CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A005</td>
<td>Consultation</td>
<td>77.20</td>
</tr>
</tbody>
</table>

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

A911 Special family and general practice consultation ..................................................... 144.75

Comprehensive family and general practice consultation
This service is a consultation rendered by a GP/FP physician who provides all the elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A912 Comprehensive family and general practice consultation ....................................... 217.15

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

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

[Commentary:
1. A911 and A912 must satisfy all the elements of a consultation (see page GP12).

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

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

A945 Special palliative care consultation ............................................................................. 144.75

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

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

A905 Limited consultation .................................................................................................. 65.90
A006 Repeat consultation .................................................................................................... 45.90
CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

A003 General assessment................................................................. 77.20

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

Emergency department equivalent - partial assessment

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

A888 Emergency department equivalent - partial assessment......................... 33.70

[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.
House call assessment

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

A901 House call assessment .......................................................... 45.15

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

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

Complex house call assessment

A complex house call assessment is a primary care service rendered in a patient's home to a patient that is considered either a frail elderly patient or a housebound patient. The service provided must satisfy, at a minimum, all of the requirements of an intermediate assessment.

A900 Complex house call assessment ............................................. 45.15

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

[Commentary:
1. A frail elderly patient is defined as:
   a. 65 years or older with one or more of the following age-related illness(es), condition(s) or presentation(s):
      i. Complex medical management needs;
      ii. Polypharmacy;
      iii. Cognitive impairment (e.g. dementia or delirium);
      iv. Age-related reduced mobility or falls; and/or
      v. Unexplained functional decline not otherwise specified.
   and
   b. resides in a home that includes:
      i. The patient's home; or
      ii. Assisted living or retirement residence (but does not include a long-term care home).

2. A housebound patient is defined as:
   a. A person will be considered homebound where all the following criteria are met:
      i. The person has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
      ii. Transportation and other strategies to remedy the access difficulties have been considered but are not available or not appropriate in the person's circumstances; and
      iii. The person's care and support requirements can be effectively and appropriately delivered at home.]

Medical record requirements:
Complex house call assessment is not payable if the medical record does not:
1. Demonstrate that an intermediate assessment was rendered; and
2. Demonstrate that the patient was a frail elderly or housebound patient.

House call assessment - Pronouncement of death in the home

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

A902 House call assessment - Pronouncement of death in the home ................. 45.15

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

Note:
For special visit premiums, please see pages GP44 to GP52 of the General Preamble.
CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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

Pre-dental/Pre-operative assessments - General/Family Practice/Paediatrics/Emergency Medicine
A903 Pre-dental/pre-operative general assessment ........................................................ 65.05

Pre-dental/Pre-operative assessments - Specialists
A904 Pre-dental/pre-operative assessment ................................................................. 33.70

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

[Commentary:
Pre-operative and pre-dental general assessments constitute “general assessments” for the purpose of calculating general assessment limits set out on GP14. See page GP34 for the definition of an “Emergency Department Physician”.
]
4. A904 is not eligible for payment:
   a. where the service is rendered on the day of surgery;
   b. to a physician practising in the following specialties: General and Family Practice (00) Paediatrics (26), and Emergency Medicine (12); or
   c. unless it includes as a minimum the elements of a partial assessment.
5. An admission general assessment (C003) or general re-assessment (C004) is not eligible for payment for an elective surgery patient for whom a pre-dental/pre-operative assessment has already been claimed, within 30 days of this pre-dental/pre-operative assessment.
6. Only one of A904/C904/W904 or A903/C903/W903 is eligible for payment for the same patient for the same surgical procedure.

On-call admission assessment
On-call admission assessment is the first hospital in-patient admission general assessment per patient per 30-day period if:
   a. the physician is a general practitioner or family physician participating in the hospital’s on-call roster whether or not the physician is on-call the day the service is rendered;
   b. the admission is non-elective; and
   c. the physician is the most responsible physician with respect to subsequent in-patient care.

The amount payable for any additional on-call admission assessment rendered by the same physician to the same patient in the same 30-day period is reduced to the amount payable for a general re-assessment.
A933 On-call admission assessment ................................................................. 79.90
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 GP26 for additional information.]

Certification of death

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

A771 Certification of death .................................................................................................................. 20.60
A777 Intermediate assessment - Pronouncement of death (see General Preamble GP18) .................... 33.70
A002 Enhanced 18 month well baby visit (see General Preamble GP22) ........................................ 62.20
A007 Intermediate assessment or well baby care .............................................................................. 33.70
A001 Minor assessment .................................................................................................................... 21.70
Focused practice assessment (FPA)
FPA is an assessment rendered by a GP/FP physician with additional training and/or experience in sport medicine, allergy, pain management, sleep medicine, addiction medicine (including methadone) or care of the elderly (age 65 or older). The assessment must satisfy, at a minimum, all of the requirements of an intermediate assessment.

