The Ministry of Health and Long-Term Care
ONTARIO le ministère de la Santé et des Soins de longue durée

Schedule of Facility Fees

For Independent Health Facilities

Under the *Independent Health Facilities Act*

GENERAL PREAMBLE

1. Every licensee is responsible for ensuring that facility fees are charged to the Ministry, and payment accepted, only in accordance with the *Independent Health Facilities Act* (IHFA) and its regulations.

2. Facility fees shall be charged to the Ministry only in respect of a service rendered by a physician for which an amount payable is prescribed by the regulations under the *Health Insurance Act* (HIA), or a service prescribed as an insured service under the HIA rendered by a practitioner within the meaning of that Act (i.e., OHIP-insured medically necessary services provided to an insured person pursuant to a requisition.*)

3. Previous payment of a facility fee shall not be construed as approval of any particular billing practice.

4. Each independent health facility (IHF) licence is issued with respect to a specified single location or, in the case of mobile IHFs, with respect to specified multiple locations. Licensees are not permitted to charge facility fees to the Ministry, or to receive payment, in respect of services provided at locations other than the location(s) specified on the IHF licence. The unique billing number issued by the Ministry to each IHF shall only be used to charge facility fees to the Ministry for services provided at the location(s) specified on the facility licence. Non-compliance may lead to recovery of funds, licensing action in accordance with the IHFA, prosecution pursuant to the *Provincial Offences Act*, and/or such other legal action may be appropriate in the circumstances.

5. Where a referring physician requests a single site imaging study (for example, one breast, one limb), any additional imaging of a portion of the anatomy for comparison purposes is not an insured service and shall not be charged to the ministry.

6. Where a referring physician requests a single site imaging study, any additional imaging study is not an insured service and shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record.

7. Where a licensee provides breast ultrasound services, a scan of the axilla is an integral part of the breast imaging exam. The licensee shall not charge any facility fees to the ministry in connection with an additional insured service fee code such as J182 (extremity ultrasound).

8. Where a referring physician requests mammography, the addition of ultrasound breast imaging services shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record.

9. Where a copy of an imaging study is requested for the purpose of continuing medical care, the licensee shall not charge any person for costs of preparing a CD or other imaging media. If a licensee charges a patient in such circumstances, the ministry will reimburse the patient and recover the full amount from the licensee through set-off from future billings, in addition to applying an administrative penalty of $50 per occurrence, pursuant to the IHFA and regulations.

* "written requisition" means: a written requisition from a referring physician or a requisition from a practitioner as may be permitted under the IHFA or the HIA and the regulations.

NUCLEAR MEDICINE – IN VIVO

PREAMBLE

SPECIFIC ELEMENTS

For Facility Fee Component (F fee)

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

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

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the facility fee components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility fee components are claimed separately. Claims for the facility fee component F are submitted using listed fee code with suffix B. Where the IHF is submitting professional fee claims on behalf of the interpreting physician, claims for professional component are submitted using fee code with suffix C (e.g. J802C).

2. If examination of Brain, Lung, Liver or Spleen is limited to one view, the benefit (F fee) is to be reduced by 50%.

3. Repeat studies on the same day may be claimed only after exercise or drug intervention.

NUCLEAR MEDICINE – IN VIVO

Code			F
CARDIOVASCULAR SYSTEM			
	Venography		
J802	- peripheral and superior vena cava		96.35
	First Transit		
J804	- without blood pool images		16.10
J867	- with blood pool images		57.30
	Cardioangiography		
J806	- first pass for shunt detection, cardiac output and transit studies		95.10
	Myocardial Perfusion Scintigraphy		
J807	- resting, immediate post stress		217.55
J866	- application of SPECT (maximum one per examination)	add	43.50
J808	- delayed		80.10
J809	- application of SPECT (maximum two per examination)	add	43.50
	Myocardial scintigraphy		
J810	- acute infarction, injury		88.25
	Myocardial wall motion		
J811	- studies		95.10
J812	- repeat same day (to a maximum of three repeats)		48.15
J813	- studies with ejection fraction		135.15
J814	- repeat same day (to a maximum of three repeats)		48.15
	Note: J811 and/or J812 rendered in conjunction with J813 and/or J814 are insured services payable at nil.		
J815	Detection of venous thrombosis using radioiodinated fibrinogen up to ten days		131.70
ENDOCRINE SYSTEM			
	Adrenal scintigraphy		
J816	- with iodocholesterol		385.90
J868	- with iodocholesterol and dexamethasone suppression		451.30
J869	- with MIBG		555.35
	Thyroid scintigraphy		
J818	- with Tc99m or I-131		64.15
J871	- with I-123		103.10
	Thyroid		
J817	- uptake		28.65
J870	- repeat		14.65

NUCLEAR MEDICINE – IN VIVO

Code		F
ENDOCRINE SYSTEM (continued)		
	Parathyroid scintigraphy	
J820	-dual isotope technique with T1201 and Tc99m Iodine	234.70
J872	Metastatic survey with I-131	240.60
GASTROINTESTINAL SYSTEM		
	Schilling test	
J821	- single isotope	44.65
J823	- dual isotope	48.15
	Malabsorption test	
J824	- with C^{14} substrate	57.30
J873	- with whole body counting	137.70
	Gastrointestinal	
J825	- protein loss	82.45
J874	- blood loss using – Cr^{51}	61.90
J829	- transit	103.10
	Calcium absorption	
J826	- Ca^{45}	61.90
J875	- Calcium^{47} absorption/excretion	253.10
J827	Oesophageal motility studies – one or more	118.90
	Gastro-oesophageal	
J876	- reflux	56.70
J877	- aspiration	40.15
	Abdominal scintigraphy – for gastrointestinal bleed	
J830	- Tc99m sulphur colloid or Tc^{04}	87.00
J878	- labelled RBCs	143.20
J879	- LeVeen shunt patency	66.30
J831	Biliary scintigraphy	114.50
J832	Liver/spleen scintigraphy	80.10
J833	Salivary gland scintigraphy	96.25
GENITOURINARY SYSTEM		
J834	Dynamic renal imaging	96.25
	Computer assessed renal function	
J835	- includes first transit	131.70
J880	- repeat after pharmacological intervention	44.85

