an uninsured service funded under the Ontario Virtual Care Program and rendered prior to December 1, 2022, is considered evidence of an Existing/Ongoing Patient-Physician Relationship.]

[Commentary]:

Where a physician who has been paid for a consultation for the patient for the same diagnosis makes a request for a *referral* for ongoing management of the patient, the service rendered following the *referral* is not payable as a consultation, unless the request for *referral*, if the *referral* is made, allows for an ongoing patient physician relationship in the context of a consultation by Video.]

4. Where a physician provides any of the following services, or has provided any of the following services in the preceding 24-months:

- A920 – Medical management of early pregnancy - initial service by Video or Telephone,
- A945/C945 – Special palliative care consultation by Video,
- A680/C680 – Initial assessment - substance abuse by Video,
- A814, A817, A818 – Midwife or Aboriginal Midwife-Requested Assessments (MRAs) by Video,
- A802 – Extended midwife or Aboriginal Midwife-requested genetic assessment by Video,

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

- A801 – Comprehensive midwife or Aboriginal Midwife-requested genetic assessment by Video,
- A800 – Midwife or Aboriginal Midwife-requested genetic assessment by Video,
- A253 – Optometrist-Requested Assessment (ORA) by Video,
- A256 – Special optometrist-requested assessment by Video,
- A957 – Addiction medicine FPA by Video,
- K680 – Substance abuse – extended assessment by Video.

[Commentary:

1. Follow-up Virtual Care Services provided in the 24-months subsequent to the services listed in 3 or 4 may be claimed as Comprehensive Virtual Care Services.
2. A special palliative care consultation billed as an insured service under K092/K093 and rendered prior to December 1, 2022, is considered evidence of an Existing/Ongoing Patient-Physician Relationship.]

GP Focused Practice Physician means, for the purpose of eligibility to provide a focused practice consultation by Video (A010, A011, A906, A913, A914), a physician who has been designated by the bi-lateral MOH-OMA GP Focused Practice Review Committee or a physician who is eligible for the focused practice psychotherapy premium.

Limited Virtual Care Service means a Virtual Care Service rendered where an Existing/Ongoing Patient-Physician Relationship does not exist, and in the physicians' professional opinion in accordance with accepted professional standards and practice, the person's care and support requirements can be effectively and appropriately delivered by Video or Telephone.

Verified-Virtual Visit Solution means virtual service delivery platforms listed on Ontario Health's public list of verified solutions.

Virtual Care Service means a service provided using information technologies to render eligible services to patients remotely.

Eligible Virtual Care Service modalities are:

Telephone means synchronous audio-only communication (no visualization); and

Video means 2-way synchronous video-conference (audio and Video visualization) using a Verified-Virtual Visit Solution;

Terms and Conditions for Virtual Care Services

1. Other than a direct physical encounter, all other requirements and conditions for the appropriate service as described in the *Schedule* must be met.
2. Virtual Care Services are *not eligible for payment* where it is not medically appropriate to provide the specific service without a direct physical encounter.
 - a. If during the course of a Virtual Care Service it becomes apparent that the service cannot be appropriately completed without a direct physical encounter, the Virtual Care Service is *not eligible for payment* (only the service with a direct physical encounter is eligible for payment).

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

- b. Where a patient requests a virtual visit (is not willing to present in-person, despite the physician's advice and availability), physicians may submit a claim for the appropriate fee code for the service that was rendered virtually.
- 3. Video services are *only eligible for payment* when performed using a Verified Virtual Visit Solution.

[Commentary:

Ontario Health's public list of verified solutions is available at: <https://www.ontariohealth.ca/our-work/digital-standards/virtual-visits-verification-standard/vendor-list.>]

- 4. All other insured services that are rendered by Video or Telephone to insured persons and that are not Comprehensive Virtual Care Services, Limited Virtual Care Services, or specifically listed as insured services or are a component of an insured service are *not eligible for payment*.
- 5. Virtual Care Services are *not eligible for payment* unless the delivery modality is documented on the patient's medical record.
- 6. Virtual Care Services are *not eligible for payment* unless initiated by the patient or the *patient's representative*, or the service represents a medically necessary follow-up visit to a preceding visit initiated by the patient or the *patient's representative*.

[Commentary:

As per GP15, following an insured service, discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by Telephone or otherwise, on matters related to the service is a specific element of the preceding service and should not be separately claimed. This includes reporting results of related procedures and/or assessments (when professionally appropriate to report without additional patient assessment) and monitoring the patient's condition remotely until the next medically necessary assessment.

For clarity, administrative staff may co-ordinate appointments and organize care in a manner analogous to in-person encounters without violating this condition. Similarly, medically necessary follow-up services may be organized by the provider (or by their staff) without violating the condition. However, a physician-initiated call to "check-in" on a patient would not be eligible for payment, nor would any telephone calls or Video encounters conducted for administrative purposes (such as to inform patients of clinic closures or the availability of remote services).

Furthermore, services are not eligible for payment when initiated by the physician (or the physician's staff) without a clear and medically necessary reason for doing so. For example, the communication of normal lab work, unless medically necessary (in so far as the clinical management of the patient is altered) should not be billed.

Physician-initiated communication to provide advice or guidance regarding a previously rendered service is also not separately eligible/ billable. A common example of this would occur when a patient is provided with a prescription along with instruction to fill it only upon receipt of a positive test result. The call to inform the patient of the test result is not eligible for payment as it would be considered a Specific Element of the initial (refer to: item F, GP15, Schedule of Benefits).

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

As a general rule, the provider should consider whether the remote encounter would have occurred in their “in-person” practice. In circumstances where an in-person encounter would not have taken place, it is unlikely that a claim for a virtual service could be supported.

Consultations, which arise from requests from other providers, would not violate the condition in so far as the patient would have assented to the referral as part of their discussion with the referring provider.]

7. Virtual Care Services are *not eligible for payment* unless personally performed by the physician or rendered in accordance with the payment rules regarding supervision of a Medical Trainee.
8. Virtual Care Services are *not eligible for payment* for services provided to hospital inpatients or patients in a Long-Term Care institution unless all of the following requirements have been met:
 - The physician providing the service is not the patient's MRP.
 - The hospital/Long-Term Care institution does not have a physician on staff and present in the community with the expertise to render the necessary service, as documented by the referring physician in the patient's medical record.
 - An assessment with a direct physical encounter by the referring physician must have been completed within 30 days preceding a virtual in-patient *specialist* consultation to confirm the need for a consultation.
9. Services involving a direct physical encounter must be made available by the physician providing Comprehensive Virtual Care Services, or by the physician's group, within a clinically appropriate time-frame, if it becomes apparent during a Virtual Care Service that a service involving a direct physical encounter is medically necessary, or if at the time of scheduling the service the patient expresses preference for a service involving a direct physical encounter.

[Commentary:

For the purpose of this provision, with respect to *specialist* and GP Focused Practice Physicians, a group is defined as: those physicians in the same hospital specialty call rotation, or who are co-located in shared clinical physical space, and have shared access to the patient's medical record. For family and general practice physicians, a group is defined as: Patient Enrollment Model physicians who are signatory or contracted to the same specific group contract (i.e., as identified by the same group billing number), or those physicians who are co-located in a shared clinical physical space and have shared access to the patient's medical record].

10. If during the course of a Virtual Care Service the modality changes (for example, a Telephone service transitions into a Video service), only the service performed by the modality that represents the greater part (more than 50%) of the time spent providing the Virtual Care Service is payable. For *time-based services*, the combined time of both modalities will be used to calculate the number of time units eligible for payment.
11. For *time-based services*, only time spent in direct communication with the patient or the patient's representative in the provision of the insured service will be used to calculate the number of time units eligible for payment.

[Commentary:

Both the patient and physician must be located in Ontario for the services to be insured and payable under OHIP (see section 37.1 of Regulation 552 under the HIA).]

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

Claims submission instructions:

Comprehensive Virtual Care Services rendered within an Existing/Ongoing Patient-Physician Relationship must be claimed using the fee codes listed in Appendix J – Section 1.

Claims submitted for Comprehensive Virtual Care Services must include the modality indicator that identifies the technology used to deliver the service:

K300A – identifies Video technology used during the service

K301A – identifies Telephone technology (audio only) used during the service

Submit claims for Comprehensive Virtual Care Services using the in-person fee value regardless of whether the service is rendered by Video or Telephone. Payments for Telephone services will be automatically reduced as set out below.

Limited Virtual Care Services rendered outside of an Existing/Ongoing Patient-Physician Relationship must be claimed using the fee codes listed in Appendix J – Section 2.

Payment rules:

Comprehensive Virtual Care Services rendered by Video are payable at fees that are equivalent to the corresponding in-person fees for those services; or for Limited Virtual Care Services, the fees listed in Appendix J – Section 2 that correspond to those services.

The amount payable for Comprehensive Virtual Care Services rendered by Telephone is 85% of the corresponding in-person fee except for K007, K005, K197 and K198 which will be payable at 95% of the corresponding in-person fee.

Comprehensive Virtual Care Services – Virtual Only Fee Codes

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) by Video

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) by Video is an assessment of a mother or *newborn* provided by a physician upon the written request of a midwife or Aboriginal Midwife because of the complex, obscure or serious nature of the patient's problem and is payable to a family physician or obstetrician for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient's permanent medical record. The MRA must include the common and *specific elements* of a specific assessment by Video and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or Aboriginal Midwife, and in writing to both the midwife or Aboriginal Midwife and the patient's primary care physician, if applicable. Maximum one MAMRA (A814 or A813) per patient per physician per pregnancy.

A814 Midwife or Aboriginal Midwife-Requested Assessment
(MAMRA) by Video.....

111.70

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video

Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video must include constituent elements of A814 and is payable in any setting:

- a. to a paediatrician for an urgent or emergency assessment of a *newborn*; or
- b. to a family physician or obstetrician for assessment of a mother or *newborn* when, because of the very complex, obscure or serious nature of the problem, the physician must spend at least 50 minutes in direct 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 A814. Maximum one MAMRSA (A817 or A815) per patient per physician per pregnancy.

A817 Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video 186.95

Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video

Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video is an assessment of a mother or *newborn* provided by an anaesthesiologist upon the written request of a midwife or Aboriginal Midwife because of the complex, obscure or serious nature of the patient's problem and is payable to an anaesthesiologist for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient's permanent medical record. The MRAA must include the common and *specific elements* of a specific assessment by Video and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or Aboriginal Midwife and in writing to both the midwife or Aboriginal Midwife and the patient's primary care physician, if applicable. Maximum one MAMRAA (A818 or A816) per patient per anaesthesiologist per pregnancy.

A818 Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video 106.80

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

GENERAL LISTINGS

Focused practice consultation by Video

Focused practice consultation by Video is a consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

A010 GP focused practice consultation by Video 87.90

Focused practice repeat consultation by Video

Focused practice repeat consultation by Video is a repeat consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

A011 GP focused practice repeat consultation by Video 45.90

Focused practice limited consultation by Video

Focused practice limited consultation by Video is a limited consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

A906 GP focused practice limited consultation by Video 73.25

Focused practice special consultation by Video

Focused practice special consultation by Video is a consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function and who spends a minimum of 50 minutes of direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A913 GP focused practice special consultation by Video 150.70

Focused practice comprehensive consultation by Video

Focused practice comprehensive consultation by Video is a consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function and who spends a minimum of 75 minutes of direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A914 GP focused practice comprehensive consultation by Video ... 226.05

[Commentary:

Required elements of consultations are set out under the heading Consultations in the General Preamble.]

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

Limited Virtual Care Services

Definitions/Required Elements of Service

A Limited Virtual Care Service is an assessment which includes at a minimum, history-taking and medically appropriate exam to arrive at a diagnosis and provide an appropriate management plan and/or management, and when provided, the other specific elements of assessments.

A101	Limited Virtual Care by Video	20.00
A102	Limited Virtual Care by Telephone.....	15.00

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

VIRTUAL CARE SERVICES – PREMIUMS AND MANAGEMENT FEES

Premiums

The applicable premium(s) listed in the Premiums Table below are payable to physicians when providing eligible Comprehensive Virtual Care Services:

Applicable Premium	Descriptor	Premium Payable
E060	Post renal transplant assessment premium	25% of fee for virtual service
E078	Chronic Disease Assessment Premium	50% of fee for virtual service
E080 (video only)	First visit by primary care physician after hospital discharge	\$25.25
E088	Congestive heart failure premium	50% of fee for virtual service
E098	Gastroenterology chronic disease assessment premium	28% of fee for virtual service
K187	Acute post-discharge community psychiatric care	15% of fee for virtual service
K188	High-risk community psychiatric care	15% of fee for virtual service
K189 (video only)	Urgent community psychiatric follow-up	\$216.30
E079	Smoking cessation: Initial discussion with patient, to eligible services	\$13.20 for phone and \$15.55 for video
Age-Based Fee Premiums	-	10-30% of fee for virtual service
Focused Practice Psychotherapy Premium	-	17% of fee for virtual service
Internal Medicine Office Assessment Premium	-	12% of fee for virtual service
FHG In-Basket Premium	-	10% of fee for virtual service

CONSULTATIONS AND VISITS

VIRTUAL CARE SERVICES

Management Fees

Comprehensive Virtual Care Services are included as a consultation or assessment for the purposes of meeting the requirements for payment of the applicable management fee(s) listed in the Management Fees for Services by Telephone or Video Table below.

[Commentary:

All requirements and conditions for the appropriate management fee as described in the *Schedule* must be met.]

Fee Code	Descriptor
K045	Endocrinology & Metab/Internal Med-Diabetes management by a <i>specialist</i> -annual
K046	Endocrinology & Metab/Internal Med-Diabetes team management-annual
Q040	GP/FP-Diabetes management incentive-annual
K119	Paediatrics-Paediatric developmental assessment incentive-annual
K481	Rheumatology-Rheumatoid arthritis management by a <i>specialist</i> -annual
K682	Opioid Agonist Maintenance Program monthly management fee-intensive, per month
K683	Opioid Agonist Maintenance Program monthly management fee-maintenance, per month
K684	Opioid Agonist Maintenance Program-team premium, per month, to K682 or K683 add
K030*	Diabetic management assessment

Payment rules:

* A virtual K030 is only eligible for payment if a K030 involving a direct physical encounter has been performed in the preceding 12 months.

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

General Listings

A055 Consultation.....	125.60
------------------------	--------

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
--	--------

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
---	--------

Medical record requirements:

For A050 and A400, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1.A050 and A400 must satisfy all the elements of a consultation (see General Preamble GP16).

2.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 GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C055 Consultation.....	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

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

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	34.10
C057	- sixth to thirteenth week (maximum 3 per patient per week)	per visit	34.10
C059	- after thirteenth week (maximum 6 per patient per month)	per visit	34.10

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment.....	61.15
C123	- second day following the hospital assessment	61.15
C124	- day of discharge.....	61.15

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

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	61.15
C143	- second subsequent visit by the MRP following transfer from an intensive care area.....	61.15
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	34.10
C058	Concurrent care.....	34.10
C982	Palliative care (see General Preamble GP50)	34.10

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 inpatients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

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

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

Note:

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

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W052	- first 4 subsequent visits per patient per month	per visit	34.10
W051	- additional subsequent visits (maximum 6 per patient per month).....	per visit	34.10
W982	- palliative care (see General Preamble GP50).....	per visit	34.10

Nursing home or home for the aged

W053	- first 2 subsequent visits per patient per month	per visit	34.10
W058	- additional subsequent visits (maximum 3 per patient per month)	per visit	34.10
W972	- palliative care (see General Preamble GP50).....	per visit	34.10
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	34.10

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)	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	670.55	7

[Commentary:

1. For Extracranial approach to include balloon catheter techniques see N107 in Neurological Surgical Procedures.
2. For Carotid-cavernous fistula; extracranial approach to include balloon catheter techniques see N118 in Neurological Surgical Procedures.]