- A917 Sport medicine FPA ................................................................. 33.70
- A927 Allergy FPA ........................................................................... 33.70
- A937 Pain management FPA .......................................................... 33.70
- A947 Sleep medicine FPA ............................................................... 33.70
- A957 Addiction medicine FPA ......................................................... 33.70
- A967 Care of the elderly FPA ............................................................ 33.70

Payment rules:
1. No other consultation, assessment, visit or counselling service is eligible for payment when rendered the same day as one of A917, A927, A937, A947, A957 or A967 to the same patient by the same physician.
2. E079 is not eligible for payment with any FPA.

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

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

- A008 Mini assessment ....................................................................... 13.05

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

Periodic health visit
K017 child .............................................................................................. 43.60
K130 adolescent ................................................................................... 77.20
K131 adult age 18 to 64 inclusive ......................................................... 50.00
K132 adult 65 years of age and older ..................................................... 77.20

Note: For definitions and payment rules - see General Preamble GP14.

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

Periodic oculo-visual assessment
see General Preamble GP19 for definitions and conditions

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

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

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

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

A115 Major eye examination................................................................. 51.10

Note:
1. This service is only insured if the patient is described in (a) or (b) below:
   a. A patient has one of the following medical conditions:
      i. diabetes mellitus, type 1 or type 2
      ii. glaucoma
      iii. cataract
      iv. retinal disease
      v. amblyopia
      vi. visual field defects
      vii. corneal disease
      viii. strabismus
      ix. recurrent uveitis
      x. optic pathway disease; or
   b. The patient must have a valid "request for eye examination requisition" completed by another physician or by a registered nurse holding an extended certificate of registration (RN(EC)).

2. This service is limited to one per patient per consecutive 12 month period regardless of whether the first claim is or has been submitted for a major eye examination rendered by an optometrist or physician. Where the services described as comprising a major eye examination are rendered to the same patient more than once per 12 month period, the services remain insured and payable at a lesser assessment fee.

3. Any service rendered by the same physician to the same patient on the same day that the physician renders a major eye examination is not eligible for payment.

4. If all the elements of a major eye examination are not performed when a patient described in note 1 above attends for the service, the service remains insured but payable at a lesser assessment fee.

5. The requisition is not valid following the end of the fiscal year (March 31) of the 5th year following the year upon which the requisition was completed.

[Commentary:
Assessments rendered solely for the purpose of refraction for patients aged 20 to 64 are not insured services.]
Midwife-Requested Anaesthesia Assessment (MRAA)

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

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

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

Midwife-Requested Assessment (MRA)

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

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

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

Midwife-Requested Special Assessment (MRSA)

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

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

b. to a family physician or obstetrician for assessment of a mother or newborn when, because of the very complex, obscure or serious nature of the problem, the physician must spend at least 50 minutes in direct patient contact, exclusive of tests. The start and stop times of the assessment must be recorded on the patient's permanent medical record. In the absence of such information, the service is payable as A813. Maximum one per patient per physician per pregnancy.

A815 Midwife-Requested Special Assessment (MRSA) ...................................................... 186.95
## CONSULTATIONS AND VISITS

### FAMILY PRACTICE & PRACTICE IN GENERAL (00)

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C005</td>
<td>Consultation</td>
<td>77.20</td>
</tr>
<tr>
<td>C911</td>
<td>Special family and general practice consultation - subject to the same conditions as A911</td>
<td>144.75</td>
</tr>
<tr>
<td>C912</td>
<td>Comprehensive family and general practice consultation - subject to the same conditions as A912</td>
<td>217.15</td>
</tr>
<tr>
<td>C915</td>
<td>Special palliative care consultation - subject to the same conditions as A915</td>
<td>144.75</td>
</tr>
<tr>
<td>C905</td>
<td>Limited consultation</td>
<td>65.90</td>
</tr>
<tr>
<td>C006</td>
<td>Repeat consultation</td>
<td>45.90</td>
</tr>
<tr>
<td>C003</td>
<td>General assessment</td>
<td>77.20</td>
</tr>
<tr>
<td>C004</td>
<td>General re-assessment</td>
<td>38.35</td>
</tr>
<tr>
<td>C816</td>
<td>Midwife-Requested Anaesthesiologist Assessment (MRAA) - subject to the same conditions as A816</td>
<td>106.80</td>
</tr>
<tr>
<td>C813</td>
<td>Midwife-Requested Assessment - subject to the same conditions as A813</td>
<td>101.70</td>
</tr>
<tr>
<td>C815</td>
<td>Midwife-Requested Special Assessment - subject to the same conditions as A815</td>
<td>186.95</td>
</tr>
<tr>
<td>C903</td>
<td>Pre-dental/pre-operative general assessment (maximum of 2 per 12 month period)</td>
<td>65.05</td>
</tr>
<tr>
<td>C904</td>
<td>Pre-dental/pre-operative assessment</td>
<td>33.70</td>
</tr>
<tr>
<td>C933</td>
<td>On-call admission assessment - subject to the same conditions as A933</td>
<td>79.90</td>
</tr>
<tr>
<td>C777</td>
<td>Intermediate assessment - Pronouncement of death - subject to the same conditions as A777</td>
<td>33.70</td>
</tr>
<tr>
<td>C771</td>
<td>Certification of death - subject to the same conditions as A771</td>
<td>20.60</td>
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### Subsequent visits