NUCLEAR MEDICINE – IN VIVO

Code		F
GENITOURINARY SYSTEM (continued)		
J836	Static renal scintigraphy	33.25
J837	ERPF by blood sample method	40.15
J838	GFR by blood sample method	40.15
J839	Cystography for vesicoureteric reflux	120.55
	Testicular and scrotal scintigraphy	
J840	- includes first transit	82.45
HAEMATOPOIETIC SYSTEM		
J841	Plasma volume	43.50
J843	Red cell volume	48.15
J847	Ferrokinetics – clearance, turnover, and utilization	400.95
J848	Red cell, white cell or platelet survival	102.60
J849	Red cell survival with serial surface counts	148.25
	Bone marrow scintigraphy	
J881	- whole body	113.70
J882	- single site	84.85
	In-111 leukocyte scintigraphy	
J883	- whole body	364.30
J884	- single site	320.80
MUSCULOSKELETAL SYSTEM		
	Bone scintigraphy	
J850	- general survey	103.70
J851	- single site	84.85
	Gallium scintigraphy	
J852	- general survey	177.55
J853	- single survey	123.70
	Application of Tomography (SPECT)	
J819	- where each SPECT image represents a different organ or body area, to J852, maximum three images per examination add	43.50
	Note: J850 and J851 are not to be billed together. J804 may be claimed in addition to J850 or J851 for blood pool study.	
NERVOUS SYSTEM		
	CSF circulation	
J857	- with Tc99m or I-131 HAS	120.25
J885	- with In-111	308.20

NUCLEAR MEDICINE – IN VIVO

Code		F
NERVOUS SYSTEM (continued)		
J886	- via shunt puncture	88.55
J858	Brain scintigraphy	90.40
RESPIRATORY SYSTEM		
J859	Perfusion lung scintigraphy	85.90
J887	Ventilation lung scintigraphy	107.70
J860	Perfusion and ventilation scintigraphy – same day	171.85
MISCELLANEOUS		
J861	Radionuclide lymphangiogram	112.20
J862	Ocular tumour localization	75.60
J864	Tear duct scintigraphy	97.35
J865	Total body counting	187.95
	Application of Tomography (SPECT), other than to J808 or J852	
J866	- maximum one per Nuclear Medicine examination add	43.50
SCINTIMAMMOGRAPHY		
	Scintimammography is not eligible for payment unless at least one of the following conditions is met: a. the patient has a dense breast(s) and one or both of the following risk factors: i. a first degree relative with breast cancer diagnosed prior to age 50; or ii. a first degree relative with breast cancer diagnosed over age 50 and patient is within 5 years of the age when the relative was diagnosed with breast cancer. b. architectural distortion of the breasts due to prior breast surgery, radiotherapy, chemotherapy or the presence of breast prosthesis rendering mammography interpretation difficult; c. malignant breast lesion when mammography is unable to exclude multifocal disease; or d. solitary lesion identified on mammography of greater than 1 cm	
	Scintimammography	
J863	- unilateral or bilateral	99.95
	Note: For the purpose of this provision, “dense breast(s)” means (a) breast(s) occupied by over 75% fibroglandular tissue as noted on mammography.	

DIAGNOSTIC RADIOLOGY

PREAMBLE

SPECIFIC ELEMENTS

For Facility Fee Component (F fee)

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure or assisting in the performance of fluoroscopy.

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

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

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility fee components are claimed separately. Claims for facility fee component F are submitted using the listed fee code with suffix B.

2 If less than the minimum number of views are performed, reduce listed fees by 25%.

3. If insured diagnostic radiology procedures yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient governed by the needs of the patient and the requirements of the referring physician or practitioner, the radiologist may add further views and claim for the additions which are to be noted in the report.

4. Where a referring physician requests a single site imaging study (for example, one breast, one limb), any additional imaging of a portion of the anatomy for comparison purposes is not an insured service and shall not be charged to the ministry.

5. A stereo pair is to be counted as two views.

6. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.

7. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examination requests.

8. Mandible X006 and Temporomandibular joints X007 are not both to be routinely claimed on the same patient but only when specifically ordered.

9. Conventional films of the spine should not be routinely done and claimed for before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they have been done at an outside office, then it is a matter for the radiologist and the referring physician to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required procedure of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.

10. Lumbar or lumbosacral spine X028 does not include the entire sacrum. An x-ray of the sacrum may be carried out and claimed for only when specifically indicated.

11. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.

12. Chest studies should not be routinely done and claimed in mammography cases.

13. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examinations, e.g. examinations of the GI tract, urinary tract, and special procedures.

14. 'Colon - air contrast' may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.

15. 'Oesophagus, stomach and duodenum - double contrast' presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.

16. 'Pharynx and oesophagus - cine or videotape' (X106) should not be claimed routinely with X108 and X109 but only when specifically indicated.

17. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.

18. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.

19. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who has the authority to determine what examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed, a single film is usually inadequate.

20. No extra fee should be claimed for rapid sequence IVP.

21. Nephrotomography is covered by the listings for intravenous pyelogram and planigram.

DIAGNOSTIC RADIOLOGY

22. For the following surgical procedures, the technical fee components for chest x-ray, X090, X091, X092 are only eligible for payment in the preoperative preparation of the patient when the referring physician obtains prior authorization of payment from the Ministry of Health and Long-Term Care and demonstrates the medical necessity of the service:

a. cataract surgery;
b. colonoscopy;
c. cystoscopy;
d. carpal tunnel surgery; or
e. arthroscopic surgery.