# J058	Vascular stenting	101.55	6
--------	-------------------------	--------	---

Note:

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

# J066	Renal angioplasty	504.40	6
--------	-------------------------	--------	---

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.....	44.00	6
# J048	Percutaneous trans-hepatic catheter portal venography	311.05	6

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

ANGIOGRAPHY

		Spec	Anae
Peripheral arteriogram			
# J027 - direct puncture.....		76.55	6
Peripheral venogram			
# J026 - direct puncture.....		70.80	6
# J033 Splenoportogram		128.35	6
# J034 Trans-lumbar aortogram		89.90	6
Vertebral angiogram			
# J032 - direct puncture or by retrograde brachial injection		111.50	6
Embolization (e.g. for treatment of haemangioma or renal carcinoma)			
# J040 - first vessel, claim appropriate angiographic procedural and radiological fees plus.....		121.25	
# J047 - each additional vessel catheterized and occluded per vessel.....		56.80	
# 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....		34.00	
# J035 Pressure measurements during angiography.....		34.00	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
# J001	Arthrogram, tenogram or bursogram	34.00	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..... add	21.75	
# J020	- with posterior fossa views	add	23.85
# J012	Nephrotomogram.....	-	6
# J060	Nephrostogram.....	34.00	
# J045	Percutaneous antegrade pyelogram.....	140.55	6
# J055	Percutaneous gastrostomy	257.60	
# J061	Percutaneous cecostomy	257.60	
# J062	Percutaneous cholecystostomy	257.60	
# J063	Percutaneous jejunostomy	298.80	
# J064	Exchange of drainage tubes, including supervision, imaging and hard copy film interpretation if any	72.65	
# J046	Percutaneous nephrostomy.....	257.60	6
# J041	Percutaneous removal of intravascular and intraureteric foreign bodies	339.90	IC
# J065	Dilation of non-vascular structures	23.60	6
# J059	Non-vascular stenting	116.90	
# J069	Percutaneous focal thermal ablation of solid tumours using CT or ultrasound guidance	515.70	

Payment rules:

1.J069 is *only eligible for payment* for focal thermal ablation of solid tumours in patients meeting clinical criteria consistent with current clinical practice guidelines

2.J069 includes any image guidance, when rendered, by any physician. Obtaining and interpreting any images in conjunction with J069 are *not eligible for payment* to any physician.

[Commentary:

Physicians should consult Ontario Health/Cancer Care Ontario's Focal Tumour Ablation in Ontario: Recommendations Report 2015 or subsequent guidelines to verify clinical indications for J069 <https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/48981>]

# J051	Percutaneous spinal cord puncture for syringogram	108.90	6
# J013	Percutaneous trans-hepatic cholangiogram	121.25	6
# J057	Transjugular intrahepatic portosystemic shunt (TIPS).....	906.45	7
# J052	Positive contrast cisternogram.....	99.90	6
Z597	Intracavitary/intratumoural injections	103.75	7
# J039	Renal cyst puncture	140.40	6
# J018	Sialogram.....	52.25	6
# J007	Tomogram.....	-	7

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
# J028	Urethrogram and/or urethrocytogram and/or or intestinal conduit examination, cystogram.....	34.00	
# J029	Vasogram.....	69.00	6

Note:

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

DIAGNOSTIC ULTRASOUND

PREAMBLE

SPECIFIC ELEMENTS

Diagnostic Ultrasound procedures are divided into a *professional component* listed in the columns headed with a "P", and a *technical component* listed in the column headed with an "H". The *technical component* of the procedures subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" on page GP11, is *eligible for payment* only if the service is:

- a. rendered at a hospital; or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

In addition to the *common elements*, the components of Diagnostic Ultrasound procedures include the following *specific elements*.

For Professional Component

- A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate.
- B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.
- C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect of D that is performed at a place other than the place in which the procedure is performed.

Note:

1. Element D must be personally performed by the physician who claims for the service.
2. If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician.
3. Where the only component provided is interpreting the results of the diagnostic procedure, the *specific elements* A and C listed for the *professional component* are included in the *specific elements* of the technical component.

For Technical Component H

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure(s).
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or *patient's representative*, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring provider.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional 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). Costs for the *technical component* of these services are only billable under the *Integrated Community Health Services Centres Act, 2023* and are listed in the Schedule of Facility Costs.
3. A-Mode - implies a one-dimensional ultrasonic measurement procedure.
4. M-Mode - implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
5. Scan B-Mode - implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display. All ultrasound examinations include a permanent record and interpretative report.
6. If insured diagnostic ultrasound procedures yield abnormal findings or if they would yield information which in the opinion of the interpreting physician would be insufficient governed by the needs of the patient and the requirements of the referring provider or practitioner, the interpreting physician may add further views and claim for them (if listed).
7. All benefits listed apply to unilateral examinations unless otherwise specified. When imaging of only one anatomical area is requested, comparison ultrasound(s) initiated by the interpreting physician or facility are *not eligible for payment*.

[Commentary:

Ultrasound services are not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the *Act*.]

DIAGNOSTIC ULTRASOUND

HEAD AND NECK

H P

Brain

J122 - complete, B-mode 47.20 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

Note:

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

Abdomen and Retroperitoneum

Abdominal scan

J135 - complete 48.75 26.45

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	33.80
J160	- for high risk pregnancy or complications of pregnancy	48.75	32.25
J166	- multiple gestation, for each additional fetus, to J160 add	41.45	22.10

Gestational age for Maternal Serum Screening Program

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

Limited

J158	- for high risk pregnancy or complications of pregnancy	32.10	17.55
J167	- fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158	32.10	30.00

Payment rules:

J167 is *only eligible for payment* when rendered by a physician for assessment of:

- a. fetal anemia, or
- b. intrauterine growth retardation
 - i. with estimated fetal weight OR abdominal circumference measuring below the 10th percentile, or
 - ii. >=30 percentile decrease in estimated fetal weight since previous imaging, or
- c. in high-risk pregnancies.

J168	- nuchal translucency for Prenatal Genetic Screening (maximum one per pregnancy)	39.00	20.85
J169	- multiple gestation, for each additional fetus, to J168 . add	33.15	16.35

Payment rules:

Ultrasound services listed under the headings "Abdomen and Retroperitoneum" or "Pelvis" or "Pregnancy" rendered on the same day to the same patient by any physician as J168 are *not eligible for payment*.

DIAGNOSTIC ULTRASOUND

PELVIS

H P

Pelvis

J162 - complete*	48.75	26.55
J138 Intracavitory ultrasound* (e.g. transrectal, transvaginal)	48.75	26.50

Note:

*For ovulation induction purposes, the limit is one per cycle. Additional ultrasounds may be claimed as J164.

J165 Transvaginal sonohysterography - may include saline or other 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 J47 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
---	-------	-------

Intracavitory ultrasound

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

Note:

1. For residual urine measurement by ultrasound (G900), see Diagnostic and Therapeutic Procedures, section J, Urology.
2. Residual urine measurement by ultrasound (G900) is *not eligible for payment* when rendered with an ultrasound of the pelvis or intracavitory ultrasound.

J164 Follicle monitoring studies	24.40	12.30
--	-------	-------

[Commentary:

Ultrasound services are not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the *Act*.]

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
------	---	------	------

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
------	-------------------------------	-------	-------

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 provider.

Duplex assessment of patency obstruction, and flow direction of vascular shunts

J207	- must include doppler interrogation and documentation of vascular shunts	22.05	14.20
------	---	-------	-------

Note:

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

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
------	------------------------------	------	------

Penile Doppler Evaluation

J199	- doppler scan	6.85	7.80
------	----------------------	------	------

Note:

Penile Doppler is only insured for the following indications:

- 1.priapism;
- 2.trauma;
- 3.revascularization;
- 4.primary erectile dysfunction; or
- 5.failure of both oral and injectable therapy for erectile dysfunction.

[Commentary:

Penile Doppler performed for other indications is not an insured service.]

Transcutaneous tissue

J203	- oxygen tension measurements	24.10	5.50
J204	- when done in addition to Doppler studies	13.20	5.50

DIAGNOSTIC ULTRASOUND

MISCELLANEOUS

	H	I	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
--	----------	---	-------

Note:

E475 is payable on a per unit basis. Unit means $\frac{1}{4}$ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

J290 - Spinal sonography.....	-	30.60
-------------------------------	---	-------

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 GP11, is *eligible for payment* only if the service is:

- a. rendered at a hospital; or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

The *technical component "T"* of the procedure is *eligible for payment* for services rendered in a physician's office or a hospital with the latter subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" and "Payment for Diagnostic and Therapeutic Services Rendered at a Hospital" on page GP11.

In addition to the *common elements*, the components of Pulmonary Function diagnostic procedures include the following *specific elements*.

For Professional Component P

- A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.
- B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.
- C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician, who must personally perform the service.

Element D must be personally performed by the physician who claims for the service.

For Technical Component H and T

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or *patient's representative*, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring provider.

PULMONARY FUNCTION STUDIES

PREAMBLE

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional 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). Costs for the *technical component* of services rendered in an *ICHSC* are listed in the Schedule of Facility Costs.
3. Each of the following tests designated by an individual code number is considered to be specific and requires individual ordering.
4. Exercise assessment (J315, E450, E451, J316) requires a physician to be in attendance at all times.
5. The technical and professional fee components for pulmonary function studies are *not eligible for payment* in the routine preoperative preparation or screening of a patient for non-thoracic surgery unless required for respiratory diagnosis, 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)	9.85	7.85
J324	- repeat after bronchodilator.....	2.97	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	19.60	11.55
J327	- repeat after bronchodilator.....	2.97	6.90

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	18.90
J307	- by body plethysmography	17.50	19.20

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	17.25
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	19.40
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..... add	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	11.35
J334	- J332 with at least two levels of supplemental O ₂	30.55	16.85
J336	- with single blind assessment of exercise on room air and with supplemental oxygen	30.55	16.85

Note:

- 1.J323 is *not eligible for payment* when rendered with J332, J315, J316, G315, G319, G111, G112, G570, G571, G582, G583, G574, G575 or any overnight sleep study.
- 2.J332 is *not eligible for payment* when rendered with J315, J316, G315, G319, G111, G112, G570, G571, G582, G583, G574, G575 or any overnight sleep study.
- 3.J336 is *only eligible for payment* for evaluation of a patient to determine eligibility for funding under the Ontario Home Oxygen Program.
- 4.J336 is not payable in addition to J332 or J334.
- 5.J301, J304, J324, or J327 are *not eligible for payment* when rendered to a patient who does not have symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

Medical record requirements:

J323, J332, J334 or J336 are *not eligible for payment* unless a permanent record of the study is maintained.

J322	Standard O ₂ consumption and CO ₂ production.....	5.30	6.45
J333	Non-specific bronchial provocative test (histamine, methacholine, thermal challenge)	48.25	37.35
J335	Antigen challenge test	51.85	30.95

Fee

Z459	Arterial puncture for blood gas analysis.....	10.20
------	---	-------

Note:

For *home/self-care ventilation listing* - see Diagnostic and Therapeutic Procedures page J51.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

SPECIFIC ELEMENTS

The *specific elements* of some of the services listed in this section are identified at the relevant listing. These services include some that are defined in terms of either an assessment or series of assessments.

The *technical component* "T" of the service if rendered in a hospital is subject to the conditions stated under "Payment for Diagnostic and Therapeutic Services Rendered at a Hospital" on page GP11.

- A. Where the services are not identified with prefix #, the *specific elements* are those listed in the General Preamble GP15.
- B. Where the services are identified with prefix #, the *specific elements* are those listed in the General Preamble GP15 except for specific element H. In place of H includes providing premises, equipment, supplies and personnel for any aspect(s) of the *specific elements* that is (are) performed in a place other than the place in which the included procedures are performed.

R prefix and Z prefix codes in this section are subject to the provisions found in the Surgical Preamble.

The remaining services in this section of the *Schedule* are either non-invasive diagnostic procedures, invasive diagnostic procedures or therapeutic procedures, the *specific elements* for which are listed below.

Non-Invasive Diagnostic Procedures (other than Laboratory Medicine)

Some non-invasive diagnostic procedures are divided into a *technical component* and a *professional component*. In addition to the *common elements*, the components of non-invasive diagnostic procedures include the following *specific elements*.

For Professional Component

- A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate.
- B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.
- C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

Note:

1. Element D must be personally performed by the physician who claims for the service.
2. If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician.
3. Where the only component provided is interpreting the results of the diagnostic procedure, the *specific elements* A and C listed for the *professional component* are included in the *specific elements* of the *technical component*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

For Technical Component

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure(s).
- C. Making arrangements for any appropriate follow-up care.
- D. Preparing and providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring provider.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the *technical* and *professional 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 provider.
- D. Making arrangements for any related assessments, procedures or therapy, including obtaining any specimens from the patient and interpretation of any results where appropriate.
- E. Where indicated, making or supervising the making of arrangements for follow-up care and post-procedure monitoring of the patient's condition, including intervening, until the next insured service is provided.
- F. Discussion with, and providing advice and information, including prescribing therapy to the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- G. Providing premises, equipment, supplies and personnel for the *specific elements*
 - 1. for services not identified with prefix #, for all elements.
 - 2. for services identified with prefix #, for any aspect(s) of A, B, D, E and F that is (are) performed in a place other than the place in which the procedure is performed.

OTHER TERMS AND DEFINITIONS

Services listed in the Diagnostic and Therapeutic Procedures Section are eligible for payment in addition to a consultation or assessment except where they are specifically listed as included in consultation or assessment services. When a procedure(s) is the sole reason for a visit, add G700, the basic fee-per-visit premium for those procedures marked (+) regardless of the number of procedures carried out during that visit. However, G700 is *not eligible for payment* to a physician in situations where:

- 1. a consultation or assessment is payable to the same physician for the same patient on the same day; and
- 2. that physician has a financial interest in the facility where the service is rendered.

Note:

- 1. G700 is *not eligible for payment* for a service provided in a hospital.
- 2. G700 is *not eligible for payment* when the service marked with (+) is *not eligible for payment*.
- 3. G700 is payable at 15% of the listed fee when the service is rendered to a patient who has signed the Ministry's Patient Enrolment and Consent to Release Personal Health Information form and who is enrolled to a physician or group of physicians who are signatories to a Ministry alternate funding plan agreement paying physicians primarily by capitation rather than fee for service, applicable regardless of which physician of the group renders the service to the enrolled patient.

	Fee
G700 Basic fee-per-visit premium for procedures marked(+)	5.60

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 GP15).

# G185 Drug(s) desensitisation - in a hospital where full cardioresuscitative equipment is readily available because a significant risk of life-threatening anaphylaxis exists. The service must be performed under direct and ongoing physician attendance.....	184.95
+ G200 Acute desensitisation, e.g. ATS, penicillin	8.65
+ G201 Direct nasal tests, to a maximum of 3 per year per test	1.60

Hyposensitisation

G202 - each injection	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
---	-------

Ophthalmic tests

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

Patch test

G206 - maximum of 90 per patient, per year	per test
G198 - for industrial or occupational dermatoses, to a maximum of 125 per patient, per year	per test
+ G207 Bronchial provocative testing - per session, to a maximum of 6 per year	14.15

Provocation testing

For foods, food additives and medications, by blinded or open technique, maximum 5 testing sessions per *12 month period*.

G208 Provocation testing	per unit
	21.25

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.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ALLERGY

Fee

[Commentary:

See General Preamble GP7 for definitions and time keeping requirements.]

G190 Serial oral or parenteral provocation testing to a food, drug or other substance when the service is rendered in a hospital, when an anaphylactic reaction is considered likely based on a documented history and the service is performed under direct and ongoing physician attendance	184.95
---	--------

[Commentary:

See G208 for similar services rendered in office.]