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C002</td>
<td>first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C007</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C009</td>
<td>after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C008</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C010</td>
<td>Supportive care</td>
<td>18.85</td>
</tr>
<tr>
<td>C882</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
### 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**.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
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<tbody>
<tr>
<td>H007</td>
<td>Attendance at maternal delivery for care of high risk baby(ies)</td>
<td>61.65</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H001</td>
<td>Newborn care in hospital and/or home</td>
<td>52.20</td>
</tr>
</tbody>
</table>

### Low birth weight baby care (uncomplicated)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H002</td>
<td>Initial visit (per baby)</td>
<td>32.75</td>
</tr>
<tr>
<td>H003</td>
<td>Subsequent visit</td>
<td>16.25</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

EMERGENCY DEPARTMENT PHYSICIAN

Note:
See General Preamble GP34 for definitions and conditions for Emergency Department Physician.

In-patient interim admission orders
In-patient interim admission orders is payable to an Emergency Department Physician who is on-call or on duty in the emergency department or Hospital Urgent Care Clinic for writing in-patient interim admission orders pending admission of a “non-elective” patient by a different most responsible physician (see General Preamble GP3).

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

It also includes the following as indicated:

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

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

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

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

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

**FAMILY PRACTICE & PRACTICE IN GENERAL (00)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
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<tbody>
<tr>
<td>H065</td>
<td>Consultation in Emergency Medicine</td>
<td>74.25</td>
</tr>
<tr>
<td>H105</td>
<td>In-patient interim admission orders</td>
<td>26.25</td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H102</td>
<td>Comprehensive assessment and care</td>
<td>37.20</td>
</tr>
<tr>
<td>H103</td>
<td>Multiple systems assessment</td>
<td>35.65</td>
</tr>
<tr>
<td>H101</td>
<td>Minor assessment</td>
<td>15.00</td>
</tr>
<tr>
<td>H104</td>
<td>Re-assessment</td>
<td>15.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>H132</td>
<td>Comprehensive assessment and care</td>
<td>46.30</td>
</tr>
<tr>
<td>H133</td>
<td>Multiple systems assessment</td>
<td>42.40</td>
</tr>
<tr>
<td>H131</td>
<td>Minor assessment</td>
<td>18.70</td>
</tr>
<tr>
<td>H134</td>
<td>Re-assessment</td>
<td>18.70</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H152</td>
<td>Comprehensive assessment and care</td>
<td>63.30</td>
</tr>
<tr>
<td>H153</td>
<td>Multiple systems assessment</td>
<td>56.95</td>
</tr>
<tr>
<td>H151</td>
<td>Minor assessment</td>
<td>25.50</td>
</tr>
<tr>
<td>H154</td>
<td>Re-assessment</td>
<td>25.50</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H122</td>
<td>Comprehensive assessment and care</td>
<td>73.90</td>
</tr>
<tr>
<td>H123</td>
<td>Multiple systems assessment</td>
<td>65.95</td>
</tr>
<tr>
<td>H121</td>
<td>Minor assessment</td>
<td>29.80</td>
</tr>
<tr>
<td>H124</td>
<td>Re-assessment</td>
<td>29.80</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H112</td>
<td>- nights (00:00h to 08:00h)</td>
<td>34.20</td>
</tr>
<tr>
<td>H113</td>
<td>- daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays</td>
<td>19.80</td>
</tr>
</tbody>
</table>
**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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H100</td>
<td>Emergency department investigative ultrasound</td>
<td>19.65</td>
</tr>
</tbody>
</table>

**Payment rules:**

1. H100 is limited to two (2) services per patient per day where the second service is rendered as a follow-up to the first service for the same condition(s).

2. Services listed in the Diagnostic Ultrasound section of the *Schedule*, both technical and *professional components* are *not eligible for payment* to any physician when ultrasound images described by H100 are eligible for payment.

**Note:**

H100 is *only eligible for payment* when it is rendered using equipment that meets the following minimum technical requirements:

1. Images must be of a quality acceptable to allow a different physician who meets standards for training and experience to render the service to arrive at the same interpretation;
2. Scanning capabilities must include B- and M-mode; and
3. The trans-abdominal probe must be at least 3.5MHz or greater.

**Medical record requirements:**

The service is *only eligible for payment* when the Emergency Department investigative ultrasound includes both a permanent record of the image(s) and an interpretative report.