[Commentary:
If there is an indication requiring a chest x-ray other than strictly for preoperative preparation for the above surgical procedures, prior approval is not required and the technical fee may be claimed.]

23. Mammography or x-ray of the chest, ribs, arm, wrist, hand, leg, ankle or foot, rendered in an Independent Health Facility or a hospital in-patient or out-patient department is insured in accordance with the Health Insurance Act when referred by a registered nurse holding an extended certificate of registration (RN(EC)).

DIAGNOSTIC RADIOLOGY

Code		F
HEAD AND NECK		
	Skull	
X001	- four views	32.20
X009	- five or more views	40.11
X003	Sella turcica (when skull not examined)	16.05
	Facial bones	
X004	-three views	23.37
	Nose	
X005	- two views	16.05
	Mandible	
X006	- three views (unilateral or bilateral)	23.37
X012	- four or more views	32.20
X007	Temporomandibular joints – four views including open and closed mouth views	23.37
	Sinuses	
X008	- three views	23.37
	Mastoids	
X010	- bilateral – six views	30.85
X011	Internal auditory meati (when skull not examined)	23.37
	Note: Dental x-rays of the teeth are not an insured benefit.	
X016	Eye, for foreign body	15.99
X017	Eye, for localization, additional	16.48
X018	Optic foramina	18.15
X019	Salivary gland region	14.81
	Neck for soft tissues	
X020	- two views	14.81
SPINE AND PELVIS		
	Cervical spine	
X025	- two or three views	27.89
X202	- four or five views	35.97
X203	- six or more views	43.45
	Thoracic spine	
X027	- two views	25.47
X204	- three or more	32.20

DIAGNOSTIC RADIOLOGY

Code		F
SPINE AND PELVIS (continued)		
	Lumbar or lumbosacral spine	
X028	- two or three views	27.89
X205	- four or five views	35.97
X206	- six or more views	43.45
	Entire spine (scoliosis series)	
X032	- four views	57.67
	- orthoroentgenogram (3 foot film)	
X033	- single view	23.37
X031	- two or more views	31.98
	Sacrum and/or coccyx	
X034	- two views	25.79
X207	- three or more views	33.44
	Sacro-iliac joints	
X035	- three or more views	23.37
X208	- four or more views	31.18
	Pelvis and/or hip(s)	
X036	- one view	16.05
X037	- two views (e.g. AP and frog view, both hips, or AP both hips plus lateral one hip)	29.88
X038	- three or more views (e.g. pelvis and sacro-iliac joints, or AP both hips plus lateral each hip)	34.35
UPPER EXTREMITIES		
	Clavicle	
X045	- two views	16.05
X209	- three or more views	24.66
	Acromioclavicular joints (bilateral) with or without weighted distraction	
X046	- two views	23.37
X210	- three or more views	31.88
	Sternoclavicular joints (bilateral)	
X047	- two or three views	19.33
X211	- four or more views	27.57
	Shoulder	
X048	- two views	19.33
X212	- three or more views	27.57
	Scapula	
X049	- two views	19.33
X213	- three or more views	27.78

DIAGNOSTIC RADIOLOGY

Code		F
UPPER EXTREMITIES (continued)		
	Humerus including one joint	
X050	- two views	16.05
X214	- three or more views	24.50
	Elbow	
X051	- two views	16.05
X215	- three or four views	24.66
X216	- five or more views	33.22
	Forearm including one joint	
X052	- two views	16.05
X217	- three or more views	24.66
	Wrist	
X053	- two or three views	16.05
X218	- four or more views	24.66
	Hand	
X054	- two or three views	16.05
X219	- four or more views	24.66
	Wrist and hand	
X055	- two or three views	23.37
X220	- four or more views	29.78
	Finger or thumb	
X056	- two views	12.38
X221	- three or more views	16.05
LOWER EXTREMITIES		
	Hip (unilateral)	
X060	- two or more views	25.58
	Femur including one joint	
X063	- two views	16.05
X223	- three or more views	23.91
	Knee including patella	
X065	- two views	16.05
X224	- three or four views	24.66
X225	- five or more views	33.22
	Tibia and fibula including one joint	
X066	- two views	16.05
X226	- three or more views	24.66

DIAGNOSTIC RADIOLOGY

Code		F
LOWER EXTREMITIES (continued)		
	Ankle	
X067	- two or three views	16.05
X227	- four or more views	24.66
	Calcaneus	
X068	- two views	16.05
X228	- three or more views	24.66
	Foot	
X069	- two or three views	16.05
X229	- four or more views	24.66
	Toe	
X072	- two views	12.38
X230	- three or more views	16.05
X064	Leg length studies (orthoroentgenogram)	23.37
SKELETAL SURVEYS		
	Skeletal survey for bone age	
X057	- single film	16.05
X058	- two or more films or views	23.37
	Other survey studies – e.g. rheumatoid, metabolic or metastatic	
X080	- single view	8.02
X081	- each additional film or view	8.02
CHEST AND ABDOMEN		
	Chest	
X090	- single view	16.05
X091	- two views	23.58
X092	- three or more views	30.31
	Note: Miniature chest film for survey purposes only is not an insured benefit.	
	Ribs	
X039	- two or more view	19.33
	Sternum	
X040	- two or more view	19.33
	Thoracic inlet	
X096	- two or more view	16.05