T

P

Skin testing

G209 - technical component, to a maximum of 50 per year	per test	0.72
G197 - professional component, to a maximum of 50 per year	per test	0.37

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
--	-------

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 GP94, no anaesthesia service other than E023C is eligible for payment when rendered in support of Z432.

[Commentary:

Refer to E023C on GP100 for anaesthesia services rendered in support of Z432.]

Z432 EUA with or without intubation, and may include removal of vaginal foreign body	54.10
Z430 Provision of anaesthetic services for patients undergoing magnetic resonance imaging	- 6

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

Fee | **Anae**

Vascular cannulation

Z459 Arterial puncture	10.20
# G268 Cannulation of artery for pressure measurements including cut down as necessary.....	31.25

Note:

G268 is *not eligible for payment* with G249, G259, G261, G176, G177, G178, G288, Z443 or Z440.

# G269 Cannulation of central vein for pressure measurements or for feeding line - not to be billed with right heart catheterization (Z439) or with Swan-Ganz catheter insertion.....	31.25
# G270 Intraosseous infusion.....	23.90
# G309 Umbilical artery catheterization (including obtaining of blood sample).....	45.55

Venipuncture

+ G480 - infant.....	9.90
+ G482 - child	7.35
+ G489 - adolescent or adult	3.54

Note:

G489 is not insured when rendered for the monitoring of adverse effects resulting from a calorie restricted weight loss program.

+ G483 Therapeutic venisection.....	9.70
G282 Umbilical vein catheterization (including obtaining of blood sample).....	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	193.40	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.....	85.25	6
# E684 - when performed in infant or child, to Z456 or Z446add	214.10	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

Fee

Anae

FOR ANTICOAGULANT SUPERVISION - LONG-TERM, TELEPHONE ADVICE

In addition to the *common elements*, the components of this service include the following *specific elements*.

- A. Monitoring the condition of a patient with respect to anticoagulant therapy, including ordering blood tests, interpreting the results and inquiry into possible complications.
- B. Adjusting the dosage of the anticoagulant therapy and, where appropriate, prescribing other therapy.
- C. Discussion with, and providing advice and information to the patient or patient's representative, by telephone, on matters related to the service even when initiated by the patient or patient's representative.
- D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.
- E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G271 Anticoagulant supervision - long-term, telephone advice
..... per month

12.75

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

Fee | **Anae**

BLOOD TRANSFUSIONS

# G275 Exchange transfusion	205.45
-----------------------------------	--------

Note:

Assistant at exchange transfusion (see General Preamble GP85).

# G280 Intra-uterine fetal transfusion - initial or subsequent.....	186.90
---	--------

G276 Donor cell pheresis (platelets or leukocytes).....	15.35
---	-------

Therapeutic plasma exchange

# G277 - initial and repeat, to a maximum of 5 per yeareach	82.00
---	-------

# G278 - more than 5 per yeareach	41.80
---	-------

# G272 Manual plasmapheresis (see General Preamble GP12)	I.C
--	-----

LDL apheresis

# G287 - initial and repeat, to a maximum of 5 per yeareach	82.00
---	-------

# G290 - more than 5 per yeareach	41.80
---	-------

Note:

LDL apheresis is an insured service only for the treatment of homozygous familial hypercholesterolemia.

CARDIOVERSION

# Z437 Cardioversion (electrical and/or chemical) - maximum of three sessions per patient, per day	92.45	6
--	-------	---

CARDIAC CATHETERIZATION

Note:

1. Cardiac catheterization procedures (Z439 to G288) include insertion of catheter (including cutdown and repair of vessels if rendered), catheter placement, contrast injection, imaging and interpretation.

2. When more than one procedure is carried out at one sitting, the additional procedures are payable at 50% of the listed benefits. (Z439 to G288, excluding G262 and G263).

HAEMODYNAMIC/FLOW/METABOLIC STUDIES

Right heart

# Z439 - pressures only	166.90	6
-------------------------------	--------	---

Left heart

# Z440 - retrograde aortic	208.50	7
----------------------------------	--------	---

# Z441 - transeptal.....	297.15	7
--------------------------	--------	---

# G296 Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab	110.95
---	--------

# G285 Dye dilution densitometry when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438	32.90
--	-------

# G286 Thermal dilution studies when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438	32.90
---	-------

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

Fee Anae

Note:

1. G296 is *not eligible for payment* on the same patient, same day as Z438.
2. G296, G299 and/or G289 are *not eligible for payment* with anaesthesia services rendered for a surgical procedure.
3. G285 or G286 are *not eligible for payment* on the same patient, same day as G296.
4. G285 is limited to a maximum of three services per Swann-Ganz insertion.

# G299 Oximetry studies by catheterization.....	110.95
# G289 Fick determination	110.95
# G300 Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations.....	110.95
# G301 Exercise studies during catheterization	122.40
# G306 Isotope studies during cardiac catheterization.....	110.95
# G305 Intracardiac phonocardiography	122.40

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.....	117.55
---	--------

Bypass graft angiogram

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

Note:

Includes internal mammary artery implant.

Selective coronary catheterization

# Z442 - both arteries	286.75	6
# G263 - with other drug interventional studies	96.45	

Note:

Includes injection of intracoronary nitroglycerin.

Transluminal coronary angioplasty

# Z434 - one or more sites on a single major vessel	467.05	6
G262 - each additional major vessel..... add	210.40	

Note:

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

# G298 Coronary angioplasty stent, per stent.....	78.95
---	-------

Note:

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

Percutaneous angioplasty

# Z448 - aortic valve, pulmonic valve, pulmonary branch stenosis ..	487.90	20
# Z449 - for coarctation of aorta	415.15	20
# Z460 - closure of patent ductus 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
--	--------

Arrhythmia induction

To include programmed electrical stimulation, drug provocation and termination of arrhythmia, if necessary - once per patient per 24 hours.

# G261 - atrial.....	331.05
# G259 - ventricular.....	383.30

Note:

G261and/or G259 are *not eligible for payment* with G521, G522, G523, G395 and G391.

Electrophysiologic Pacing, Mapping and Ablation

Includes percutaneous access, insertion of catheters and electrodes, electrocardiograms, intracardiac echocardiograms and image guidance when rendered.

# G176 - atrial pacing and mapping	334.25
# G177 - ventricular pacing and mapping	416.80
# Z423 - with the use of an advanced nonfluoroscopic computerized mapping and navigation system ("advanced mapping system") and/or procedure duration >4 hours	690.25 10

Note:

Z423 is *only eligible for payment* when rendered with G176 or G177.

[Commentary:

1. As of October 2009, the advanced mapping system is typically used in hospital for the mapping of the following arrhythmias:

Arrhythmias	Description
Atrial arrhythmia	Atrial fibrillation Atypical atrial flutter Post-surgical atrial flutter Atrial tachycardia Redo typical atrial flutter Redo reentrant tachycardia (accessory pathways, AV nodal reentry)
Ventricular arrhythmia	Ischemic ventricular tachycardia/premature ventricular ectopics Non-ischemic ventricular tachycardia/premature ventricular ectopics Idiopathic ventricular tachycardia/premature ventricular ectopics (e.g. fascicular, ARVD, bundle branch reentry, aortic cusp, outflow tract, etc.)
Other	Congenital heart disease arrhythmia

2. Examples of procedures lasting more than 4 hours and not utilizing the advanced mapping system are mapping and ablation of multiple accessory pathways and/or thick band accessory pathway(s).]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

Fee | **Anae**

Electrophysiologic pacing, mapping and ablation

# G178 - catheter ablation therapy.....	352.05
# G179 - repeat pacing, mapping and catheter ablation for additional distinct arrhythmia(s) without the use of an advanced mapping system	111.20

Note:

G179 is *not eligible for payment* with Z423.

# Z424 - transseptal left heart catheterization, with or without pressure measurements, with or without dye injection.....	297.15	6
--	--------	---

Note:

1.Z424 is *only eligible for payment* when rendered with G176, G177 and/or G178.

2.Z424 is eligible for payment for each transseptal catheter placement to a maximum of 2.

# Z422 - retrograde aortic left heart catheterization with or without pressure measurement(s)	210.55	6
---	--------	---

Note:

1.Z422 is *only eligible for payment* when rendered with G176, G177 and/or G178.

2.Z422 is limited to a maximum of one per electrophysiological pacing, mapping and/or ablation sitting.

G115 External cardiac pacing (temporary transthoracic) once per 24-hour period	46.30
--	-------

Note:

G115 is *not eligible for payment* with G521, G522, G523, G395 and G391.

# G366 Testing of arrhythmia inducibility by acute administration of anti-arrhythmic or adrenergic drugs to a maximum of 2 per 24 hours	148.50
---	--------

Note:

G366 is *not eligible for payment* for the use of isoproterenol for arrhythmia induction when rendered with G261 and/or G259.

# Z443 Insertion of temporary endocardial electrode	154.10	6
# Z431 Repositioning of temporary endocardial electrode	64.25	6

Endomyocardial Biopsy

# G288 - transvascular, right or left	200.00
---	--------

Tilt table testing of vasomotor syncope

# G314 - to include arterial cannulation, provocative and blocking drugs, physician must be continually present.....	112.00
--	--------

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

Fee

PREAMBLE

1. The *technical* and *professional* fee components for electrocardiogram, G310 and G313, are *not eligible for payment* in the routine preoperative preparation or screening of a patient for non-cardiac surgery unless the patient has at least one risk factor for cardiac disease or has known or suspected cardiorespiratory disease including dysrhythmias, unless there is a clinical indication requiring an ECG other than solely for preoperative preparation of the patient.

[Commentary:

1. Risk factors *may include* but are not limited to:

hypertension, diabetes, vascular disease, renal disease, hyperlipidemia, smoking history, older age.

2. ECG testing is not indicated prior to low risk surgery under local anaesthetic *with or without* procedural sedation such as cataract surgery unless there is an independent clinical indication unrelated to the surgery.]

G175 Insertion of oesophageal electrode in monitoring position..... 21.85

T

P

Electrocardiogram - twelve lead

G310 - technical component 7.00

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	45.95
G319 - professional component	62.05

Dobutamine stress test

G174 - technical component, when rendered outside of hospital	add	49.35
---	-----	-------

Dipyramidole Thallium stress test

G111 - technical component	53.60
G112 - professional component	74.25

Note:

1. The *technical* and *professional* fee components for maximal stress ECG are *not eligible for payment* in the routine preoperative preparation or screening of a patient for surgery where the patient will undergo a low risk procedure or has a low risk of perioperative cardiac complications, unless there is a clinical indication requiring a exercise stress test study other than solely for preoperative preparation of the patient.
2. G315, G319, G174, G111 and G112 are *uninsured 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 be 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 device capable of recording three or more simultaneous channels and the acquisition of a continuous ambulatory electrocardiographic recording of all beats, using three or more skin electrodes. The device must also have the ability to analyze and manually review all parts of the recording, and to produce graphical and quantitative reports of relevant parameters and diagnostic quality tracings for visual review, including post-hoc review of any portion of the recording to enable diagnostic rhythm analysis. Must include a patient diary and event marker capability to enable symptom-rhythm correlation. Minimum 12 hours of monitoring.

G651	- technical component - 12 to 35 hours recording	25.25
G652	- technical component - 12 to 35 hours scanning	34.55
G650	- professional component - 12 to 35 hours recording	47.90
G682	- technical component - 36 to 59 hours recording	50.50
G683	- technical component - 36 to 59 hours scanning	69.05
G658	- professional component - 36 to 59 hours recording	75.45
G684	- technical component - 60 hours to 13 days recording.....	75.70
G685	- technical component - 60 hours to 13 days scanning	103.60
G659	- professional component - 60 hours to 13 days recording ..	95.85
G647	- technical component - 14 or more days recording	119.00
G648	- technical component - 14 or more days scanning	173.20
G649	- professional component - 14 or more days recording	122.25

Level 2

All other monitoring devices with fewer than three skin electrodes, or that record only portions of the monitoring period or do not provide trend analysis. Minimum 12 hours monitoring.

G654	- technical component - 12 to 35 hours recording	24.05
G655	- technical component - 12 to 35 hours scanning	16.45
G653	- professional component - 12 to 35 hours recording	34.10
G686	- technical component - 36 to 59 hours recording	48.15
G687	- technical component - 36 to 59 hours scanning	32.95
G656	- professional component - 36 to 59 hours recording	51.15
G688	- technical component - 60 hours to 13 days recording.....	72.20
G689	- technical component - 60 hours to 13 days scanning	49.45
G657	- professional component - 60 hours to 13 days recording ..	68.20
G694	- technical component – 14 or more days recording	113.05
G695	- technical component – 14 or more days scanning	83.15
G696	- professional component – 14 or more days recording	86.80

Note:

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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

T P

2. Where the duration of the service is more than 36 hours, claims for such services must be submitted using the appropriate listed code for that time duration and cannot be submitted using multiples of lesser time duration codes.
3. G647, G648, G649, G694, G695 and G696 are *only eligible for payment* once per 30 day period per patient.
4. Services related to external cardiac loop recording devices that rely solely on patient activation to record electrocardiographic data and do not have the capability of real-time rhythm analysis are not insured.

Medical record requirements:

In order to demonstrate that payment requirements have been met, all test reports that form part of the patient record under this section must include the following information: the number of channels recorded, whether the recording was continuous, whether it was analyzed in real time, post-hoc or both and other information, such as, the name of the manufacturer and the model of the device(s) used in the performance of the test.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

T P

Interpretation of telephone transmitted ECG rhythm strip

G311 - technical component	2.03
G320 - professional component	4.30

Single chamber reprogramming including electrocardiography

G284 - technical component	9.30
G283 - professional component	11.30

Dual chamber reprogramming including electrocardiography

G181 - technical component	12.20
G180 - professional component	16.95

Pacemaker pulse wave analysis including electrocardiography

G308 - technical component	9.30
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
--	-------

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	10.90
G518 - professional component	11.20

Impedance plethysmography

G121 - technical component	13.25
G120 - professional component	7.00

Digital photoplethysmography

G127 - technical component, per extremity.....	13.25
G126 - professional component, per extremity	7.00

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GYNAECOLOGY

	Fee
G363 Cervical mucous penetration test	22.00
G378 Insertion of intrauterine contraceptive device	39.95
G552 Removal of intrauterine contraceptive device.....	20.00
E542 - when performed outside hospital	11.55

Payment rules:

G552 is not eligible for payment on the same day as G378.

+ G362 Insertion of laminaria tent	6.25
E870 - when laminaria tent supplied by the physician..... add	8.35
G334 Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (not eligible for payment same day as visit), to a maximum of 10 per cycleper call	4.05
G399 Transvaginal sonohysterography, introduction of catheter, with or without injection of contrast media	44.15

Note:

G399 is *only eligible for payment* when transvaginal sonohysterography professional and technical services (J165 or J476) are rendered (either by the same or another physician).

[Commentary:

1. See Diagnostic Ultrasound section page G6.
2. G334 is not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the Act.]

Cervical cancer screening

+ G365 Collection of cervical cancer screening specimen(s).....	12.00
E430 - when cervical cancer screening specimen(s) are collected outside of hospital or ICHSC, to G365..... add	11.95

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GYNAECOLOGY

	Fee
+ G394 Collection of additional cervical cancer screening specimen(s) for any of the following purposes:	
- Follow-up test once after low grade cytology results, where the follow-up specimen(s) are collected between March 3, 2025 and September 30, 2026; or	
- Once every 3 years for patients who are immunocompromised; or	
- Follow-up test once, a minimum of 24 months after testing human papillomavirus (HPV)-positive for other high risk subtype as defined by Ontario cervical cancer screening guidelines with normal/low grade cytology results; or	
- Follow-up test once, a minimum of 24 months after discharge from colposcopy when increased screening is recommended by Ontario cervical cancer screening guidelines; or	
- Repeat after an invalid HPV test or an unsatisfactory cytology test; or	
- Post-hysterectomy vaginal vault testing for patients with histologic evidence of dysplasia in the cervix at the time of hysterectomy; or	
- Where the physician is of the opinion that the patient is a member of a vulnerable group that may have difficulty accessing the services within the specified time period...	
E431 - when cervical cancer screening specimen(s) are collected outside of hospital or ICHSC, to G394	12.00
	add
	11.95

[Commentary:

E430 is payable when the requirements for G365 are met. E431 is payable when the requirements for G394 are met.]