**Claims submission instructions:**

Claims in excess of two (2) services of H100 per day by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

[Commentary:

1. See page GP34 for the definition of an “Emergency Department Physician”.
2. Current standards and minimum requirements for training and experience for Emergency Department investigative ultrasound may be found at the Canadian Emergency Ultrasound Society website at the following internet link: http://www.ceus.ca.]
# CONSULTATIONS AND VISITS

## FAMILY PRACTICE & PRACTICE IN GENERAL (00)

### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W105</td>
<td>Consultation</td>
<td>77.20</td>
</tr>
<tr>
<td>W911</td>
<td>Special family and general practice consultation - subject to the same conditions as A911</td>
<td>144.75</td>
</tr>
<tr>
<td>W912</td>
<td>Comprehensive family and general practice consultation - subject to the same conditions as A912</td>
<td>217.15</td>
</tr>
<tr>
<td>W106</td>
<td>Repeat consultation</td>
<td>45.90</td>
</tr>
</tbody>
</table>

#### Admission assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W102</td>
<td>Type 1</td>
<td>69.35</td>
</tr>
<tr>
<td>W104</td>
<td>Type 2</td>
<td>20.60</td>
</tr>
<tr>
<td>W107</td>
<td>Type 3</td>
<td>30.70</td>
</tr>
<tr>
<td>W109</td>
<td>Periodic health visit</td>
<td>70.50</td>
</tr>
</tbody>
</table>

#### Intermediate assessment - Pronouncement of death - subject to the same conditions as A777

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W777</td>
<td></td>
<td>33.70</td>
</tr>
</tbody>
</table>

#### Certification of death - subject to same conditions as A771

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W771</td>
<td></td>
<td>20.60</td>
</tr>
</tbody>
</table>

#### General re-assessment of patient in nursing home (per the Nursing Homes Act)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W004</td>
<td></td>
<td>38.35</td>
</tr>
</tbody>
</table>

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

#### Pre-dental/pre-operative general assessment (maximum of 2 per 12 month period)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W903</td>
<td></td>
<td>65.05</td>
</tr>
</tbody>
</table>

#### Pre-dental/pre-operative assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W904</td>
<td></td>
<td>33.70</td>
</tr>
</tbody>
</table>

#### Subsequent visits (see General Preamble GP33)

- **Chronic care or convalescent hospital**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W002</td>
<td>first 4 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W001</td>
<td>additional subsequent visits (maximum 4 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W882</td>
<td>palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
</tbody>
</table>

- **Nursing home or home for the aged**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W003</td>
<td>first 2 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W008</td>
<td>additional subsequent visits (maximum 2 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W872</td>
<td>palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
</tbody>
</table>

- **Additional visits due to intercurrent illness (see General Preamble GP33)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W121</td>
<td></td>
<td>31.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W010</td>
<td>Monthly management fee (per patient per month) (see General Preamble GP35 to GP36)</td>
<td>108.85</td>
</tr>
</tbody>
</table>

---

**Note:**

- W004 may be claimed 6 months after Periodic health visit (per the Nursing Homes Act).
- W003 may be claimed 2 months after Periodic health visit (per the Nursing Homes Act).
- W010 may be claimed 1 month after Periodic health visit (per the Nursing Homes Act).
- Monthly Management of a Nursing Home or Home for the Aged Patient is subject to the same conditions as W121.
Primary mental health care

Primary mental health care is not to be billed in conjunction with other consultations and visits rendered by a physician during the same patient visit unless there are clearly different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

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

Counselling

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

Individual care

K013 - first three units of K013 and K040 combined per patient per provider per 12 month period………………………………………………………………………………..per unit 62.75
K033 - additional units per patient per provider per 12 month period………………per unit 38.15

Group counselling - 2 or more persons

K040 - where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12 month period…………………………………………………………………………………………………………………………………………………..per unit 62.75
K041 - additional units where any group member has received 3 or more units of any counselling paid under codes K013 and K040 combined per provider per 12 month period…………………………………………………………………………………………………………………………………………………..per unit 38.80

K014 Counselling for transplant recipients, donors or families of recipients and donors
- 1 or more persons........................................................................per unit 62.75

K015 Counselling of relatives - on behalf of catastrophically or terminally ill patient
- 1 or more persons........................................................................per unit 62.75
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Patients</th>
<th>Unit Price per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>K140</td>
<td>2</td>
<td>31.40</td>
</tr>
<tr>
<td>K141</td>
<td>3</td>
<td>20.90</td>
</tr>
<tr>
<td>K142</td>
<td>4</td>
<td>15.80</td>
</tr>
<tr>
<td>K143</td>
<td>5</td>
<td>13.00</td>
</tr>
<tr>
<td>K144</td>
<td>6-12</td>
<td>11.05</td>
</tr>
</tbody>
</table>

[Commentary:
A claim must be submitted for each patient receiving a service. For example, if three patients are seen in a shared appointment, K141 is submitted for each patient. If four patients are seen, K142 is submitted for each patient.
]

Payment rules:
1. Unit means ½ hour or major part thereof - see General Preamble GP6, GP45 to GP50 for definitions and time-keeping requirements.

2. The service is only eligible for payment when:
   a. the appointment is pre-scheduled; and
   b. each patient regularly visits the physician or another physician in the same physician group for management of their chronic disease.

3. Chronic disease shared appointment rendered the same day as an additional assessment by the same physician to the same patient is not eligible for payment unless there are clearly defined different diagnoses for the two services.