DIAGNOSTIC RADIOLOGY

Code		F
CHEST AND ABDOMEN (continued)		
	Abdomen	
X100	- single view	16.05
X101	- two or more views	24.55
GASTROINTESTINAL TRACT		
	Palatopharyngeal analysis	
X105	- cine or videotape	31.77
	Pharynx and oesophagus	
X106	- cine or videotape	31.77
X107	Oesophagus when X103, X104, X108 or X109 not claimed	28.75
	Oesophagus, stomach and duodenum	
X108	- including survey film, if taken	49.86
X104	- double contrast, including survey film, if taken	52.23
X103	- double contrast, including survey film, if taken, and small bowel	65.64
X110	Hypotonic duodenogram	42.38
X109	Oesophagus, stomach and small bowel	63.64
	Small bowel only	
X111	- when only examination performed during patient's visit	28.43
	Colon	
X112	- barium enema including survey film, if taken	52.12
X113	- air contrast, primary or secondary, including survey films, if taken	66.01
	Gallbladder	
X114	- one or multiple day examinations	32.25
X120	- one or multiple day examinations with preliminary plain film	42.86
X116	T-tube cholangiogram	23.37
X123	Operative pancreatogram or ERCP	23.37
GENITOURINARY TRACT		
X129	Retrograde pyelogram, unilateral or bilateral	23.37
X130	Intravenous pyelogram including preliminary film	53.47
X137	Cystogram (catheter)	25.68
X135	Cystourethrogram, stress or voiding (catheter)	29.61
X131	Cystourethrogram (non-catheter)	6.19
X191	Intestinal conduit examination or nephrostogram	23.37
X138	Percutaneous antegrade pyelogram	23.37
X139	Percutaneous nephrostogram	23.37

DIAGNOSTIC RADIOLOGY

Code		F
GENITOURINARY TRACT (continued)		
X134	Retrograde urethrogram	19.33
X136	Vasogram	19.33
X141	Cavernosography	22.24
OBSTETRICS AND GYNAECOLOGY		
X147	Hysterosalpingogram	32.09
FLUOROSCOPY – BY PHYSICIAN WITH OR WITHOUT SPOT FILMS		
X195	Chest	9.96
X196	Skeleton	9.96
X197	Abdomen	9.96
X189	Fluoroscopic control of clinical procedures done by another physician per ¼ hour	7.86
SPECIAL EXAMINATIONS		
	Abdominal, thoracic, cervical or cranial angiogram by catheterization	
	Using single films	
X179	- non-selective	31.88
X180	- selective (per vessel, to a maximum of 4)	41.94
	Using film changer, cine or multiformat camera	
X181	- non-selective	64.24
X182	- selective (per vessel, to a maximum of 4)	85.40
X140	- selective (5 or more vessels)	341.75
	Carotid angiogram by direct puncture	
X160	**-** unilateral	52.66
X161	- bilateral	84.64
	Peripheral angiogram	
X174	- unilateral	32.09
X175	- bilateral	42.38
X198	Splenoportogram	63.64
X199	Translumbar aortogram	63.64
	Vertebral angiogram – direct puncture or retrograde brachial injection	
X132	- unilateral	52.66
X133	- bilateral	86.04
X156	Arthrogram, tenogram or bursogram	28.27
X200	- with fluoroscopy and complete positioning throughout by physician	39.52

DIAGNOSTIC RADIOLOGY

Code		F
SPECIAL EXAMINATIONS (continued)		
	Bronchogram	
X158	- unilateral	31.18
X159	- bilateral	41.35
X122	Cholangiogram, percutaneous trans-hepatic	31.77
BONE MINERAL DENSITY (BMD) MEASUREMENT		
	Dual-energy X-Ray Absorptiometry (DXA) – by axial technique only **Definition:** For the purpose of second and subsequent testing, **"high risk patient"** means a patient; 1. at risk for accelerated bone loss (in the absence of other risk factors, patient age is deemed not to place a patient at high risk for accelerated bone loss); 2. with osteopenia or osteoporosis on any previous BMD testing; or 3. with bone loss in excess of 1% per year as demonstrated by previous BMD testing. **"low risk patient"** means a patient who is not a high risk patient **Definition/Required Elements of Service:** BMD measurement by DXA is an insured service only when all the following conditions have been met: 1. the service is rendered for the prevention and management of osteoporosis or osteopenia; 2. when more than one site is measured, the sites include both hip and spine and where measurement of both hip and spine is not technically feasible the site measured consists of either hip or spine. [**Commentary:** Measurement of hip and spine would be considered not technically feasible due to prosthesis or deformity.]	
	Baseline Test	
X145	- one site	46.14
X146	- two or more sites	59.44
	Second test - low risk patient	
X152	- one site	46.14
X153	- two or more sites	59.44
	Subsequent test - low risk patient	
X142	- one site	46.14
X148	- two or more sites	59.44

DIAGNOSTIC RADIOLOGY

Code		F
BONE MINERAL DENSITY (BMD) MEASUREMENT (continued)		
	Subsequent test - high risk patient	
X149	- one site	46.14
X155	- two or more sites	59.44

Payment rules:

1. Patients are limited to one baseline test (X145 or X146) in their lifetime.
2. Second test – low risk patient (X152/X153) is limited to a maximum of one test rendered not earlier than 36 months following the baseline test (X145/X146).
3. Subsequent test – low risk patient (X142/X148) is *not eligible for payment* when rendered earlier than 60 months following the second or any subsequent test.
4. Any combination of services described by X152 or X153 that were rendered to a patient between July 1, 2007, and April 1, 2008, for which claims were submitted and paid as insured services under the *Health Insurance Act* constitutes, a "second test – low risk patient" for the purpose of determining service maximums for a second or subsequent test – low risk patient, and is deemed to have been rendered on July 1, 2010.
5. Any service described by X152 or X153 rendered between April 1, 2008, and July 1, 2010, for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes a subsequent test – low risk patient for the purpose of determining service maximums for second or subsequent test – low risk patient and is deemed to have been rendered on July 1, 2010.
6. Subsequent test - high risk patients (X149/X155) is limited to a maximum of one test every 12 months unless the ordering physician obtains written prior authorization from a *medical consultant*.