Payment rules:

1. For G365 services provided between March 3, 2025 and March 31, 2028, G365 is limited to once per patient per 33 month period. For G365 services provided on or after April 1, 2028, G365 is limited to one per patient per 54 month period.
2. G365 is uninsured for patients less than 25 years of age.
3. G394 is limited to once per patient per lifetime for vaginal vault testing post-hysterectomy for patients with histologic evidence of dysplasia in the cervix at the time of hysterectomy.
4. G365 and G394 are *not eligible for payment* when performed in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment or routine post-natal visit when a pelvic examination is a normal part of the foregoing services. One of the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured collection of cervical cancer screening specimen(s) is performed outside of hospital or ICHSC.
5. G365 and G394 are *not eligible for payment* when performed in conjunction with an insured colposcopy service. One of the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured collection of cervical cancer screening specimen(s) is performed outside of hospital or ICHSC.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

GYNAECOLOGY

Fee

Medical record requirements:

Physicians claiming G394 must document the clinical indication for the service in the patient's medical record. G394 is *not eligible for payment* if this documentation is not present.

[Commentary:

1. Collection of cervical cancer screening specimen(s) in excess of the specified limits are not insured.
2. Cervical cancer screening is generally not recommended for patients over 70 years of age.
3. Ontario cervical cancer screening Guidelines can be found at <https://www.cancercare.on.ca/>
4. The Ontario cervical cancer screening guidelines define the immunocompromised screening population as people who:
 - a. Have a cervix; and
 - b. Are, or have ever been, sexually active; and
 - c. Are asymptomatic; and
 - d. Are part of any of the following populations at higher risk of pre-cancer and cervical cancer:
 - People who are living with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), regardless of viral load
 - People with congenital (primary) immunodeficiency
 - Transplant recipients (solid organ or allogeneic stem cell transplants)
 - People requiring treatment (either continuously or at frequent intervals) with medications that cause immune suppression for three years or more
 - People who are living with systemic lupus erythematosus (SLE), regardless of whether they are receiving immunosuppressant treatment
 - People who are living with renal failure and require dialysis.]

Z463 Removal of Norplant 65.30

Medical management of prolapse - Pessary

G398 Pessary fitting – initial or re-fitting 63.65

G550 Pessary care – pessary removal, care and reinsertion 10.00

Payment rules:

1. G398 is *eligible for payment* once per patient per 12-month period
2. G550 is *eligible for payment* up to 6 times per 12-month period
3. G550 is *not eligible for payment* for the same patient on the same day as G398
4. G398 or G550 are *not eligible for payment* when pessary removal is performed with no pessary care or reinsertion

[Commentary:

If applicable, a visit fee may be claimed in addition to pessary fitting or pessary care provided to the same patient during the same visit.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

HAEMATOLOGY

Fee

HAEMOGLOBINOPATHIES AND CONGENITAL HAEMOLYTIC ANEMIAS

Transfusion support

The service rendered for transfusion support, iron overload management and Sickle Cell crisis management and prevention related to Sickle Cell Disease, Thalassemia or transfusion dependent Congenital Hemolytic Anemia. The service includes routine outpatient visits (including, for example, supervised blood transfusions, iron chelation therapy, monitoring of complications of iron overload, pain management of acute or chronic Sickle Cell Disease) and any counselling/psychotherapy/genetic counselling of the patient, the patient's relatives or their representatives.

The *specific elements* of this service are all services performed by the specialist in charge of the patient during a one-week period in providing non-emergency care to the patient, including providing any advice whether by telephone or otherwise and even when initiated by the patient, patient's relative(s), or their representative(s) and including providing all premises, equipment, supplies and personnel used by the specialist in charge of the patient to perform these services.

G098 Transfusion support, per patient per week 32.35

Note:

When physicians are required to make emergency visits, the appropriate visits and premiums are eligible for payment. When the patient requires hospitalization, the appropriate fees for in-patient services are eligible for payment instead of G098.

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

Note:

When physicians are required to make emergency visits to see patients on any form of *home/* self care haemophilia infusion, the appropriate visits and premiums may be claimed. When the patient requires hospitalization, the appropriate fees for daily care and in-hospital infusions may be claimed instead of G100.

HOME/SELF-CARE VENTILATION

Home/self-care ventilation - to include positive and negative respirators and negative pressure respirators, diaphragmatic pacing devices and oscillating beds.

- a. services rendered by *most responsible physician*;
- b. includes routine clinic visits, *home* visits, telephone advice, communication with family and other medical personnel, care of supervised tracheostomy, counselling/psychotherapy of patients and relatives and supervised ventilation when required.

The *specific elements* of this service are all services performed by the *most responsible physician* during a one-week period in providing non-emergency care to the patient who is self administering ventilation therapy, including providing any advice and supervision in regard to self administration, whether by telephone or otherwise and even when initiated by the patient, or their representative and including providing all premises, equipment, supplies and personnel used by the *most responsible physician* to perform these services.

G101 Home/self-care ventilation, per patient per week 33.55

Note:

When physicians are required to make emergency visits to see patients on *home/self-care ventilation*, the appropriate visit and premium fees may be claimed. When the patient requires hospitalization, the appropriate fees for daily care and in-hospital ventilation may be claimed instead of G101.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

Fee

BOTULINUM TOXIN SERVICES

G869 Botulinum toxin injection(s) of bladder detrusor muscle	150.00
--	--------

Payment rules:

1. G869 is *only eligible for payment* for management of symptomatic refractory overactive bladder that has not been responsive to a minimum of three months of active treatment with behavioral modification or anticholinergics.
2. Only one G869 service is eligible for payment per patient per day and includes all injections necessary to deliver the total dosage (one treatment) that is recommended in current practice guidelines
3. G869 is *only eligible for payment* for one treatment per patient every 12 weeks. If, in the opinion of the treating physician, more frequent treatments are necessary, submit claim for manual review with supporting documentation. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

Medical record requirements:

Subsequent G869 services are only eligible for payment if the patient's response(s) to previous G869 services are documented in the permanent medical record.

[Commentary:

Z606 is eligible for payment with G869, if performed]

G870 Botulinum toxin injection(s) of extraocular muscle(s), (unilateral)	120.00
G871 Botulinum toxin injection(s) for blepharospasm, (unilateral or bilateral).....	120.00
G872 Botulinum toxin injection(s) for hemifacial spasm, (unilateral or bilateral).....	120.00
G873 Botulinum toxin injection(s) for spasmodic dysphonia	120.00
G874 Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral).....	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	30.60

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

		Fee
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. With the exception of G869, 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 G370 add	11.55
G328	Aspiration of bursa or complex joint, with or without injection	39.80
G329	- each additional bursa or complex joint, to a maximum of 2	20.25
E542	- when performed outside hospital, to G328 add	11.55
E446	- peripheral joint injection using image guidance following a failed blind attempt, to G370 or G371 add	30.00

Note:

1. For the purpose of G328 and G329, a joint is defined as complex only if it is:

- a. a joint other than the knee; or
- b. a knee joint in which the anatomy is distorted by disseminated lupus erythaematosus, dermatomyositis, rheumatoid arthritis, Still's disease, ankylosing spondylitis or other seronegative spondyloarthropathies.

2. E446 is *only eligible for payment* when injection of the joint must be repeated using any method of image guidance following a failed blind attempt(s) by the same or different physician. Professional and/or technical fees for obtaining and interpreting the images required for the purpose of guidance of the injection are *not eligible for payment* to any physician.

Payment rules:

1. G370, G371, G328 or G329 are *not eligible for payment* when rendered in conjunction with a surgical procedure involving the same site or area.
2. Only one of G370, G371, G328 and G329 is eligible for payment for the same bursa, joint or complex joint.
3. Aspiration and/or injection of the olecranon bursa is *only eligible for payment* as G370/G371.
4. G328/G329 are *not eligible for payment* solely for injection of complex joint.
5. G370, G371, G328, G329 are *uninsured 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

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	5.40
+ G841 Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric.....	6.35
+ G842 Hepatitis B (HB).....	5.40
+ G843 Human Papillomavirus (HPV).....	5.40
+ G844 Meningococcal C Conjugate (Men-C).....	5.40
+ G845 Measles, Mumps, Rubella (MMR)	5.40
+ G846 Pneumococcal Conjugate.....	5.40
+ G847 Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult	5.40
+ G848 Varicella (VAR).....	5.40
+ G538 Other immunizing agents not listed above.....	5.80
+ G590 Influenza agent	5.65
+ G593 COVID-19 vaccine	13.00

INTRALESIONAL INFILTRATION

+ G375 - one or two lesions	8.85
+ G377 - 3 or more lesions.....	13.30
G383 - extensive (see General Preamble GP12).....	I.C

Note:

Intralesional injection of acne lesions with corticosteroids is not an insured service.

G462 Administration of oral polio 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 <i>12 month period</i> .	
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 <i>not eligible for payment</i> .	
[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 <i>Schedule of Benefits</i> , 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 <i>rendered personally by the physician</i> .	
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 <i>not eligible for payment</i> in addition to G536 and G537.	
3. Assistant units nil for G536, G537.	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

Fee

SPECIFIC ELEMENTS

For Management of parenteral alimentation

In addition to the *common elements*, this service includes the *specific elements* of assessments (see General Preamble GP15). Not to be claimed in addition to hospital visits.

G510 Management of parenteral alimentation - physician in charge per visit	21.00
---	-------

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
---	-------

[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
--	--------

[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.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

INJECTIONS OR INFUSIONS

	Fee
G075 Test dose (bleomycin and l-asparatiginase) once per patient per drug	30.50
G390 Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy)	262.40

Monthly telephone supervision

G382 Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, monthly	13.95
--	-------

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

25.75

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

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 or preparing cervical cancer screening specimen(s) or interpreting a cervical cancer screening test.

G029 Antithrombin III assay	28.44
-----------------------------------	-------

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

LABORATORY MEDICINE

	Fee
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 <i>may include</i> any of the following: alcohol, methadone, methadone metabolite, morphine, a synthetic or semi-synthetic opiate, cocaine, benzodiazepines, amphetamines, methamphetamines, cannabinoids, barbiturates or any other drug of abuse.]	
G039 Creatinine	1.03
Payment rules:	
1. For the purposes of opioid agonist maintenance treatment, G040, G042, G041 and G043 are <i>only eligible for payment</i> 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 <i>Controlled Drugs and Substances Act</i> 1996.	
2. G040 and G041 are limited to a maximum of five (5) services per patient (any combination) per <i>month</i> 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 <i>month</i> 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 <i>month</i> 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 <i>month</i> for the same patient to any physician.	
5. G040, G041, G042 and G043 are <i>not eligible for payment</i> unless K623 or K624 or a consultation, assessment or time-based service involving a direct physical encounter with the patient is payable in the <i>same month</i> 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 <i>week</i> , any physician.	
7. G039 is <i>only eligible for payment</i> 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	6.40
G001 Cholesterol, total.....	5.70
G002 Glucose, quantitative or semi-quantitative.....	2.26
G481 Haemoglobin screen and/or haematocrit (any method or instrument)	1.37
G004 Occult blood.....	1.58
G005 Pregnancy test.....	3.88

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

LABORATORY MEDICINE

Fee

Payment rules:

1. G005 is only insured when an immediate determination of pregnancy is required to prevent imminent physical harm to the patient.

G009 Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)	4.45
G010 One or more parts of above without microscopy	2.64
G011 Fungus culture including KOH preparation and smear.....	13.05
G012 Wet preparation (for fungus, trichomonas, parasites).....	1.93
G014 Rapid streptococcal test	5.70

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.....	311.90
# G408 2nd to 10th day, inclusive per diem	155.90
# G409 11th to 21st day, inclusive per diem	77.95

Payment rules:

1. G412, G408, G409 are *not eligible for payment* following transplantation of an organ other than the kidney.

Note:

G412, G408, G409 includes complete patient care.

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 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
G260 Major plexus block	80.00

Payment rules:

1. The G260 service is a block of one of the following: brachial plexus, lumbar plexus, sacral plexus, deep cervical plexus, or a combined 3-in-1 block which must include the femoral, obturator and lateral femoral cutaneous nerves.
2. When a major plexus block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

[Commentary:

If a peripheral nerve block is performed that is not within the same nerve distribution of a major plexus block, then both blocks are eligible for payment. For example, a sciatic nerve block performed in addition to a combined 3-in-1 block.]

3. When 2 or more nerve blocks of major and/or minor peripheral nerves that are within the distribution of a major plexus are rendered individually, only G260 is eligible for payment.

[Commentary:

For example, if radial, median and ulnar nerve blocks are performed individually, only the brachial plexus block (i.e. major plexus block) is eligible for payment. If femoral, obturator and lateral femoral cutaneous blocks are performed individually, only the combined 3-in-1 (i.e. major plexus) block is eligible for payment.]

G060 Peripheral nerve block, major	55.00
--	-------

Payment rules:

1. The G060 service must consist of one of the following:
 - a 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;
 - a paravertebral block – first injection only;
 - an ankle block (must include 2 or more of the following: deep peroneal, superficial peroneal, posterior tibial, saphenous or sural nerve); or
 - 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
---	-------

Payment rules:

1. G279 is eligible for payment in addition to the applicable peripheral nerve or plexus block.
2. G260 is *not eligible for payment* in addition to G279 when rendered for a continuous combined 3-in-1 block; G060 is eligible for payment in addition to G279 in this circumstance.
3. No guidance (e.g. nerve stimulation, ultrasound) used for percutaneous nerve block catheter insertion is eligible for payment.

G066 Intrapleural block	55.00
-------------------------------	-------

G067 Intrapleural block with continuous catheter.....	80.00
---	-------

# G068 Epidural blood patch	125.00
-----------------------------------	--------

# G065 Epidural blood patch injected through existing epidural catheter	62.50
---	-------

G224 Nerve block by same physician performing the procedure.....	15.55
--	-------

[Commentary:

Refer to the Preamble of this section for additional information regarding G224.]

G247 Hospital visits, to a maximum of 3 per patient per day	30.10
---	-------

Payment rules:

G247 is *only eligible for payment* to the physician most responsible, or to a physician substituting for the physician most responsible, for providing management and supervision of a:

1. continuous catheter infusion for analgesia for a hospital in-patient; or
2. lumbar sub-arachnoid drainage catheter placed in association with a surgical procedure where there is increased risk of spinal cord ischemia.

[Commentary:

G247 is not for visits to patients solely receiving intravenous pain management, such as patient controlled analgesia alone; a continuous nerve/plexus block or epidural/spinal catheter must be present for G247 to be payable.]

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 or otherwise, on matters related to the service, regardless of the identity of the person initiating the discussion.
- D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.
- E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G064 Management and supervision of outpatient continuous nerve block infusion..... per day 20.00

Payment rules:

1. G064 is *only eligible for payment* when:
 - a. rendered by the physician most responsible for the patient's care or by a physician substituting for that physician (the "substitute physician"); and
 - b. the clinical decision(s) pertaining to the medical advice, direction or information provided is formulated personally by the physician or substitute physician.
2. G064 is *only eligible for payment* for a day when one or more components of element C are rendered in that day.
3. G064 rendered on the same day as a consultation or visit by the same physician is *not eligible for payment*.
4. G064 is limited to a maximum of 7 services per patient per G279 service.

Medical record requirements:

A dated summary of each contact must be recorded in the patient's permanent medical record or the service is *not eligible for payment*.