4. Chronic disease shared appointments are only eligible for payment for up to a maximum of twelve (12) patients per shared appointment.

Medical record requirements:
The service is only eligible for payment where the clinically appropriate assessment rendered on the same day is recorded in each patient's permanent medical record.

Claims submission instructions:
A locum tenens replacing an absent physician in the absent physician's office must submit claims under their own billing number.

[Commentary:
Chronic disease shared appointment does not apply to lectures.
]
Psychotherapy
Includes narcoanalysis or psychoanalysis or treatment of sexual dysfunction - see General Preamble GP37.

Note:
Psychotherapy outside hospital and hypnotherapy may not be claimed as such when provided in conjunction with a consultation or other assessments rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

K007 Individual care per unit 62.75

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

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

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

K006 Individual care* per unit 62.75

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

Certification of mental illness
See General Preamble GP22 for definitions and conditions.

Form 1
Application for psychiatric assessment in accordance with the Mental Health Act includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.
K623 Application for psychiatric assessment per unit 104.80

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 per unit 129.05
K629 All other re-certification(s) of involuntary admission including completion of appropriate forms per unit 38.25

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Community treatment order (CTO)

CTO Services - are time-based all-inclusive services payable per patient to one or more physicians for the purpose of personally initiating, supervising and renewing a CTO. Eligible physicians include both the most responsible physician and any physician identified in the Community Treatment Plan (CTP). Each physician will individually submit claims for only those insured CTO services personally rendered by that physician. Services rendered by persons other than the physician who submits the claim are payable at nil.

In addition to the common elements of insured services and the specific elements of any service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section, CTO services include:

a. all consultations and visits with the patient, family or substitute decision-maker for the purpose of mandatory assessment of the patient in support of initiation, renewal, or termination of the CTO;

b. interviews with the patient, family or substitute decision-maker to give notice of entitlement to legal and rights advice or to obtain informed consent under the Health Care Consent Act;

c. all consultations, assessments and other visits including psychotherapy, psychiatric care, interviews, counselling or hypnotherapy with the patient family or substitute decision-maker pertaining to on-going clinical management of the patient under a CTO;

d. preparation of a CTP, including any necessary chart review and clinical correspondence;

e. participation in scheduled or unscheduled case conferences or other meetings with one or more health care providers, community service providers, other persons identified in the CTP, legal counsel and rights advisors relating to initiation, supervision or renewal of a CTO;

f. providing advice, direction or information by telephone, electronic or other means in response to an inquiry from the patient, family, substitute decision-maker, health care providers, community service providers, other persons identified in the CTP, legal counsel and rights advisors relating to initiation, renewal or on-going supervision of a CTO; and

g. completion of CTO related forms, including but not limited to Form 45 CTO Initiation or Renewal, Form 47 Order for Examination and related forms or notices regarding notice of rights advice and notice of 2nd renewal to Consent and Capacity Board.

The following insured services and any associated premiums are not considered CTO services and may be claimed separately:

a. assessments and special visits for emergent call to the emergency department or to a hospital in-patient;

b. services related to application for psychiatric assessment or certification of involuntary admission;

c. services relating to assessment and treatment of a medical condition or diagnosis unrelated to the CTO; and

d. in-patient services, except those directly related to mandatory assessment for the purpose of initiating a CTO.

Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for Definitions and time-keeping requirements. A single all-inclusive claim for CTO Initiation or CTO Renewal is submitted once per patient per physician per initiation or renewal in any six month period on an Independent Consideration basis. A single all-inclusive claim for CTO Supervision is submitted once per patient per month on an Independent Consideration basis. The form provided by the MOHLTC for elapsed times must be completed and submitted with each claim and a copy retained on the patient’s permanent medical record. The total number of allowable units rendered per claim shall be determined by adding the actual elapsed time of each insured activity rounded to the nearest minute, dividing by 30 and rounding to the nearest whole unit. In the absence of a claim in accordance with these requirements, the amount payable for CTO services is nil.

K887 CTO initiation including completion of the CTO form and all preceding CTO services directly related to CTO initiation .............................................................per unit 84.70

K888 CTO supervision including all associated CTO services except those related to initiation or renewal .................................................................per unit 84.70

K889 CTO renewal including completion of the CTO form and all preceding CTO services directly related to CTO renewal ..................................................per unit 84.70

Note:

1. Travel to visit an insured person within the usual geographic area of the physician’s practice is a common element of insured services. Time units for any CTO services based in whole or in part on travel time are therefore insured but payable at nil.

2. Travel time and expenses related to appearances before the Consent and Capacity Board are not insured.
Interviews

Interviews are not eligible for payment when the information being obtained is part of the history normally included in the consultation or assessment of the patient. The interview must be a booked, separate appointment lasting at least 20 minutes. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

K002 Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act.................................................................per unit 62.75

Payment rules:
K002 is only eligible for payment if the physician can demonstrate that the purpose of the interview is not for the sole purpose of obtaining consent.