[Commentary:
Authorization will be dependent on the referring physician demonstrating that the test is generally accepted as necessary for the patient under the circumstances.}

[**Commentary:**

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

DIAGNOSTIC RADIOLOGY

Code		F
MISCELLANEOUS EXAMINATIONS		
X163	Dacrocystogram	31.88
	Discogram(s)	
X164	- one or more levels	31.18
X167	Fistula or sinus	23.15
X169	Laminogram, planigram, tomogram	42.97
X170	Laryngogram	31.18
X171	Lymphangiogram	52.77
X192	Mammary ductography	26.98
	Mammogram – Signs or Symptoms	
	[Commentary: For individuals with identified signs or symptoms or follow-up of established disease.]	
	Dedicated equipment	
X184	- unilateral	30.21
X185	- bilateral	40.01
	Mammogram – No Signs or Symptoms	
	[Commentary: Where the sole reason for the request for a mammogram is for an individual with identified risk factors in accordance with clinical practice guidelines]	
	Dedicated equipment	
X172	- unilateral	30.21
X178	- bilateral	40.01
X194	Additional coned views with or without magnification (limit of two per breast) per film	6.41
X201	Breast biopsy specimen x-ray, per specimen	6.41
X150	Mechanical evaluation of knee	27.41
X193	Microradioscopy of the hands	15.61
X173	Myelogram – spine and/or posterior fossa	37.64
X190	Pantomography	19.11
X154	Penis	17.18
X176	Sialogram	32.09
X177	Skin thickness measurement	16.80
X166	Examination using portable machine “in home” add to first examination only	69.74
	Note: X166 does not apply to the use of a portable machine in a hospital. Can only be claimed once per day regardless of the number of people x-rayed in the same “home” including “nursing home”.	

DIAGNOSTIC ULTRASOUND

PREAMBLE

SPECIFIC ELEMENTS

For Facility Fee Component (F)

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

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

F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring physician.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility fee components are claimed separately. Claims for the facility fee component F are submitted using listed fee code with suffix B. Claims for professional component are submitted using fee code with suffix C (e.g. J102C).

2. A-Mode - implies a one-dimensional ultrasonic measurement procedure.

3. M-Mode - implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.

4. 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.

5. 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.

6. Ultrasound of the abdomen, pelvis or breast, rendered in an Independent Health Facility or a hospital in-patient or out-patient department, is insured in accordance with the Health Insurance Act when referred by a registered nurse holding an extended certificate of registration (RN(EC)).

7. Ultrasound for normal, complicated or high risk pregnancy (but not for the postpartum period) rendered in an Independent Health Facility is insured when referred by a midwife who is a member of the College of Midwives of Ontario.

DIAGNOSTIC ULTRASOUND

8. The diagnostic ultrasound benefit includes the generally accepted components of the procedure. For example, where a licensee provides breast ultrasound services, a scan of the axilla is an integral part of the breast imaging exam. The licensee shall not charge any facility fees to the ministry in connection with an additional insured service fee code such as J182 (extremity ultrasound)

9 Where a referring physician requests a single site imaging study (for example, one breast, one limb), any additional imaging of a portion of the anatomy for comparison purposes is not an insured service and shall not be charged to the ministry.

10.Ultrasound of extremity (J182) are to be claimed per limb, not per joint. Scanning two joints on one limb and claiming two services for J182 is incorrect.

11. The practice of routinely submitting claims for more diagnostic ultrasound services than were requested by the referring physician for the majority of patients scanned, will result in a ministry review and potential recovery of funds and/or potential licensing actions. Examples of this unacceptable practice include;

- Bilateral Scans

  2 Breasts routinely imaged and billed when only one was requested without the approval of the site radiologist , J127

  2, 3, or 4 Extremities routinely imaged and billed when only one or two were requested J182
  Axilla scanned and routinely billed as J182 (extremity) during a breast ultrasound [J127 includes scanning of the axilla]

- Routine Addition of scans

  Addition of trans vaginal US J138 to a requisition for pelvic US J162

  Addition of extremity ultrasound J182 to peripheral vessel assessment, J202

  Addition of chest US, J125 to abdominal imaging studies where this is not indicated

  Addition of limited pelvis US, J163 to abdominal US, J135, or to limited abdomen, J128

12. Ultrasound services are not insured when rendered in support of in-vitro fertilization services or artificial insemination services.

DIAGNOSTIC ULTRASOUND

Code		F
HEAD AND NECK		
	Brain	
J122	- complete, B-mode	47.20
	Echography – ophthalmic (excluding vascular study)	
J102	- quantitative, A-mode	22.40
J103	- B-scan immersion	43.95
J107	- B-scan contact	21.75
J108	- biometry (Axial length – A-mode)	22.80
	Face and/or neck	
J105	- excluding vascular study	47.30
	Note: J105 is *not eligible for payment* when rendered for ultrasound imaging of the sinus(es).	
THORAX, ABDOMEN AND RETROPERITONEUM		
	Thorax	
J125	Chest masses, pleural effusion – A & B-mode	48.75
	Abdomen and Retroperitoneum	
	Abdominal scan	
J135	- complete	48.75
J128	- limited study (e.g. gallbladder only, aorta only or follow-up study)	32.10
PREGNANCY		
	Complete	
J159	- on or after 16 weeks gestation (maximum one per normal pregnancy)	48.75
J160	- for high risk pregnancy or complications of pregnancy	48.75
J166	- multiple gestation, for each additional fetus, to J160	41.45
	Gestational age for Maternal Serum Screening Program	
J157	- before 16 weeks gestation (maximum one per normal pregnancy)	32.10
	Limited	
J158	- for high risk pregnancy or complications of pregnancy	32.10
J167	- fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158, add	32.10
	Note: J167 is *only eligible for payment* when rendered by a physician for assessment of fetal anemia or intrauterine growth retardation measuring below the 10th percentile	
J168	- nuchal translucency for Prenatal Genetic Screening (maximum one per pregnancy)	39.00
J169	- multiple gestation, for each additional fetus, to J168 add	33.15