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 MOH. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy

# N556 First site	142.80	6
# E396 - each additional site to N556..... add	71.40	

Sacroiliac joint injections

G916 Percutaneous diagnostic and/or corticosteroid sacroiliac joint injection with fluoroscopic guidance, unilateral	75.00
--	-------

Nerve root injections

G917 Percutaneous diagnostic selective nerve root block with fluoroscopic guidance, with or without contrast – any number of sites.....	160.00
---	--------

Payment rules:

G917 is limited to a maximum of 1 service per patient per *week* and a maximum of 12 services per patient per *12 month period*.

# N534 Percutaneous radio frequency posterior dorsal root rhizotomy - any number of levels	379.45	8
--	--------	---

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 G918	add 16.60
E442 - when performed using a transforaminal technique, to G246, G117, G119 or G918	add 20.00
E443 - with catheter for continuous infusion, to G246, G117, G119 or G918	add 80.00
# E833 - with insertion of subcutaneous port, G117, G119, G246 or G918	add 116.10

Payment rules:

1. Percutaneous epidural injections are limited to 12 services per patient per *12 month period* for any combination of G119, G117, G246 and G918. If, in the opinion of the treating physician, more frequent treatments are necessary, the physician may obtain written prior authorization from the MOH. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.
2. G246, G117, G119 or G918 are *only eligible for payment* same patient same day with G236, G234 and G920 if rendered to diagnose or treat a separate condition.

[Commentary:

The sympathetic block that may result from an epidural injection is not payable as G920, G234 or G236.]

3. G246, G117, G119 or G918 are *not eligible for payment* with any concurrent surgical procedure or any 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 J74.
2. For epidural blood patch, refer to G068 and G065 page J73.]

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;

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

Fee

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 MOH. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.
2. G920, G234 and G236 are *only eligible for payment* same patient same day with other nerve block and/or injection services if rendered to diagnose or treat a separate condition.
3. G234 is *not eligible for payment* with G920 same patient same day.
4. The sympathetic block that may result from epidural, spinal, plexus and peripheral nerve blocks is not payable as G920, G234 or G236.

Miscellaneous

# G374 I.V. regional guanethidine	54.30
---	-------

Ganglion/Plexus injections

G233 Percutaneous celiac, splanchnic or hypogastric ganglion/plexus block with fluoroscopic guidance	200.00
E444 - with radiofrequency ablation, to G233 add 50%	
G217 Percutaneous trigeminal ganglion block with fluoroscopic guidance	200.00
G232 Percutaneous spheno-palatine ganglion block with fluoroscopic guidance.....	150.00
E445 - when alcohol or other sclerosing solutions are used, to G920, G234, G236, G233, G217 or G232 add 50%	
G921 Spheno-palatine ganglion block, transnasal topical, uni or bilateral.....	12.50

Payment rules:

G921 is not eligible for payment same patient same day with G232.

[Commentary:

For percutaneous provocation vertebral discography, refer to J006 Discogram page E4.]

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 BLOCK S - 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 GP43.]

G218 Ilioinguinal and iliohypogastric nerves	54.65
G219 Infraorbital.....	34.20
G220 Intercostal nerve	34.20
G221 - for each additional one..... add	16.95
G258 Intrapleural block (single injection)	44.25
G257 Intrapleural block (with the introduction of a catheter for the purpose of continuous analgesia)	77.25
G225 Mental branch of mandibular nerve	34.20
G250 Maxillary or mandibular division of trigeminal nerve	75.10

Obturator nerve

G241 - unilateral.....	54.65
G242 - bilateral.....	82.45
G227 Other cranial nerve block.....	54.65
G228 Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves.....	34.10
G123 - for each additional one (to a maximum of 4). add	17.10

Pudendal

G229 - unilateral.....	54.65
G240 - bilateral.....	82.45

Note:

For obstetrical continuous conduction anaesthesia, see P014 and P016, listed in the Obstetrics section of the *Schedule*.

G422 Retrobulbar injection (not to be claimed when used as a local anaesthesia).....	34.20
--	-------

Sciatic nerve

G230 - unilateral.....	54.65
G226 - bilateral.....	82.45

Somatic or peripheral nerves not specifically listed

G231 - one nerve or site.....	34.10
G223 - additional nerve(s) or site(s)	add 17.10

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NERVE BLOCK S - PERIPHERAL/OTHER INJECTIONS

	Fee
G256 Superior laryngeal nerve.....	34.10
G235 Supraorbital	34.10
G238 Transverse scapular nerve	34.10
E958 - when alcohol or other sclerosing solutions are used, the appropriate nerve block fees as listed above..... add 50%	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NEUROLOGY

	Fee
Z804 Lumbar puncture.....	150.00

Payment rules:

1. Z804 is *not eligible for payment* with C-suffix anaesthesia services rendered for surgical procedures, obstetrical anaesthesia procedures or with epidural services described in the nerve block sections of the *Schedule*.
2. Z804 includes injection of any medication or other therapeutic agent introduced at time of lumbar puncture.
3. Z804 includes image guidance if performed.

# G410 Amytal test (Wada)-bilateral - supervision and co-ordination of tests	68.40
# G413 Electrocorticogram - supervision and interpretation	170.85

Note:

G413 payable at nil when claimed with G267 same patient, same day.

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.....	25.75
G415 Routine EEG - professional component	23.15
G418 Routine EEG - professional component (16 - 21 channel EEG)	62.50

Sleep-deprived/induced EEG

A sleep-deprived/induced EEG is an EEG recording (*with or without* video monitoring) performed after an overnight period of sleep deprivation of greater than 4 hours; or the administration of a sedative/hypnotic agent prior to the EEG recording for the purposes of sleep induction, and must include all of the following:

- a. at least 60 minutes of EEG recording time;
- b. a minimum of 16 channels of EEG; and
- c. recordings of at least two physiological parameters.

G541 - technical component	41.20
G543 - professional component.....	120.00

EEG with time-locked video recording

An EEG with time-locked video recording must include all of the following:

- a. at least 30 minutes of EEG recording time;
- b. a minimum of 16 channels of EEG;
- c. recordings of at least two physiological parameters; and
- d. a time-locked video recording

G541 - technical component	41.20
G496 - professional component	120.00

Note:

1. The amount payable for a sleep-deprived/induced EEG, or an EEG with time-locked video recording that does not meet the above requirements will be reduced to that for a routine EEG fees (i.e. G414 and G415/G418).
2. G414 is *not eligible for payment* with G541.
3. Only one of G415, G418, G543 or G496 are *eligible for payment* per day.
4. EEG services (i.e. G414, G415, G418, G496, G541, G543, G540, G545, G542, G546, G554, G555, or G544) are *not eligible for payment* with any overnight or daytime sleep study (i.e. J898, J899, J990, J896, J897, J895, J890, J889, J893 or J894).

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NEUROLOGY

T | P

Prolonged EEG monitoring

Videotape recording of clinical signs in association with spontaneous EEG. Unit means ¼ hour or major part thereof. See General Preamble GP7 for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG.

G540 - technical component	per unit	9.55
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	24.40
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	48.90
G555 - professional component	120.00

Polygraphic recording of parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.)

G544 - technical component, per item	add	8.75
--	-----	------

Note:

G544 limited to a maximum of 3.

[Commentary:

Examples of physiological parameters include ECG, respirations, EMG, extra-ocular movements, oxygen saturation, and temperature.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NEUROLOGY

T P

EVOKED POTENTIALS

Upper or lower limbs

G140 - technical component	42.40
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

OTOLARYNGOLOGY

	Fee
# G103 Debridement of maxillectomy cavity	6.05
+ G420 Ear syringing and/or extensive curetting or debridement unilateral or bilateral	13.15

Note:

1.G420 is *not eligible for payment* when rendered in addition to Z906, Z907, Z908 or Z913.

2.G420 is only insured when:

- a.there is impacted ear wax resulting in hearing loss that is unresponsive to topical application of cerumenolytics; or
- b.immediate removal of ear wax is medically necessary to visualize the tympanic membrane or the external ear canal for diagnostic and/or therapeutic purposes.

+ G403 Particle repositioning maneuvre for benign paroxysmal positional vertigo	21.15
--	-------

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 GP62.
2. Interpretation of DHT services - To qualify for payment, the physician who claims the *professional component* must personally interpret the DHT and cannot delegate the interpretation to another person.
3. Controlled Acts - Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis, or prescribing a hearing aid for a hearing impaired person are controlled acts. If a physician interprets a diagnostic hearing test without communicating the diagnosis to the patient or his or her personal representative, a controlled act has not occurred.
4. Fixed level screening audiometry is not an insured service.
5. DHTs at the request of or arranged by third party, e.g. school boards, employers or WSIB etc. are not insured services. See Appendix A regarding third party service.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OTOLARYNGOLOGY

T | P

BASIC DIAGNOSTIC HEARING TESTS

Pure tone threshold audiometry with or without bone conduction

G440 - technical component	10.85
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	18.90
G526 - professional component	16.45

ADVANCED DIAGNOSTIC HEARING TESTS

Impedance audiometry by manual or automated methods

G442 - technical component	3.44
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	22.90
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	8.25
G530 - professional component, to a maximum of 1.....	per test	5.95

Cortical evoked audiometry

G143 - technical component	38.00
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	38.00
G144 - professional component	19.15

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OTOLARYNGOLOGY

T P

Electrocochleography (per ear):

G815 - technical component	38.00
G816 - professional component	19.15

DIAGNOSTIC BALANCE TESTS

Positional testing with electronystagmography (ENG)

G104 - technical component	19.60
G105 - professional component	20.90

Caloric testing with ENG

G451 - technical component	19.60
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
---	----------	-------

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.....	67.75
---	-------

Payment rules:

1. The service is *only eligible for payment* when rendered by the physician most responsible for the patient's care, or by a physician substituting for this physician.
2. G511, K071 or K072 are *not eligible for payment* to any physician when rendered during a week that G512 is rendered.
3. G512 is limited to a maximum of one per *week* (Monday to Sunday inclusive) per patient and, in the instance a patient is transferred from one *most responsible physician* to another, is *only eligible for payment* to the physician who rendered the service the majority of the week.
4. In the event of the death of the patient or where care commences on any day of the *week*, G512 is eligible for payment even if the service was not provided for the entire *week*.

[Commentary:

1. Services not excluded in payment rule #2 such as assessments, subsequent visit fees, W010, K023, special visit premiums etc. remain eligible for payment when rendered with G512.
2. See the Definitions section of the General Preamble for the definition of *palliative care*
3. This service is eligible for payment for services rendered to patients receiving *palliative care* in any location including their *home*, hospital, nursing *home* etc.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PHYSICAL MEDICINE

T | P

NEEDLE ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

PREAMBLE

1. When patients are referred directly to an electromyography (EMG) and/or nerve conduction studies (NCS) facility for diagnostic testing, then consultation or assessment by the diagnostic physician is *not eligible for payment* except where a medically necessary consultation or assessment is requested by the referring provider in addition to the EMG.
2. If a physician owns the EMG/NCS equipment and either employs and provides clinical supervision for a technician to perform the procedure or performs the procedure personally, then both the technical and the *professional component* are payable to the physician.
3. *Schedule A, Schedule B, Schedule C* and Single Fibre Electromyography refer to procedures performed using intramuscular placement of a recording needle electrode. Claims for surface EMG or other EMG techniques are *not eligible for payment*.
4. A nerve conduction study is a procedure using direct electrical stimulation of relevant peripheral nerve(s) with corresponding measurement(s) of evoked latency, conduction velocity, and amplitude using surface or percutaneous recording electrodes. Additional recordings, such as late responses or reflexes, are included in the service, if rendered. A permanent record of the procedure must be maintained in the patient chart.

Schedule A

Complete procedure i.e. conduction studies on two or more nerves presumed to be involved in the disease process together with EMG studies of appropriate muscles, as necessary and/or detailed studies of neuromuscular transmission. It also includes as necessary study of normal nerve and/or opposite side for comparison.

G455 - technical component	28.90
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	19.45
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	28.90
G473	- professional component, when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results	275.00

Payment rules:

1. G473 is *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 GP7 and GP55 for definitions and time-keeping requirements.

[Commentary:

Complex neuromuscular disorders where *Schedule C* nerve conduction studies/electromyography may be appropriate include demyelinating neuropathies, mononeuritis multiplex, motor neuron disease, brachial/lumbosacral plexopathies and neuromuscular transmission disorders.]

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PHYSICAL MEDICINE

Fee

Single fibre electromyography

G458 Single fibre electromyography 191.70

CHEMODENERVATION INJECTION

Chemodenervation injection of individual peripheral motor nerve using phenol, ethyl alcohol or similar non-anaesthetic chemical agents for reduction of focal spasticity, and *may include* electromyography (EMG) guidance of injection(s).

G485 - first major nerve and/or branches 45.45

G486 - each additional major nerve and/or its branches same day add 28.50

Repeat or additional procedure within 30 days of previous chemodenervation injection

G487 - first major nerve and/or its branches 28.50

G488 - each additional major nerve and/or its branches same day add 18.80

Note:

1. Use nerve block listings under Nerve Blocks sub-section if anaesthetic agents are used instead of phenol or alcohol or similar non-anaesthetic chemical agents.

2. Chemodenervation injection into same muscle same day as botulinum toxin is an insured service payable at nil.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PSYCHIATRY AND RESPIRATORY DISEASE

Fee Anae

PSYCHIATRY

Electroconvulsive therapy (ECT) cerebral - single or multiple

# G478 - in-patient.....	89.70	6
# G479 - out-patient	103.40	6

Note:

Electrosleep therapy or Sedac therapy are not insured benefits.

RESPIRATORY DISEASE

G404 Chronic ventilatory care outside an Intensive Care Unit.....	61.00
---	-------

Note:

Maximum 2 per week. Any other amount payable for consultations or assessments same patient, same physician, same day will be reduced to nil.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

UROLOGY

Fee P

G900 Residual urine measurement by ultrasound 12.70

Note:

Residual urine measurement by ultrasound (G900) is *not eligible for payment* in addition to an ultrasound of the pelvis, intracavity ultrasound, G192 - G194, or G475 when cystometrogram and/or voiding pressure studies are rendered.

[Commentary:

G475 is payable with G900 when uroflow studies are performed (flow rate *with or without* postural studies) with residual urine measurement by ultrasound.]

+ G475 Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including interpretation 23.75

G192 Video fluoroscopic multichannel urodynamic assessment to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with simultaneous fluoroscope imaging and recording of filling and voiding phases including interpretation 73.65

G193 Complete multichannel urodynamic assessment - to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with or without pressure-flow studies 43.85

G194 - with EMG add 8.35

G477 Interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel) 5.40

+ G476 Prostatic massage 5.40

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 GP85.

FOR DEFINITION OF THE ROLES OF THE ANAESTHESIOLOGIST - SEE GENERAL PREAMBLE GP92.

With the exception of the listings in the "Consultations and Visits" section, all references to surgeon in this *Schedule* are references to any physician performing the surgical procedure.

1. If the surgeon is required to perform a service(s) not usually associated with the original surgical procedure, he/she may claim for these on a fee-for-service basis.

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 GP65 to GP78 and GP104).

SURGICAL PREAMBLE

PREAMBLE

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.
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.]

SURGICAL PREAMBLE

PREAMBLE

9. Unless otherwise stated, the listed benefits are for unilateral procedures only.
10. When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 11), is not in keeping with the intent of the benefit *schedule*.
11. When a surgical benefit (non-/OP, Complete Care, Fracture or Dislocation) is less than the surgical consultation benefit, and the case is referred, a physician may claim a surgical consultation benefit instead of the surgical benefit. However, to avoid the consultation being counted as such under the Ministry of Health limitation rules on the number of consultations allowed per year, the physician should claim the consultation fee under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.
12. If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician should claim for the procedure as well as the appropriate assessment.
13. Where a procedure is listed with a "Z" code, the procedure is an "*Independent Operative Procedure (IOP)*". If the major pre-operative visit is rendered in the previous *12-month period* prior to the *IOP* service by the same physician, only the following assessment services are eligible for payment on the same day prior to the *IOP* service:
 - a. a minor assessment if rendered by a General and Family Physician; or
 - b. a partial assessment if rendered by a *specialist*.When the major preoperative assessment is rendered on the same day as the *IOP*, no other consultation or assessment is eligible for payment if rendered prior to the *IOP* service by the same physician on the same day.
When multiple or bilateral *IOP* are performed at the same time by the same physician, the listed procedural benefits should be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed.
When an *IOP* service is rendered on the same day as a non-*IOP* service by the same physician, the 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 GP12).