K003 Interviews with Children’s Aid Society (CAS) or legal guardian on behalf of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent .................................................................per unit 62.75

Note:
K002, K003 are claimed using the patient’s health number and diagnosis. These listings apply to situations where medically necessary information cannot be obtained from or given to the patient or guardian, e.g. because of illness, incompetence, etc.

K008 Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities .................................................................per unit 62.75

Note:
K008 is claimed using the child’s health number. Psychological testing is not an insured service.
Multidisciplinary cancer conference

A multidisciplinary cancer conference (MCC) is a service conducted for the purpose of discussing and directing the management of one or more cancer patients where the physician is in attendance either in person, by telephone or videoconference as a participant or chairperson in accordance with the defined roles and minimum standards established by Cancer Care Ontario.

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

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

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

[Commentary:
1. The 2006 Multidisciplinary Cancer Conference standards can be found at the Cancer Care Ontario website at the following internet link: http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=14318.
2. “Payment, other than by fee-for-service” includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.
3. One common medical record in the patient's chart for the MCC that indicates the physician participants (including listing the time the service commenced and terminated and individual attendance times for each participant if different) would satisfy the medical record requirements for billing purposes.]
[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.]

<table>
<thead>
<tr>
<th>Number of Patients Discussed</th>
<th>Minimum Total Time of Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 patient</td>
<td>10 minutes</td>
</tr>
<tr>
<td>2 patients</td>
<td>20 minutes</td>
</tr>
<tr>
<td>3 patients</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4 patients</td>
<td>40 minutes</td>
</tr>
<tr>
<td>5 patients</td>
<td>50 minutes</td>
</tr>
<tr>
<td>6 patients</td>
<td>60 minutes</td>
</tr>
<tr>
<td>7 patients</td>
<td>70 minutes</td>
</tr>
<tr>
<td>8 patients</td>
<td>80 minutes</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th># Units</th>
<th>Minimum time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 unit</td>
<td>10 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>16 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>26 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>36 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>46 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>56 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>66 minutes [1h 6m]</td>
</tr>
<tr>
<td>8 units</td>
<td>76 minutes [1h 16m]</td>
</tr>
</tbody>
</table>
Payment rules:
1. A case conference is only eligible for payment if the physician is actively participating in the case conference, and the physician’s participation is evident in the record.
2. A case conference is only eligible for payment in circumstances where there is a minimum of 10 minutes of patient related discussion.
3. A case conference is only eligible for payment if the case conference is pre-scheduled.
4. Any other insured service rendered during a case conference is not eligible for payment.
5. A case conference is not eligible for payment in circumstances where the required participants necessary to meet the minimum requirements of the case conference service receive remuneration, in whole or in part, from the physician claiming the service.
6. The case conference is not eligible for payment to a physician who receives payment, other than by fee-for-service under this Schedule, for the preparation and/or participation in the case conference.
7. Where payment for a case conference is an included element of another service, services defined as case conferences are not eligible for payment.

[Commentary:
1. Chronic dialysis team fees are all-inclusive benefits for professional aspects of managing chronic dialysis and includes all related case conferences (see page J32).
2. “Payment, other than by fee-for-service” includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.]

Medical record requirements:
A case conference is only eligible for payment where the case conference record includes all of the following elements:
1. identification of the patient;
2. start and stop time of the discussion regarding the patient;
3. identification of the eligible participants, and
4. the outcome or decision of the case conference.

[Commentary:
1. In circumstances where more than one patient is discussed at a case conference, claims for case conference may be submitted for each patient provided that the case conference requirements for each patient have been fulfilled.
2. One common medical record in the patient’s chart for the case conference signed or initialled by all physician participants (including listing the time the service commenced and terminated and individual attendance times for each participant if different) would satisfy the medical record requirements for billing purposes.]
Hospital in-patient case conference
In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a hospital in-patient case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a hospital in-patient.

K121 Hospital in-patient case conference.............................................................per unit 31.35

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

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

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

K700 Palliative care out-patient case conference.................................................per unit 31.35

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.]
Paediatric out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a paediatric out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that include physicians, regulated social workers, regulated health professionals, education professionals, and/or personnel employed by an accredited centre of Children's Mental Health Ontario, regarding an out-patient less than 18 years of age.

K704  Paediatric out-patient case conference .................................................. per unit 31.35

Payment rules:
1. No other case conference or telephone consultation service is eligible for payment with K704 for the same patient on the same day.
2. K704 is limited to a maximum of 4 services per patient, per physician, per 12 month period.
3. A maximum of 8 units of K704 are payable per physician, per patient, per day.
4. K704 is only eligible for payment when the physician most responsible has a specialty designation in Paediatrics (26) or Psychiatry (19).

[Commentary:
1. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.
2. For case conferences regarding an in-patient in a long term care institution, see K705 or K124.
3. K704 is eligible for payment to physicians other than those who are specialists in Paediatrics (26) or Psychiatry (19) as long as the physician most responsible is a paediatrician or psychiatrist.
4. For a list of mental health centres accredited by Children's Mental Health Ontario, see the following link: http://www.kidsmentalhealth.ca/about_us/memberslist.php.]