DIAGNOSTIC ULTRASOUND

Code		F
PREGNANCY (continued)		
	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*.	
PELVIS		
	Pelvis	
J162	- complete*	48.75
J138	Intracavitary ultrasound* (e.g. transrectal, transvaginal)	48.75
	Note: *For ovulation induction purposes, the limit is one per cycle. Additional ultrasounds may be claimed as J164.	
J165	Transvaginal sonohysterography – may include saline or other intracavitary contrast media except Echovist for demonstration of tubal patency	99.95
J476	Transvaginal sonohysterography – including Echovist contrast media for demonstration of tubal patency	232.90
	Note: J138 and J161 rendered in conjunction with J165 are insured services payable at nil.	
J163	- limited study – for other than pregnancy	32.10
	Intracavitary ultrasound	
J161	- limited – for other than pregnancy	32.10
J164	Follicle monitoring studies	24.40
[Commentary: Ultrasound services are not insured when rendered to support in-vitro fertilization services or artificial insemination services.]		
VASCULAR SYSTEM		
	Extra-cranial vessel assessment – above the aortic arch	
	Bilateral carotid and/or subclavian and/or vertebral arteries only	
J190	- doppler scan or B scan	42.65
J201	- duplex scan i.e. simultaneous real time, B-mode imaging and spectral analysis	55.05
	Peripheral vessel assessment (distal to inguinal ligament or axilla), artery and/or vein evaluation per extremity. Not to be billed routinely with J190, J191 or J192.	
J193	- doppler scan or B scan, unilateral	22.05
J202	- duplex scan i.e. simultaneous real time, B-mode imaging and spectral analysis, unilateral	28.50

DIAGNOSTIC ULTRASOUND

Code		F
VASCULAR SYSTEM (continued)		
	Venous assessment	
J198	- bilateral – includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manoeuvres and permanent record	7.40
	Note: Note 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
	Duplex evaluation of portal hypertension	
J206	- must include doppler interrogation and documentation or superior mesenteric vein, splenic vein, portal veins, hepatic veins and hepatic arteries	22.05
	Note: Not to be billed unless study specifically requested by referring physician.	
	Duplex assessment of patency obstruction, and flow direction of vascular shunts	
J207	- must include doppler interrogation and documentation of vascular shunts	22.05
	Note: Not to be billed unless study specifically requested by referring physician.	
VASCULAR LABORATORY FEES		
	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
J196	- with exercise and/or quantitative measurement, to J200 add	8.00
	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 of the Schedule of Benefits.]	
	Penile pressure recordings	
J197	- two or more pressures	6.85
	Penile Doppler Evaluation	
J199	- Doppler scan	6.85

DIAGNOSTIC ULTRASOUND

Code		F
VASCULAR LABORATORY FEES (continued)		
	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 erective dysfunction. **[Commentary:** Penile Doppler performed for other indications is not an insured service.]	
	Transcutaneous tissue	
J203	- oxygen tension measurements	24.10
J204	- when done in addition to Doppler studies	13.20
MISCELLANEOUS		
	Extremities	
J182	- per limb (excluding vascular study)	25.50
	Breast	
J127	- scan B-mode (per breast)	23.70
	Scrotal	
J183	- scan	47.30
ULTRASONIC GUIDANCE		
	SPECIFIC ELEMENTS In addition to the *common elements*, the components of Ultrasonic Guidance include the following *specific elements*. 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(s)*, 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.	
J149	Ultrasonic Guidance of biopsy, aspiration, amniocentesis or drainage procedures (one physician only)	47.30
	Note: J138 and J161 performed during the same visit as J149 is an insured service payable at nil.	

PULMONARY FUNCTION STUDIES

PREAMBLE

SPECIFIC ELEMENTS

For Facility Fee Component (F)

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

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

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility fee components are claimed separately. Claims for facility fee component F are submitted using listed fee code with suffix B. Claims for professional component P are submitted using listed fee code with suffix C.

2. Each of the following tests designated by an individual code number is considered to be specific and requires individual ordering.

3. Exercise assessment (J315, E450, E451, J316) requires a physician to be in attendance at all times.

PULMONARY FUNCTION STUDIES

Code		F
	Functional residual capacity	
J311	- by gas dilution method	16.30
J307	- by body plethysmography	17.50
	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
J306	Airways resistance by plethysmography or estimated using oesophageal catheter	16.20
J303	Extra pulmonary airways resistance by plethysmography	16.20
J340	Maximum inspiratory and expiratory pressures	2.81
J310	Carbon monoxide diffusing capacity by single breath method	21.40
J308	Carbon dioxide ventilatory response	19.90
	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
E450	- J315 plus J301 or J304 before and/or after exercise add	13.30
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
	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
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
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
J331	Estimate of shunt (Qs/Qt) breathing pure oxygen	27.55
J313	Mixed venous PCO_2, by the rebreathing method	11.25
	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
J334	- J332 with at least two levels of supplemental O_2	30.55
J336	- with single blind assessment of exercise on room air and with supplemental oxygen	30.55
	Note: 1. J323 is *not eligible for payment* when rendered with J332, J315, J316 or any overnight sleep study. 2. J332 is *not eligible for payment* when rendered with J315, J316, 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.	

PULMONARY FUNCTION STUDIES

Code		F
PULMONARY FUNCTION STUDIES (continued)		
	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
J333	Non-specific bronchial provocative test (histamine, methacholine, thermal challenge)	48.25
J335	Antigen challenge test	51.85
	Note: For home/self-care ventilation listing – see Diagnostic and Therapeutic Procedures page J27 of the Schedule of Benefits.	