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 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, thorax, peritoneal cavity, retroperitoneum, pelvis, or hip and:

- a. the patient has a *Body Mass Index (BMI)* greater than 40 for major surgery on the thorax, peritoneal cavity, retroperitoneum, pelvis, or hip, or a BMI greater than 45 for major surgery on the neck;
- b. the surgery is rendered under *general anaesthesia* using either an open technique for the neck, thorax, or hip, or an open or laparoscopic technique for the peritoneal cavity, pelvis, retroperitoneum; and
- c. the principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, mediastinoscopy, thoracoscopy, cautery, ablation nor catheterization.

E676A Morbidly obese patient, surgeon, to procedural fee(s)..... add 25%

E676B Morbidly obese patient, surgical assistant, to major procedure
add 6 units

Note:

E676A/B is only payable with the following procedures: D043, D046, D047, D052, E090, E499, E500, 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, M142, M143, M144, 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, S089, S090, S114, S115, S116, S117, S118, S120, S121, S122, S123, S124, S125, S128, S129, S131, S132, S133, S134, S137, S138, S139, S140, S149, S150, S154, S157, S158, S159, S160, S162, S164, S165, S166, S167, S168, S169, S170, S171, S172, S173, S175, S176, S177, S180, S182, S183, S184, S185, S187, S188, S189, S191, S192, S193, S194, S195, S196, S197, S199, S204, S207, S213, S214, S215, S217, S218, S222, S227, S265, S266, S267, S269, S270, S271, S274, S275, S276, S278, S280, S281, S282, S285, S287, S291, S292, S294, S295, S297, S298, S299, S300, S301, S302, S303, S304, S305, S306, S307, S308, S309, S310, S311, S312, S313, S314, S315, S318, S319, S321, S323, S325, S329, S332, S340, S342, S343, S344, S345, 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 GP85).

28. Bariatric surgery

S120 (gastric bypass or partition), S189 (intestinal bypass) and S114 (sleeve gastrectomy) are insured services only when all of the following 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

SURGICAL PREAMBLE

PREAMBLE

- 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

Z101	- subcutaneous - one	nil	25.75
Z173	- subcutaneous - two.....		30.35
Z174	- subcutaneous - 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	11.55

Abscess or haematoma - General anaesthetic

# Z102	- subcutaneous - one	44.35	6
# Z172	- subcutaneous - 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

E515 Incision of abscess or hematoma when performed as sole procedure under general anaesthetic in an operating room but not in an emergency department or *emergency department equivalent*. To Z102, Z172, Z105, Z107
..... add 100%.

Foreign body removal

Z114	- local anaesthetic.....	25.25	
E542	- when performed outside hospital	11.55	
# Z115	- general anaesthetic	6	88.80
# Z100	- complicated (see General Preamble GP12)	6	I.C
# 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	11.55	
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 GP12).....	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	11.55

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	11.55
#Z165	Congenital (extensive) (see General Preamble GP12)	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

Skin and Subcutaneous Tissue

Asst Surg Anae

Group 3 - cyst, haemangioma, lipoma

Face or neck - Local anaesthetic

Z122	- single lesion.....	nil	38.50	
Z123	- two lesions.....		67.80	
Z124	- three or more lesions.....		78.00	
E542	- when performed outside hospital	add	11.55	

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 GP12)	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	11.55	

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 GP12)	6	I.C	6

Group 4 - other lesions

Z096	Lipoma - 5 to 10 cm	6	80.00	6
E542	- when performed outside hospital	add	11.55	
# 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 hyperhidrosis 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	11.55	

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	11.55	

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 Queyrat
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
---	-------

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	11.55	

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	11.55	

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 GP12).....		I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst | Surg | Anae

Note:

Physicians treating vascular ectasias by laser may obtain from their Ministry of Health *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

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.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst | Surg | Anae

2. E524 is eligible for payment once per lesion. An additional E524 may be eligible for payment on an Independent Consideration (IC) basis when claimed on a subsequent day up to two 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 11.55

Payment rules:

1. Wound and ulcer debridement services are *only eligible for payment* where:

- a. the physician performs a minimum of 10 minutes of debridement; and
- b. the service is *rendered personally by the physician*.

2. Suture of laceration (Z154, Z175, Z176, Z177, Z179, Z190, Z191, Z192), and complex laceration repair (Z187, Z188, Z189) services are *not eligible for payment* with wound and ulcer debridement services.

3. All wound and ulcer debridement services include the application of any necessary dressing if rendered.

[Commentary:

Debridement of wound(s) or ulcer(s) must be performed personally by the physician. Wound dressings may be performed by the physician or by others delegated to perform wound dressings where such delegation is authorized in accordance with the *Schedule* requirements for delegated services. See page GP62 of the General Preamble of this *Schedule*.]

Note:

Wound dressing and wound and debridement services are not payable in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care.

Medical record requirements:

Wound or ulcer debridement services are *only eligible for payment* where:

1. the minimum time requirements involved in the debridement of the wound(s) or ulcer(s) are documented in the patient's permanent medical record; and
2. Documentation supporting the debridement of each separate lesion for which a claim is made is found in the medical record.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst □ Surg □ Anae

Burns

Note:

For burn care the following definitions apply:

Total Body Surface Area (TBSA) as calculated using the "rule of nines" or the Lund-Browder chart.

Young - a person 9 years of age and younger.

Adult - a person from 10 years up to, and including, 50 years of age.

Old - a person 51 years of age and older.

Minor Burn

- a. less than 10% TBSA burn in *adult*
- b. less than 5% TBSA burn in young or old
- c. less than 2% TBSA full thickness burn - any age

Moderate Burn

- a. 10 to 20 % TBSA burn in *adult*
- b. 5 to 10 % TBSA burn in young or old
- c. 2 to 5 % TBSA full thickness burn - any age
- d. the following regardless of TBSA or age of patient:
 - i. high-voltage injury
 - ii. suspected inhalation injury
 - iii. circumferential burn
 - iv. concomitant medical problem predisposing to infection (e.g. diabetes, sickle cell disease)

Major Burn

- a. more than 20% TBSA burn in *adult*
- b. more than 10% TBSA burn in young or old
- c. more than 5% TBSA full-thickness burn - any age
- d. the following regardless of TBSA or age of patient:
 - i. high voltage burn
 - ii. known inhalation injury
 - iii. any deep partial and/or full thickness burn to face, eyes, ears, genitalia, hands, feet or joints
 - iv. significant associated injuries (e.g. fracture or major trauma)

Note:

For burn care requiring anaesthetists' and assistants' services, the following fee codes apply.

# R030 Minor burns	6	-	6
# R038 Moderate burns.....	6		10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

	Asst	Surg	Anae
# R039 Major burns.....	8	-	15

Resuscitation - Major Burn, Initial Care

These fees apply to the service of being in constant or periodic attendance following a major burn, to provide all aspects of resuscitation to the patient. This follows the initial assessment, and includes such subsequent assessments as may be indicated. The *specific elements* are those of an assessment, including ongoing monitoring of the patient's condition, and intervening as appropriate (see General Preamble GP15). Instead of element H, the assessment includes, providing premises, equipment, supplies and personnel for any aspects of the *specific elements* that is(are) performed in a place other than the place in which the assessment is performed. Separately billable interventions may be claimed in addition to these fees.

# Z180 - first day	106.25
# Z181 - continuing care, 2nd to 4th day inclusive, per day	53.10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst | Surg | Anae

Debridement, excision, fasciotomy, escharotomy, and/or grafting - in Operating Room

# R691 Minor burn.....	per unit	75.00
# R692 Moderate burn	per unit	87.50
# R693 Major burn.....	per unit	100.00

Payment rules:

- 1.R691, R692 and R693 are eligible for payment only when rendered in an Operating Room.
- 2.Unit means $\frac{1}{4}$ 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, R495 are *not eligible for payment* in addition to R691, R692 or R693.

[Commentary:

See General Preamble GP7 for definitions and time-keeping requirements. As noted on GP7, start and stop times must be recorded in the patient's permanent medical record or the service is *not eligible for payment*.]

Burn debridement and excision - outside Operating Room

#R660 - hand - each digit	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
--	---	-------	---

NECROTIZING FASCIITIS

Debridement, excision, fasciotomy and flap and/or graft closure - in Operating Room

# R698 Debridement, excision, fasciotomy and flap and/or graft closure for necrotizing fasciitis	per unit	6	100.00	10
--	----------	---	--------	----

Payment rules:

- 1.R698 is *only eligible for payment* when the service is rendered in an Operating Room and the patient requires Intensive Care Unit management on the day the surgery takes place.
- 2.R698 is *not eligible for payment* for reconstructive services.
- 3.Unit means $\frac{1}{4}$ 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.
- 5.R495 is *not eligible for payment* in addition to R698

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst | Surg | Anae

[Commentary:

1. For reconstruction services, the appropriate fee codes apply.
2. See General Preamble GP7 for definitions and time-keeping requirements. As noted on GP7, start and stop times must be recorded in the patient's permanent medical record or the service is *not eligible for payment.*]

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% N2O/O2 mixture) is used, when suture of laceration is sole procedure..... add	50.40	
E531	- if extensive debridement is required (see General Preamble GP12)	I.C	
E542	- when performed outside hospital	11.55	
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
------	---------------------------------------	-------

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
------	--	-------

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 GP12).....	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

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst | Surg | Anae

C. Pedicle flaps

# R070	Small/Intermediate, e.g. cross finger, cervical finger	6	293.75	7
# R071	- each subsequent stage	6	223.35	6
# R080	Large, e.g. cross leg, deltopectoral, forehead	6	416.30	6
# R078	- each subsequent stage	6	311.45	7
# E069	- preparation of a contracted recipient site, to R070 or R080 add		134.75	
# R101	Delay, Small/Intermediate flap	6	132.45	7
# R100	Delay, major flap	6	291.90	6

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
# R006	Pectoralis major	6	734.95	6
# R155	Latissimus dorsi or unilateral rectus abdominus.....	6	734.95	6
Note:				
	R006 is <i>not eligible for payment</i> for post-mastectomy breast reconstruction.			
# R008	Lower transverse rectus abdominus flap	6	984.55	8
	Repair of abdominal defect			
# Z196	- different surgeon		377.65	
# E523	- same surgeon, to other procedure..... add		321.00	
# R009	Myocutaneous - osseous flaps e.g. pectoralis major myocutaneous flap with rib graft, trapezius flap with scapula spine.....	6	783.40	8
# R007	Other - (see General Preamble GP12).....	I.C	I.C	I.C

SKIN GRAFTS

A. Split thickness grafts (for burn grafts see pages M9 & M10)

# R084	Very minor, very small areas, e.g. trauma	92.30	7	
# R085	Minor, medium sized areas, e.g. small 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 GP12).....	I.C	I.C	I.C
--------	---	-----	-----	-----

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
		I.C	I.C	I.C
# R058	Revision of above (see General Preamble GP12).....			
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

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 GP12) ..	10	I.C	10
# R106	Skin flaps and grafts - other than listed above (see General Preamble GP12).....	I.C	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst | Surg | Anae

FINGER OR TOE-NAIL

Z110 Extensive debridement of onychogryphotic nail involving removal of multiple laminae.....	17.45
---	-------

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	11.55	

Radical, including destruction of nail bed

# Z130 - one	nil	62.75	6
# Z131 - multiple		82.65	6
E542 - when performed outside hospital add		11.55	

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	add	58.95	
# E528 - additional expander, different incision	add	258.50	

Note:

1. Z132 is *not eligible for payment* for post-mastectomy reconstruction of the breast.
2. Authorization may be required from the Ministry of Health (e.g. for scars of legs, etc.).

Removal tissue expander injection port when sole procedure

# Z094 - general anaesthetic	6	75.45	6
# Z095 - local anaesthetic.....		37.70	
Z137 Percutaneous inflation of first tissue expander.....		23.05	
E541 - each additional expander (to a maximum of 3).....		11.55	
# Z138 Replacement of tissue expander by permanent prosthesis....		195.85	7

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS OF THE BREAST

Asst Surg Anae

INCISION

Needle biopsy

Z141 - one or more	nil	37.20
E542 - when performed outside hospital	add	11.55
Z143 - large core breast biopsy - (14 gauge or larger bore needle)		132.75

Aspiration of cyst

Z139 - one or more	nil	37.20
--------------------------	-----	-------

Drainage of intramammary abscess or haematoma

# Z140 Single or multiloculated - local anaesthetic.....		33.00
# Z740 Single or multiloculated - general anaesthetic	133.80	6

EXCISION

# R107 Tumour or tissue for diagnostic biopsy and/or treatment, e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple - same breast)	6	169.95	6
# E525 - after localization with mammographic wire or radioactive seeds, to R107		48.05	
# R111 Partial mastectomy or wedge resection for treatment of breast disease, with or without biopsy, e.g. carcinoma or extensive fibrocystic disease	6	269.40	7
# E525 - after localization with mammographic wire or radioactive seeds to R111		48.05	
# E546 - with axillary node dissection up to the level of the axillary vein, to R111		388.75	
# E505 - with limited axillary node sampling, to R111.....		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.]

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
--------	---	--------

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).

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PREAMBLE

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.]

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 repair/reconstruction is only payable when a fracture requires additional reconstruction because of inadequate healing at least 4 months following the original injury. Pseudoarthrosis repair/reconstruction includes bone graft, debridement, osteotomy and internal or external fixation other than the use of an intramedullary nail with distal and proximal locking screws, or circular external fixation if performed.
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.

FEMALE GENITAL SURGICAL PROCEDURES

VULVA AND INTROITUS

Asst Surg Anae

Abscess of vulva, Bartholin or Skene's gland - incision and drainage

Z714	- local anaesthetic.....		25.40	
E542	- when performed outside hospital	add	11.55	
# Z715	- general anaesthetic	6	56.70	6
# Z716	Marsupialization of Bartholin's cyst or abscess	6	89.80	6

EXCISION

Biopsy(ies) - when sole procedure

Z477	- local anaesthetic.....		39.60	
E542	- when performed outside hospital	add	11.55	
# Z475	- general anaesthetic	6	56.70	6
# S707	Hymenectomy (with or without perineotomy) or hymenotomy		97.20	6
# S706	Cyst of Bartholin's gland	6	129.85	6

Condylomata - single or multiple

Chemical and/or cryosurgery

Z733	- one or more		12.00	
	Surgical excision or electrodesiccation or CO ₂ laser			
Z736	- local anaesthetic.....		32.60	
# Z769	- general anaesthetic		124.60	6

Vulvectomy

# S703	- simple	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 GP12).....		I.C	I.C
# S701	Repair of infibulation - resulting from female genital mutilation		115.00	6

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

Asst Surg Anae

ENDOSCOPY

Z478 Vaginoscopy (premenarchal) with or without medication.....	56.70	6
---	-------	---

Note:

Culdoscopy - see Z552 - Abdomen, Peritoneum and Omentum - Digestive System.