Mental health out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a mental health out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that include physicians, regulated social workers, regulated health professionals, and/or personnel employed by a mental health community agency funded by the Ontario Ministry of Health and Long-Term Care, regarding an adult out-patient.

K701  Mental health out-patient case conference .................................................. per unit 31.35

Payment rules:
1. No other case conference or telephone consultation service is eligible for payment with K701 for the same patient on the same day.
2. K701 is limited to a maximum of 4 services per patient, per physician, per 12 month period.
3. A maximum of 8 units of K701 are payable per physician, per patient, per day.
4. K701 is only eligible for payment when the physician most responsible has a specialty designation in Psychiatry (19).

[Commentary:
1. For case conferences regarding an out-patient aged less than 18 years of age, see K704.
2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.
3. K701 is eligible for payment to physicians other than those who are specialists in Psychiatry (19) as long as the physician most responsible is a psychiatrist.
4. For case conferences regarding an in-patient in a long term care institution, other than a patient meeting the definition of a K705 service, see K124.]
CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Bariatric out-patient case conference
In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, bariatric out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that are working at a Bariatric Regional Assessment and Treatment Centre (RATC) and include physicians, regulated social workers and/or regulated health professionals regarding an out-patient registered with a Bariatric RATC for the purpose of pre-operative evaluation and/or post-operative follow-up medical care.

K702 Bariatric out-patient case conference ..........................................................per unit 31.35

Payment rules:
1. K702 is only eligible for payment when rendered for a patient registered in a Bariatric RATC.
2. K702 is only eligible for payment for physicians identified to the ministry as working in a Bariatric RATC.
3. No other case conference or telephone consultation service is eligible for payment with K702 for the same patient on the same day.
4. K702 is limited to a maximum of 4 services per patient, per physician per 12 month period.
5. A maximum of 8 units of K702 are payable per physician, per patient, per day.

[Commentary:
1. For the definition of a Bariatric RATC, see Definitions in the General Preamble.
2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.
3. For case conferences regarding an in-patient in a long term care institution, see K124.]

Geriatric out-patient case conference
In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, geriatric out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding an out-patient who is at least 65 years of age or, a patient less than 65 years of age who has dementia.

K703 Geriatric out-patient case conference ..........................................................per unit 31.35

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

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

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

K707 Chronic pain out-patient case conference ..................................................per unit 31.35

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

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a long-term care/community care access centre (CCAC) case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers, employees of a CCAC and/or regulated health professionals regarding a long-term care institution inpatient.

K124 Long-term care/CCAC case conference .............................................................. per unit 31.35

Payment rules:
1. K124 is limited to a maximum of 4 services per patient, per physician, per 12 month period.
2. A maximum of 8 units of K124 are payable per physician, per patient, per day.
3. K124 is not eligible for payment for radiation treatment planning services listed in the Radiation Oncology section of this Schedule.
4. Services described in the team care in teaching units section of this Schedule are not eligible for payment as K124.

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

Long-term care – High risk patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a Long-term care – High risk patient case conference is participation by a physician and at least 2 other participants that include physicians, employees of a CCAC, regulated social workers and/or regulated health professionals regarding a long-term care institution high risk inpatient.

K705 Long-term care – high risk patient conference ..................................................... per unit 31.35

Payment rules:
1. K705 is limited to a maximum of 4 services per patient, per physician, per 12 month period.
2. A maximum of 8 units of K705 are payable per physician, per patient, per day.
3. K705 is not eligible for payment for radiation treatment planning services listed in the Radiation Oncology section of this Schedule.
4. Services described in the team care in teaching units section of this Schedule are not eligible for payment as K705.

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

[Commentary:
1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704, and K707 for applicable services.
2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.
3. For case conferences regarding an in-patient in a long term care institution, other than a patient meeting the definition of a K705 service, see K124.
4. The Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for Nursing Homes can be found at the following internet link: https://www.cms.gov/NursingHomeQualityInitiatives/20_NHQIMDS20.asp.]
Convalescent care program case conference

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

K706  Convalescent care program case conference ......................................................... 31.35

Payment rules:
1. K706 is limited to a maximum of 8 services per patient, per physician, per 12 month period.
2. A maximum of 4 units of K706 are payable per physician, per patient, per day.
3. Services described in the team care in teaching units section of this Schedule are not eligible for payment as K706.

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

PHYSICIAN TO PHYSICIAN TELEPHONE CONSULTATION
Physician to physician telephone consultation is a service where the referring physician, in light of his/her professional knowledge of the patient, requests the opinion of another 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
The referring physician 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 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.