SLEEP STUDIES

PREAMBLE

SPECIFIC ELEMENTS

For Facility fee Component (F)

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

C. Making arrangements for any appropriate follow-up care.

D. Preparing and providing records of the results of the procedure to the interpreting physician.

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

F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring physician.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical components.

OTHER TERMS AND DEFINITIONS
SLEEP STUDIES
For the purpose of sleep studies (including overnight sleep studies in non-specialized facilities, overnight sleep studies rendered in specialized facilities and daytime sleep studies),

“CPSO Standards” means the publication of the College of Physicians and Surgeons of Ontario entitled “Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine” in effect 6 months prior to the date upon which the sleep study was rendered.

“Prior approval” means approved for payment as an insured service, before the service is rendered, by the Ministry of Health and Long-Term Care following assessment on a case-by-case basis in accordance with all medically relevant criteria.

Sleep studies are subject to limits set out below. Unless otherwise specifically provided, service(s) in excess of these limits are not insured services except when prior approval to exceed the limit is obtained from the Ministry of Health and Long-Term Care. Despite the foregoing, where prior approval to exceed a limit is not requested from the Ministry of Health and Long-Term Care but the service would otherwise satisfy one or more of the conditions for which prior approval to exceed the limit is routinely granted (had prior approval been requested) any service in excess of the limit is not eligible for payment.

SLEEP STUDIES

Claims submission instructions:

Submit claims for professional and facility components separately. Submit claims for the facility fee component F using listed fee code with suffix B. Submit claims for professional component using fee code with suffix C (e.g. J890C).

Facility Fee Component

Payment rules:
The facility fee component of the procedure is eligible for payment only if it meets all of the following requirements:

1. A technician is in constant attendance with the patient(s) during the period of the sleep study.

2. The qualifications of technical staff participating in the sleep study comply with the criteria set out in the CPSO Clinical Practice Parameters and Standards.

3. All equipment and test components comply with the criteria set out in the CPSO Standards.

Medical record requirements:

Records of the facility fee component must conform to the standards for facilities and facility operators (including records required prior to data analysis) as set out in the CPSO Clinical Practice Parameters and Standards, or the facility fee component is not eligible for payment.

SLEEP STUDIES

Code		F
	OVERNIGHT SLEEP STUDIES For the purpose of sleep studies (including overnight sleep studies and daytime sleep studies), “CPSO Standards” means the publication of the College of Physicians and Surgeons of Ontario entitled “Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine” in effect 6 months prior to the date upon which the sleep study was rendered. “prior approval” means approved for payment as an insured service, before the service is rendered, by the Ministry of Health and Long-Term Care following assessment on a case-by-case basis in accordance with all medically relevant criteria. Terms and Conditions Facility fees for sleep studies meeting the eligibility parameters are payable under the Independent Health Facilities Act and are listed in the Schedule of Facility Fees. Sleep studies are subject to limits set out below. Unless otherwise specifically provided, service(s) in excess of these limits are not insured services except when prior approval to exceed the limit is obtained from the Ministry of Health and Long-Term Care. Despite the foregoing, where prior approval to exceed a limit is not requested from the Ministry of Health and Long-Term Care but the service would otherwise satisfy one or more of the conditions for which prior approval to exceed the limit is routinely granted (had prior approval been requested) any service in excess of the limit is not eligible for payment. [Commentary: Services rendered in excess of a maximum are not eligible for payment.] IHF Facility Fee Payment rules: The facility fee for the procedure is eligible for payment only if it meets all of the following requirements: 1. It satisfies the conditions set out under “Sleep Studies Services Rendered at a licensed Independent Health Facility (IHF)". 2. It is rendered at a licensed IHF. 3. A technician is in constant attendance with the patient(s) during the period of the sleep study. 4. The qualifications of technical staff participating in the sleep study comply with the criteria set out in the CPSO Standards. 5. All equipment and test components comply with the criteria set out in the CPSO Standards.	

SLEEP STUDIES

Code		F
	"Sleep Studies Services Rendered at a licensed Independent Health Facility (IHF)". **A. Incomplete Overnight Sleep Studies** If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with generally accepted standards as set out in the CPSO Standards, the professional fee is *not eligible for payment* and the service constitutes one of the following, as determined by time in bed (total study time):	
J898	Sleep study less than 1 hour	92.65
J899	Sleep study between 1 and 4 hours	185.40
J990	Sleep study more than 4 hours	370.75
	Payment rules: 1. A maximum of one of any of J898, J899 and J990 is eligible for payment, per patient, per facility, per *12 month period*. 2. J898, J899 and J990 are not included in the limits for overnight studies set out below. **B. Overnight Sleep Studies in Independent Health Facilities** Level 1 Is a overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG). **Initial Diagnostic Study** "Initial Diagnostic Study" means the first overnight sleep study rendered to an insured person as an insured service in Ontario for the purpose of establishing the diagnosis of a sleep disorder (and includes a split night study). Every overnight diagnostic sleep study rendered before July 1, 2010, for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes an "initial diagnostic study" and is deemed to have been rendered on July 1, 2010.	
	Initial Diagnostic Study – Level 1	
J896	- diagnostic study	370.75
	Note: 1. A maximum of one initial diagnostic study is eligible for payment per patient per lifetime. 2. All subsequent overnight sleep studies constitute "repeat diagnostic" or "therapeutic" studies.	