INCISION

# S712 Culdotomy, drainage or needle puncture.....	115.00	6
--	--------	---

Z728 Incision and drainage of cyst, abscess or haematoma.....	97.20	6
---	-------	---

EXCISION

Biopsy(ies) - when sole procedure

Z722 - local anaesthetic.....	39.60	
-------------------------------	-------	--

E542 - when performed outside of hospital, to Z722	add	11.55
--	-----	-------

# Z723 - general anaesthetic.....	97.20	6
-----------------------------------	-------	---

# S715 Excision of cyst(s), or benign tumour(s)	6	140.45	6
---	---	--------	---

# S742 Colpectomy - e.g. for carcinoma.....	6	365.55	6
---	---	--------	---

# S702 Excision of congenital vaginal septum.....	6	159.55	6
---	---	--------	---

REPAIR

# S716 Anterior or posterior repair.....	6	250.65	7
--	---	--------	---

Anterior and posterior

# S717 - repair	6	396.80	7
-----------------------	---	--------	---

# S718 - repair of enterocoele and/or vault prolapse.....	6	432.45	7
---	---	--------	---

Posterior repair and repair of

# S719 - enterocoele and/or vault prolapse	6	366.55	7
--	---	--------	---

# S723 - anal sphincter	6	305.90	6
-------------------------------	---	--------	---

Anterior repair

# S720 - with or without posterior repair and repair of uterine prolapse (Fothergill or Watkin's interposition)	6	432.45	7
--	---	--------	---

# S721 Anterior, posterior repair with excision of cervical stump.....	6	432.45	7
--	---	--------	---

Post hysterectomy vault prolapse

# S722 - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	6	432.45	7
---	---	--------	---

# S812 - repeat - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	6	515.05	7
--	---	--------	---

Abdominal approach to vaginal vault prolapse

# S760 - vaginal sacropexy.....	6	432.45	6
---------------------------------	---	--------	---

# S813 - repeat - vaginal sacropexy	6	515.05	6
---	---	--------	---

# S761 Combined abdominal/vaginal approach for vaginal vault prolapse.....	7	431.45	7
--	---	--------	---

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
# E862	- when performed laparoscopically, to S760, S813 or S761 add 25%			
# S724	Perineorrhaphy (not eligible for payment with delivery or other vaginal surgery procedures).....	6	127.35	6
# S725	Colpocleisis (LeFort or modification)	6	300.35	7
# S726	Construction of artificial vagina (see General Preamble GP12)	6	I.C	6
Closure of fistula				
# S523	Vesicovaginal.....	6	791.85	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	391.55	6
# S546	Repeat procedure for failed retropubic or vaginal surgery for stress incontinence.....	6	496.25	7
# E862	- when performed laparoscopically, to S549 or S546 add 25%			
# S815	Tension free vaginal tape mid-urethral sling by any method/ approach	6	393.30	6

Payment rules:

Cystoscopy (Z606) is *not eligible for payment* with S815 unless the cystoscopy is rendered for suspicion of disease.

Combined Abdominal-Vaginal Procedure for Stress Incontinence (Sling Procedure)

[Commentary:

Combined abdominal vaginal sling procedures are indicated for the management of stress incontinence or genital prolapse, particularly following previous failed anti-incontinence procedures of any kind, or a very large 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.]

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
Primary approach				
# S728	One surgeon	7	429.10	7
# E862	- when performed laparoscopically, to S728	add 25%		
Two surgeons				
# S730	- vaginal surgeon	7	330.50	7
# E863	- when performed laparoscopically, to S730	add 25%		
S740	- abdominal surgeon.....	7	330.50	
# E862	- when performed laparoscopically, to S740	add 25%		
Following previous failed procedure				
# S731	One surgeon.....	7	557.95	7
# E862	- when performed laparoscopically, to S731	add 25%		
Two surgeons				
# S732	- vaginal surgeon	7	429.65	7
# E863	- when performed laparoscopically, to S732	add 25%		
# S733	- abdominal surgeon.....	7	429.65	
# E862	- when performed laparoscopically, to S733	add 25%		
Following two or more failed procedures				
# S748	One surgeon.....	7	686.70	7
# E862	- when performed laparoscopically, to S748	add 25%		
Two surgeons				
# S749	- vaginal surgeon	7	528.75	7
# E863	- when performed laparoscopically, to S749	add 25%		
S751	- abdominal surgeon.....	7	528.75	
# E862	- when performed laparoscopically, to S751	add 25%		
# S811	Rectus abdominus myocutaneous neovaginostomy - includes harvest of longitudinal, vertical or transverse rectus abdominus flap(s), formation of vaginal pouch and insertion of vaginal mold	8	829.40	8
MANIPULATION				
Examination and/or dilatation (may include insertion and/or removal of IUD)				
# Z735	- general anaesthetic - as sole procedure		56.70	6
G552	Removal of IUD without GA.....		20.00	

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL DECOMPRESSION

		Asst	Surg	Anae
All levels				
# E383	- acute spinal cord injury premium			add 255.00
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue.....			add 244.80
Cervical				
# N500	Disc excision (one level).....	10	918.00	10
# N501	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	11	1100.40	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			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			306.00

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION

Asst | Surg | Anae

Cervical - without instrumentation

# E363	- one disc level, to N500 or N501	add	357.00
# E364	- each additional disc level fused, to E363.....	add	102.00

Cervical - with instrumentation including cages

# E365	- one disc level, to N500, N501, N572, N560 or N561 .	add	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.....	add	357.00	
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N509 or N510.....	add	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.....	add	357.00	
# E368	- first disc excision, to N509, N510 or N520.....	add	306.00	

Lumbar

# N511	One level - unilateral.....	8	800.70	15
# N512	One level - bilateral.....	8	1004.70	15
# E368	- first disc excision, to N511 or N512.....	add	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	add	255.00	
# N571	Percutaneous discotomy	6	255.00	8
# E385	- each additional level of percutaneous discotomy, to N571	add	71.40	

Removal of Vertebral Body including Pedicles for Osteotomy

# N574	Above cord and conus (includes partial rib resection) - each level	9	1020.00	13
# N575	Below conus - each level	9	765.00	9
# N576	Smith Peterson Osteotomy - each level	9	255.00	9

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION OR OSTEOTOMY

Asst Surg Anae

All levels

# E378	- 3D stereotactic spinal procedure	add	510.00
# E379	- 2D stereotactic spinal procedure	add	510.00

Cervical, Thoracic & Lumbar ... without instrumentation

# E369	- one disc level, to N509, N510, N520, N511 or N512 . add	255.00
# E364	- each additional disc level fused, to E369..... add	102.00

Cervical ... with instrumentation - by same surgeon

# E384	- C1/C2 screw fixation (transarticular, pedicle, lateral mass), to N509, N510, N560, N561or N572	add	1020.00
# E370	- one disc level - below C2, to N509, N510, N572, N574, N575, N576, N560 or N561	add	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	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	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

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION OR OSTEOTOMY

Asst Surg Anae

Thoracic & Lumbar ... with instrumentation - by separate surgeon

# N513	One disc level	867.00
# E366	- each additional disc level fused, to N513..... add	153.00
# E387	- fusion to sacrum, to N513	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

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 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. 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 for repair of trauma scars to the face or neck is not required.

b. Scars in other Anatomical Areas

- i. Repair of scars which interfere with function or which are significantly symptomatic (pain, ulceration, etc.) is an insured service.
- ii. Scars with no significant symptoms or functional interference
 - Repair is an insured service if such a repair is part of a pre-planned post-traumatic (including post-surgical) staged process. Notification to the Ministry of Health must be included as part of the planning process.
 - Other post-traumatic scar revision is not an insured service.
 - Scar revision should not be claimed when excision of a scar is the method of gaining access to the surgical site of the major procedure.
 - Prior authorization from the Ministry of Health is required for all scar repair procedures in areas other than the face or neck. Scar revision codes should be used (e.g. R026-R029).

2. Keloids

a. Head or Neck

- i. The repair of all such keloids is an insured service.
- ii. Repair procedures *may include* excision, injection, dermabrasion or planning.
- iii. Prior authorization is not required.

b. Excision of keloids in other areas

- i. Not an insured service unless significantly symptomatic (pain, ulceration, etc.) or there is functional impairment.
- ii. Prior authorization from the Ministry of Health is required.

3. Tattoos

Excision or destruction of tattoos resulting from sexual or ritual abuse, concentration camp or prisoner of war experience is an insured service. Excision or destruction of any other tattoos, irrespective of the anatomical area, is not an insured service.

APPENDIX D

SURFACE PATHOLOGY

4. Benign Lesions such as nevi, haemangioma, keratoses, neurofibromata

Note:

1. Any lesions (e.g. keratosis, nevi) removed for cosmetic purposes and not for any clinical suspicion of disease or malignancy must be billed to the patient.

2. Incision of comedones, acne pustules and milia are not insured services.

a. Face or Neck

i. Excision or destruction of these lesions is an insured service, where there is any suspicion of disease or malignancy.

ii. Destruction of any Port Wine Stain on the face or neck is an insured service.

iii. Prior authorization is not required.

b. Other Anatomical Areas

i. Normally not an insured service if removed for alteration of appearance only, rather than for medical necessity or because of clinical suspicion or evidence of malignancy.

ii. Removal of very large lesions that would be considered disfiguring in patients of any age may be an insured service. Prior authorization from the Ministry of Health is required.

iii. Prior authorization from the Ministry of Health is required.

5. Hair Loss

a. Head or Neck

i. Patients aged 17 and below

- Repair is an insured service for non-hereditary etiologies. Prior authorization is not required.
- If it is possible that a planned staged procedure will extend beyond the age of 17, prior authorization from the Ministry of Health is required for those services rendered beyond the age of 17.

ii. Post-traumatic

- Repair to the area of traumatic hair loss is an insured service only if carried out within a reasonable period of convalescence. (see Paragraph 7 of this Appendix).
- Prior authorization from the Ministry of Health is required.
- Usual repair procedures *may include* skin shifts or flaps, skin grafts, or hair plugs.

iii. Other Etiology - not an insured service.

b. Other Anatomical Areas - not an insured service.

6. Epilation of Hair - not an insured service.

7. Redundant Skin

a. Excision of redundant skin for elimination of wrinkles, etc. is not an insured service.

b. Blepharoplasty is an insured service only if a vertical visual field defect crosses the fixation point and is caused by redundant eyelid. Prior authorization from the Ministry of Health is required. A computer-generated visual field report and interpretative report must accompany the request for prior authorization.

APPENDIX D

SURFACE PATHOLOGY

8. Warts

- a. Removal or treatment of warts is not an insured service subject to (b) and (c) below.
- b. Removal or treatment of 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.

10. Acne Lesions and Scars

Assessment of patients with acne, including the provision of prescriptions for oral and topical medications, is an insured service. Destruction or repair of acute acne lesions or chronic acne scars by any surgical or physical procedure (e.g. incision, excision, injections, dermabrasion, grafting, chemical peel, cryotherapy, laser, etc.) is not an insured service.

11. Congenital Deformities

a. Head or Neck

- i. Repair of a congenital deformity, which interferes with function, is an insured service. Prior authorization from the Ministry of Health is required.
- ii. Surgery to correct “Outstanding Ears” is only an insured service in patients who are under eighteen years of age. Prior authorization is not required.

b. Other Anatomical Areas

- i. Repair of a congenital deformity, which interferes with function, is an insured service.
- ii. Insertion of testicular prosthesis for congenital absence of one or both testes is an insured service. Prior authorization is not required.

12. Post-Traumatic Deformities

- a. Reconstructive procedures are insured services at the acute stage; within two years, or if part of a pre-planned staged process of repair.
- b. Reconstructive procedures *may include* bone revision, tissue shifts and grafts, prosthesis implantation etc.
- c. Prior authorization from the Ministry of Health is required for repairs beyond the acute stage.
- d. Insertion of testicular prosthesis is an insured service when performed at any time subsequent to an orchidectomy procedure. Prior authorization is not required.

APPENDIX D

SURFACE PATHOLOGY

13. Deformities resulting from local disease (such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.)

a. Head or Neck

- i. Reconstructive procedures for significant abnormalities are an insured service at the acute stage, during a chronic disease process: within a reasonable period of convalescence (see Paragraph 7 of this Appendix) or if part of a planned staged process of repair initiated during one of these periods.
- ii. Repair procedures normally *may include* tissue grafts, flaps or shifts, bone revision, prosthesis insertion, etc.
- iii. Face lifts, modified face lifts, brow lifts, etc., are not insured services if skin only is involved in the procedure. However, a repair such as ptosis repair or face-lift with underlying slings is an insured service if the procedure is to correct significant deformity following stroke, cancer, seventh nerve palsy etc.
- iv. Prior authorization from the Ministry of Health is required.

b. Other Anatomical Areas

- i. Not an insured service if the correction is for appearance only.
- ii. Correction of severe deformity resulting from polio or neurological disease will be considered for payment.
- iii. Insertion of testicular prosthesis is an insured service. Prior authorization is not required.

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:
 - a. breast aplasia;
 - b. severe unilateral hypoplasia of the breast; or
 - c. gross disproportion.
- ii. Only a unilateral procedure (i.e. augmentation or reduction mammoplasty) is insured when performed solely for gross disproportion.

[Commentary:

Augmentation mammoplasty services are subject to Paragraph (b) of Section 17 of Appendix D of this *Schedule*.]

c. Reduction Mammoplasty (other than post-mastectomy breast reconstruction)

- i. Reduction mammoplasty when performed for reasons other than post-mastectomy breast reconstruction of the contralateral breast is only insured for the following conditions and when prior authorization of payment is obtained from the Ministry of Health:
 - a. significant associated symptomatology; or
 - b. gross disproportion.
- ii. Only a unilateral procedure (i.e. augmentation or reduction mammoplasty) is insured when performed solely for gross disproportion.

[Commentary:

Ptosis and/or size alone are not sufficient grounds for coverage of reduction mammoplasty.]

d. Accessory breasts or accessory nipples

- i. Excision of accessory breast and nipple tissue is an insured service.

APPENDIX D

SUB-SURFACE PATHOLOGY

[Commentary:

The listed service under Skin and Subcutaneous Tissue of the Integumentary System Surgical Procedures section of this *Schedule* that best describes the procedure performed should be used for excision of accessory breast tissue and/or accessory nipples.

- ii. Prior authorization of payment is not required.

15. Septorhinoplasty

This is an insured service when the rhinoplasty component is necessary to obtain an adequate airway or; for persons aged 16 years and under, at the time of trauma and for whom the rhinoplasty is completed, or is part of a preplanned staged repair which is commenced, at any time following trauma and prior to the age of 19 years; or, for persons aged 17 years and older at the time of trauma and for whom the rhinoplasty is completed, or is part of a preplanned staged repair which is commenced, within 2 years following trauma. (see Paragraph 6 of this Appendix).

In cases where a septoplasty is necessary to improve function and a rhinoplasty is done for cosmetic purposes, the Ministry of Health will pay the part of the operation that was medically necessary (e.g. if a septorhinoplasty is performed and a septoplasty was necessary to improve the airway, the Ministry of Health will pay M012 and the surgeon is entitled to claim the difference from the patient). However, if a septorhinoplasty is approved by the Ministry, no extra charge may be made to the patient.

Prior authorization from the Ministry of Health is required. A description of the external deformity should be provided.

16. Excision of excess fatty tissue and/or skin

- a. Panniculectomy is only insured in the following circumstances and when prior authorization of payment is obtained from the MOH:
 - i. where there is significant associated symptomatology related to the 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 MOH.

A request for prior authorization must be completed by a physician or nurse practitioner.

APPENDIX D

SUB-SURFACE PATHOLOGY

PART A – SUPPORTING DOCUMENTATION NECESSARY FOR A REQUEST FOR PRIOR AUTHORIZATION FOR SURGERY:

A prior authorization request must include supporting assessment(s) that recommend surgery; the assessment must be completed by a provider trained in the assessment, diagnosis, and treatment of gender dysphoria in accordance with the World Professional Association for Transgendered Health (WPATH) Standards of Care that are in place at the time of the recommendation (“appropriately trained provider”).

Supporting assessments recommending surgery may be provided by an appropriately trained:

1. Physician;
2. Nurse Practitioner;
3. Registered Nurse;
4. Psychologist; or
5. Registered social worker

in accordance with the requirements of Part B below.