SLEEP STUDIES

Code		F
	Repeat Diagnostic Study "Repeat Diagnostic Study" means an overnight diagnostic sleep study rendered: a. for the purpose of obtaining a second opinion at a different facility than the facility where the preceding study was rendered, provided that the following conditions are met: i. prior to the repeat diagnostic study, the patient has been assessed by a physician who practices sleep medicine at the different facility, **[Commentary:** The different facility requirement above applies to a repeat diagnostic study rendered at a hospital, a hospital off-site premise or an independent health facility.] ii. where the previous study was rendered at an independent health facility and the repeat diagnostic study is rendered at a different independent health facility (the "different facility") than the independent health facility where the preceding study was rendered (the "first facility"), neither the owner nor the operator of the different facility is, at the time the repeat study is rendered, an associate of the owner or operator of the first facility, where "associate" has the same meaning as in the *Independent Health Facilities Act*; OR b. for one or more of the following purposes, after pre-study assessment by a physician practicing sleep medicine: i. re-evaluation of a previous negative or inconclusive diagnostic sleep study as indicated by persistent or progressive symptoms; ii. re-evaluation, other than primarily for Positive Airway Pressure therapy (PAP) adjustment, of patients previously diagnosed with a primary sleep disorder in which there has been symptom development suggesting another co-morbid sleep disorder; or iii. re-evaluation of patients with an established diagnosis of a sleep disorder other than a sleep related breathing disorder who have significant symptom progression or non-response to therapy [**Commentary:** 1. In the case of patients with previously diagnosed sleep related breathing disorders, although PAP treatment may be adjusted during a repeat study, a repeat study is *not eligible for payment* if rendered primarily for PAP treatment adjustment. 2. Examples of sleep disorders other than a sleep related breathing disorder are Narcolepsy, Idiopathic hypersomnia and Periodic Limb Movement Disorder.]	
J897	- diagnostic study	370.75

SLEEP STUDIES

Code		F
	Repeat Diagnostic Study – Level 1 (continued)	
	Payment rules: 1. Repeat diagnostic studies are limited to one per patient, per facility, per *12 month period* except where prior approval has been given. 2. Repeat diagnostic studies performed in the same facility that performed the initial diagnostic study are *not eligible for payment* in the *12 month period* following an initial diagnostic study except where prior approval has been given. Therapeutic study "Therapeutic Study" means a sleep study rendered after pre-study assessment by a physician practicing sleep medicine, for any of the following purposes: a. To establish optimal settings for nasal positive airway pressure therapy (CPAP/BiPAP/ASV etc.) and/or oxygen therapy for sleep related breathing disorders; [**Commentary:** Examples of sleep related breathing disorders are obstructive sleep apnea syndrome (OSAS), central sleep apnea syndrome (CSAS), Cheyne-Stokes breathing, complex sleep apnea syndrome, or hypoventilation syndromes.] b. To evaluate the response to surgical procedures for the treatment of OSAS; c. To determine the efficacy of oral appliance therapy for OSAS; d. To evaluate the efficacy of positional therapy for the treatment of OSAS; e. To evaluate the efficacy of substantial weight loss for the treatment of OSAS; or f. To titrate ventilatory settings for patients with respiratory control disorders, neuromuscular or neurodegenerative diseases.	
	Therapeutic Study for Sleep Related Breathing Disorders – Level 1	
J895	- therapeutic study	370.75
	Payment rules: 1. There is a limit of one therapeutic study (J895) per patient during any two consecutive *12 month* periods except where prior approval has been given. 2. J895 rendered to the same patient during the same 12 hour period as J896 or J897 is *not eligible for payment*.	
	Note: 1. For payment purposes, repeat diagnostic studies or therapeutic studies for indications or in circumstances other than listed above, or in excess of the limits set out below, require prior approval. 2. A repeat diagnostic study rendered without the required pre-study assessment by a physician practicing sleep medicine, is *not eligible for payment.*	

SLEEP STUDIES

Code		F
	Therapeutic Study for Sleep Related Breathing Disorders – Level 1 (continued)	
	3. A therapeutic study rendered without a pre-study assessment by a physician practicing sleep medicine is *not eligible for payment* except: **a.** For the therapeutic study that immediately follows an initial diagnostic or repeat diagnostic study where: **i.** the time interval is such that it is unlikely the clinical circumstances of the patient has changed; and **ii.** the physician practicing sleep medicine has previously assessed the patient and documented the applicable decisions with respect to the performance of the therapeutic study; or **b.** In exceptional circumstances where the physician can demonstrate to the ministry upon request that the CPSO standards are satisfied with the use of a clinical protocol or approved medical directive.	
	[Commentary: 1. An example of an exceptional circumstance may be where a patient is required to travel a long distance to a sleep facility and requires an initial diagnostic or repeat diagnostic study followed by a therapeutic study on a subsequent night. For payment purposes, a pre-study assessment by a physician practicing sleep medicine is not required provided the therapeutic study is rendered in accordance with a clinical protocol or medical directive that has been approved by an authority other than a physician affiliated with the sleep facility (e.g. a Medical Advisory Committee for a sleep clinic affiliated with a hospital). The physician should be prepared to provide any necessary supporting documentation to the ministry upon request. 2. Prior approval, where required, will typically be dependent on the physician demonstrating that the study is generally accepted as necessary for the patient under the circumstances. 3. Sleep studies that require prior approval also require a pre-study assessment by a physician practicing sleep medicine. It is this assessment upon which the request for prior approval is considered. 4. Prior approval requires a written request accompanied by supporting documentation including the pre-study assessment and the relevant previous sleep study reports. 5. Split-night sleep studies are claimed as J896 or J897 only, as appropriate to the study rendered.]	
	C. Daytime Sleep Studies	
J893	Multiple sleep latency test	68.95
J894	Maintenance of wakefulness test	68.95
	Payment rules: 1. J894 rendered to same patient same *day* as J893 is *not eligible for payment*. 2. A maximum of one J893 and a maximum of one J894 are payable per *12 month period* per facility per patient.	

SLEEP STUDIES

Code	F
Daytime sleep studies (continued)	
3. If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with CPSO standards, the service is *not eligible for payment*.	