[Commentary:

1. A provider must be able to provide documentation of their training in the assessment, diagnosis and treatment of gender dysphoria on request by the MOH.
2. The physician or nurse practitioner submitting a request for prior authorization may also be one of the providers who provides a supporting assessment.]

Note:

“Registered social worker” refers to a social worker who has a master’s degree in social work and who holds a current certificate of registration from the Ontario College of Social Workers and Social Service Workers.

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.

APPENDIX D

SUB-SURFACE PATHOLOGY

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 MOH.

The prior authorization request must be made by the surgeon proposing the surgery.

[Commentary:

There are additional requirements for surgical services to be received at a hospital or health facility outside Canada and a separate prior approval of the General Manager of OHIP is required. See

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 is not required.

APPENDIX D

NOT ALLOCATED

APPENDIX F

Appendix F does not form part of the Schedule of Benefits: Physician Services under the Health Insurance Act and is reproduced for your information only.

This attachment is included in the publication for information purposes only.

The services set out below are not "insured services" within the meaning of the *Health Insurance Act* but are paid by the Ministry of Health, acting as paying agent on behalf of the Ministry of 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)	105.65
K051	Health Status Report (completed separately) for initial ODSP application	84.50
K052	Activities of Daily Living Index (completed separately) for initial ODSP application	21.10
K057	Medical Form Part A for Medical Review process	37.00
K058	Medical Form Part B including both Health Status Report and Activities of Daily Living Index for Medical Review process	132.00
K059	Health Status Report of Part B (completed separately) for Medical Review process.....	105.65
K060	Activities of Daily Living Index of Part B (completed separately) for Medical Review process	26.40
K054	Mandatory Special Necessities Benefit Request Form	26.40
K055	Application for Special Diet Allowance.....	21.10
K056	Application for Pregnancy/Breast-feeding Nutritional Allowance	21.10

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, 1997</i>	51.65
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, 1997</i>	51.65

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*.

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.

3. This payment represents full payment for the service. No additional charge to either OHIP or the patient for this service is permitted.

MCSS ONTARIO WORKS PROGRAM (OW)

K053 A Limitation to Participation Form	15.85
---	-------

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.

K061 Taking of blood samples in a hospital setting at the request of a police officer	31.65
---	-------

Cortical evoked audiometry, multiple frequency (minimum of 4 frequencies in each ear) as required by WSIB:

G153 - technical component	10.30
G154 - professional component	41.70

Note:

The *technical component* of the cortical evoked audiometry service rendered in a hospital is payable at 94.68% of the listed fee.

APPENDIX G

Appendix G does not form part of the *Schedule of Benefits: Physician Services under the Health Insurance Act* and is reproduced for your information only.

MEDICAL RECORDS

Please refer to Section 18 of Regulation 114/94 made under the *Medicine Act*, 1991, and Section 37.1 of the *Health Insurance Act*.

For a complete text version of Section 18 of Regulation 114/94 under the *Medicine Act*, please refer to:

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

Appendix H does not form part of the Schedule of Benefits: Physician Services under the Health Insurance Act and is reproduced for your information only.

ASSISTING AT SURGERY AND ANAESTHESIA TIME UNITS TABLE

Time in Minutes [Hours]	Assistant Time Units for Billing	Anaesthesia Time Units for Billing
0-15	1	1
>15-30	2	2
>30-45	3	3
>45-60	4	4
>60-75 [>1h – 1h 15m]	6	6
>75-90 [>1h 15m – 1h 30m]	8	8
>90-105 [>1h 30m – 1h 45m]	10	11
>105-120 [>1h 45m – 2h]	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

APPENDIX H

Time in Minutes [Hours]	Assistant Time Units for Billing	Anaesthesia Time Units for Billing
>465-480 [>7h 45m – 8h]	82	86
>480-495 [>8h – 8h 15m]	85	89
>495-510 [>8h 15m – 8h 30m]	88	92

APPENDIX J

Section 1 – Eligible Comprehensive Virtual Care Services

VIDEO OR TELEPHONE

A001A, A007A, A008A, A013A, A014A, A020A, A023A, A024A, A033A, A034A, A043A, A044A, A051A, A053A, A054A, A058A, A063A, A064A, A071A, A073A, A074A, A078A, A083A, A084A, A093A, A094A, A111A, A113A, A114A, A118A, A131A, A133A, A134A, A138A, A151A, A153A, A154A, A158A, A161A, A163A, A164A, A168A, A173A, A174A, A181A, A183A, A184A, A188A, A193A, A194A, A203A, A204A, A221A, A233A, A234A, A243A, A244A, A261A, A262A, A263A, A264A, A283A, A284A, A310A, A311A, A313A, A318A, A338A, A340A, A341A, A343A, A348A, A353A, A354A, A411A, A413A, A414A, A418A, A441A, A443A, A444A, A448A, A461A, A463A, A464A, A468A, A471A, A473A, A474A, A478A, A480A, A481A, A483A, A484A, A488A, A510A, A511A, A570A, A601A, A603A, A604A, A608A, A611A, A613A, A614A, A618A, A621A, A623A, A624A, A628A, A632A, A633A, A638A, A643A, A644A, A661A, A713A, A760A, A917A, A920A, A927A, A937A, A947A, A957A, A967A, E424A, H313A, K002A, K003A, K004A, K005A, K007A, K008A, K010A, K012A, K013A, K014A, K015A, K016A, K019A, K020A, K022A, K023A, K024A, K025A, K028A, K029A, K030A, K033A, K037A, K039A, K040A, K041A, K044A, K122A, K123A, K140A, K141A, K142A, K143A, K144A, K195A, K196A, K197A, K198A, K203A, K204A, K205A, K206A, K208A, K209A, K222A, K623A, K680A, K887A, K888A, K889A, P005A

(Continued on next page)

APPENDIX J

VIDEO ONLY

A010A, A011A, A015A, A016A, A021A, A025A, A026A, A035A, A036A, A045A, A046A, A050A, A055A, A056A, A065A, A066A, A075A, A076A, A085A, A086A, A095A, A096A, A116A, A130A, A135A, A136A, A150A, A155A, A156A, A160A, A165A, A166A, A175A, A176A, A180A, A185A, A186A, A190A, A191A, A192A, A195A, A196A, A197A, A198A, A205A, A206A, A210A, A220A, A223A, A225A, A226A, A235A, A236A, A245A, A246A, A253A, A255A, A256A, A260A, A265A, A266A, A275A, A285A, A286A, A315A, A316A, A325A, A335A, A345A, A346A, A355A, A356A, A365A, A375A, A385A, A395A, A400A, A405A, A415A, A416A, A425A, A435A, A445A, A446A, A460A, A465A, A466A, A470A, A475A, A476A, A485A, A486A, A515A, A525A, A545A, A565A, A575A, A586A, A590A, A595A, A600A, A605A, A606A, A615A, A616A, A625A, A626A, A635A, A636A, A645A, A646A, A655A, A662A, A665A, A667A, A675A, A680A, A682A, A695A, A710A, A715A, A735A, A745A, A765A, A770A, A775A, A795A, A800A, A801A, A802A, A814A, A817A, A818A, A835A, A845A, A865A, A906A, A913A, A914A, A915A, A921A, A935A, A945A, C010A, C013A, C014A, C015A, C016A, C020A, C023A, C024A, C025A, C026A, C033A, C034A, C035A, C036A, C043A, C044A, C045A, C046A, C051A, C053A, C054A, C055A, C063A, C064A, C065A, C066A, C071A, C073A, C074A, C075A, C076A, C083A, C084A, C085A, C086A, C093A, C094A, C095A, C096A, C113A, C116A, C130A, C131A, C133A, C134A, C135A, C136A, C150A, C151A, C153A, C154A, C155A, C156A, C160A, C161A, C163A, C164A, C165A, C166A, C173A, C174A, C175A, C176A, C180A, C181A, C183A, C184A, C185A, C186A, C190A, C193A, C194A, C196A, C203A, C204A, C205A, C206A, C210A, C220A, C223A, C225A, C226A, C233A, C234A, C235A, C236A, C243A, C244A, C245A, C246A, C255A, C260A, C263A, C264A, C265A, C266A, C275A, C283A, C285A, C286A, C311A, C313A, C314A, C315A, C316A, C325A, C335A, C341A, C343A, C344A, C345A, C346A, C353A, C354A, C355A, C356A, C365A, C375A, C385A, C395A, C411A, C413A, C414A, C415A, C416A, C425A, C435A, C441A, C443A, C444A, C445A, C446A, C460A, C461A, C463A, C464A, C465A, C466A, C470A, C471A, C473A, C474A, C475A, C476A, C480A, C481A, C483A, C484A, C485A, C486A, C510A, C511A, C515A, C545A, C565A, C570A, C575A, C585A, C586A, C590A, C595A, C600A, C601A, C603A, C604A, C605A, C606A, C611A, C613A, C614A, C615A, C616A, C623A, C624A, C625A, C626A, C635A, C643A, C644A, C645A, C646A, C655A, C661A, C662A, C665A, C667A, C675A, C680A, C682A, C695A, C710A, C715A, C735A, C745A, C760A, C765A, C770A, C775A, C795A, C845A, C865A, C895A, C915A, C935A, C945A, K630A, W025A, W026A, W075A, W076A, W130A, W150A, W155A, W156A, W165A, W185A, W190A, W196A, W235A, W236A, W275A, W310A, W355A, W356A, W375A, W395A, W425A, W435A, W465A, W466A, W510A, W511A, W515A, W516A, W535A, W770A, W775A, W795A, W895A

APPENDIX J

Section 2 – Eligible Limited Virtual Care Services

Code	Description
A101A	Video
A102A	Telephone

APPENDIX J

NOT ALLOCATED

APPENDIX Q

Appendix Q does not form part of the *Schedule of Benefits: Physician Services under the Health Insurance Act* and is for your information only.

Please Refer to the Primary Health Care Fact Sheets for complete billing information.

Summary of Acronyms	
CCM	Comprehensive Care Model
FHG	Family Health Group
FHN	Family Health Network
FHO	Family Health Organization
RNPGA	Rural and Northern Physician Group Agreement
BSM	Community Sponsored Agreement Blended Salary Model
GHC	Group Health Centre
SJHC	St Joseph's Health Centre
SEAMO	South Eastern Academic Medical Organization
TPCA	Toronto <i>Palliative Care</i> Agreement
WHA	Weeneebayko Health Ahtuskaywin

Code	Description	Fee	Eligible Models
New Patient Fees			
Q023A	Unattached Patient Fee	150.00	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA
Q043A	New Patient Fee Abnormal Colorectal Cancer (CRC)/ Increased Risk Payment Based on age of patient	150.00 (up to 64 years) 170.00 (65 to 74 years) 230.00 (75 Years +)	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA For minimum requirements to claim Q043A please see INFOBulletin 4723

APPENDIX Q

Code	Description	Fee	Eligible Models
New Patient Fees			
Q053A	HCC Complex-Vulnerable Patient Fee	350.00	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Code	Description	Fee	Eligible Models
After Hours Fees			
Q012A	After Hours Fee	30%	FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA
Q016A	After Hours Fee	30%	CCM
Q017A	HIV After Hours Fees	30%	HIV

Code	Description	Fee	Eligible Models
Weekend & Holiday Access for FHO Patient			
Q888A	Weekend Access for FHO Patients	37.95	FHO

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

APPENDIX Q

Code	Description	Fee	Eligible Models
Newborn Care Fees			
Q014A	Newborn Care Episodic Fee	15.05	FHN, SEAMO
Q015A	Newborn Care Episodic Fee	13.99	FHO

Code	Description	Fee	Eligible Models
Rostering Fees			
Q200A	Per Patient Rostering Fee	0.00	CCM, FHG, FHN, FHO, RNPGA, BSM, SJHC, SEAMO, WHA
Q201A	Per Patient Rostering Fee	0.00	GHC, FHN, FHO
Q202A	Per Patient Rostering Fee	0.00	GHC, FHN, FHO

Code	Description	Fee	Eligible Models
Q590A	Basic Flu Shot - fee for visit premium	5.10	FHN, FHO
Q593A	Sole Visit Premium COVID-19 vaccine PEM	5.60	FHO, FHN, GHC, RNPGA, WHA, SJHC, TPCA, BSM, GP Focus Care of the Elderly, GP Focus HIV, Homeless Shelter Agreements, Sioux Lookout Agreements

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses			
Q150A	Colorectal Cancer Screening Fee (Once per patient every two years unless a patient has a negative colonoscopy (i.e., revealing either no polyps or only hyperplastic polyps in the sigmoid or rectum), then only after a period of 10 years, unless earlier screening is clinically indicated based on findings, advice and/or recommendations of the specialist who rendered the colonoscopy)	7.00	<p>All primary care physicians in Ontario including physicians participating in Patient Enrolment Models</p> <p>For minimum requirements to claim Q150A please see INFOBulletin 4723</p>
Q152A	Colorectal Cancer Screening Test Completion Fee (Once per patient every two years unless a patient has a negative colonoscopy (i.e., revealing either no polyps or only hyperplastic polyps in the sigmoid or rectum), then only after a period of 10 years, unless earlier screening is clinically indicated based on findings, advice and/or recommendations of the specialist who rendered the colonoscopy)	5.00	<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 Enrolment Models who are eligible for Preventive Care Bonus Payment are not eligible to bill this fee code.</p> <p>For minimum requirements to claim Q152A please see INFOBulletin 4723</p>

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q100A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 60% (\$220)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q101A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 65% (\$440)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q102A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 70% (\$770)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q103A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 75% (\$1100)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q104A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 80% (\$2200)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q105A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 60% (\$220)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q106A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 65% (\$440)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q107A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 70% (\$660)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q108A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 75% (\$1320)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q109A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 80% (\$2200)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q110A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 55% (\$220)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q111A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 60% (\$440)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q112A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 65% (\$770)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q113A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 70% (\$1320)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q114A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 75% (\$2200)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q115A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations - 85% (\$440)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q116A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations - 90% (\$1100)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q117A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations - 95% (\$2200)	Bill at \$0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q118A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 15% (\$220)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q119A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 20% (\$440)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q120A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 40% (\$1100)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q121A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 50% (\$2200)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q122A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 60% (\$3300)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q123A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 70% (\$4000)	Bill at \$0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

Code	Description	Fee	Eligible Models
Premiums Payable to Physicians When Providing Eligible Comprehensive Virtual Care Services			
Q012A	Primary care after-hours fee	30% of virtual fee paid	FHO, FHN, FHG, GHC, BSM, RNPGA, SJHC, WAHA
Q016A	CCM after-hours fee	30% of virtual fee paid	CCM
Q017A	HIV after-hours fee	30% of virtual fee paid	GP Focused HIV
Q018A	GP focus – COE1 after-hours fee	30% of virtual fee paid	GP Focused COE
Q020A	Serious mental illness premium: special payment for mental health services	\$1,200 - \$2,400	FHN, FHO, FHG, BSM, GHC, RNPGA, WAHA, SJHC, GP Focused HIV, Sioux Lookout Agreement
Q021A	Serious mental illness premium: special payment for mental health services	\$1,200 - \$2,400	FHN, FHO, FHG, BSM, GHC, RNPGA, WAHA, SJHC, GP Focused HIV, Sioux Lookout Agreement
Q042A	Smoking cessation counselling fee	7.50	BSM, CCM, FHG, FHN, FHO, GHC, GP Focused HIV, RNGPA, SJHC, WAHA
Q091	Primary care after-hours fee	10% of virtual fee paid	TPCA, GP Focused Palliative Care
Q150A	Colorectal cancer screening fee	7.00	All GP physicians
Q152A	Colorectal cancer screening test completion fee	5.00	All GP physicians

APPENDIX Q

Code	Description	Fee	Eligible Models
Premiums Payable to Physicians When Providing Eligible Comprehensive Virtual Care Services			
-	Palliative care special premium	\$3,600 - \$6,000	All GP physicians