K730 Physician to physician telephone consultation - Referring physician ...................... 31.35
K731 Physician to physician telephone consultation - Consultant physician .................... 40.45

Physician on duty in an emergency department or a hospital urgent care clinic
K734 Physician to physician telephone consultation - Referring physician ...................... 31.35
K735 Physician to physician telephone consultation - Consultant physician .................... 40.45

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

Payment rules:
1. A maximum of one K730 or K734 service is eligible for payment per patient per day.
2. A maximum of one K731 or K735 service is eligible for payment per patient per day.
3. This service is only eligible for payment for a physician to physician telephone consultation service:
   a. that includes a minimum of 10 minutes of patient-related discussion for any given patient
   b. where the referring physician 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.
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 and consultant physicians;
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 billing 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.]
CRITICALL TELEPHONE CONSULTATION

CritiCall telephone consultation is a service where the referring physician, in light of his/her professional knowledge of a patient, requests the opinion of another 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

The referring physician initiates the telephone consultation through CritiCall for the purpose of discussing the management of the patient and/or transfer of the patient to another physician (“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 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.

K732 CritiCall telephone consultation - Referring physician ............................................. 31.35
K733 CritiCall telephone consultation - Consultant physician........................................... 40.45

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

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

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

Payment rules:
1. A maximum of 2 K732 or K736 services (any combination) are eligible for payment per patient, per day.
2. A maximum of 1 K733 or K737 service is eligible for payment per physician, per patient, per day.
3. A maximum of 3 K733 or K737 services (any combination) are eligible for payment per patient, per day.
4. This service is only eligible for payment for a CritiCall telephone consultation service that fulfills all of the following criteria:
   a. the telephone consultation service is arranged by, and subject to the requirements of CritiCall Ontario; and
   b. the referring physician and patient are physically present in Ontario at the time of the telephone consultation.
5. In circumstances where a physician receives compensation, other than by fee-for-service under this Schedule, for participation in the telephone consultation, this service is not eligible for payment to that physician.

Medical record requirements:
CritiCall telephone consultation is only eligible for payment where the following elements are included in the medical record for a physician who submits a claim for the service:
1. the telephone consultation was arranged by CritiCall Ontario;
2. identification of the patient by name and health number;
3. identification of the referring and consultant physician(s);
4. the reason for the consultation; and
5. the opinion and recommendations of the consultant physician(s).
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

PHYSICIAN TO PHYSICIAN E-CONSULTATION

Physician to physician e-consultation is a service where the referring physician, in light of his/her professional knowledge of the patient, requests the opinion of another 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 to physician e-consultations.

Definition/Required elements of service – Referring physician

The referring physician 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 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.

K738 Physician to physician e-consultation – Referring physician ................................... 16.00
K739 Physician to physician e-consultation – Consultant physician................................. 20.50

Payment rules:
1. K738 and K739 are each limited to a maximum of one (1) service per patient per day.
2. K738 and K739 are each limited to a maximum of six (6) services per patient, any physician, per 12 month period.
3. K738 and K739 are each limited to a maximum of four hundred (400) services per physician, per 12 month period.
4. This service is not eligible for payment to the referring or consultant physicians in the following circumstances:
   a. when the purpose of the electronic communication is to arrange for transfer of the patient’s care to any physician;
   b. when rendered in whole or in part to arrange for a consultation, assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s);
   c. when rendered primarily to discuss results of diagnostic investigation(s); or
   d. when a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician to physician e-consultation for the same patient.
5. In circumstances where a physician receives compensation, other than by fee-for service under this Schedule, for participation in the e-consultation, this service is not eligible for payment to that physician.
6. K739 is not eligible for payment to specialists in Dermatology(02) or Ophthalmology(23).
7. K738 is eligible for payment to the primary care physician when this physician is required to collect additional data (for example dermatology or ophthalmology images not present in the primary care physician’s records) to support a specialist’s initial, repeat, follow-up or minor e-assessment (see page GP24). K738 is not eligible for payment where existing data is already available in the primary care physician’s records for submission to the specialist.

Medical record requirements:
Physician 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 and consultant physicians;
3. reason for the consultation; and
4. the opinion and recommendations of the consultant physician.
Claims submission instructions:
K739 is 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. Physicians who receive compensation other than by fee-for-service under this Schedule should consult their contract for guidance on shadow-billing.]

HIV primary care
Primary care of patients infected with the Human Immunodeficiency Virus which includes any combination of common and specific elements of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP39. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for HIV Primary Care, the HIV Primary Care service is included (in addition to the common elements) as a specific element of the other insured service. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K022 HIV primary care...............................................................per unit 62.75

Fibromyalgia/chronic fatigue syndrome care
Fibromyalgia/chronic fatigue syndrome care is the provision of care to patients with fibromyalgia or chronic fatigue syndrome. The service includes the common and specific elements of all insured services listed under “Family Practice & Practice In General” in the “Consultations and Visits” section of the Schedule.

K037 Fibromyalgia/chronic fatigue syndrome care...............................per unit 62.75

Payment rules:
1. K037 is a time based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP5, GP37 for definitions and time-keeping requirements.
2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K037 to the same patient by the same physician.

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

K023 Palliative care support ............................................................per unit 62.75

Payment rules:
1. With the exception of A945/C945, any other services listed under the "Family Practice & Practice in General" in the "Consultations and Visits" section of the Schedule are not eligible for payment when rendered with this service.
2. Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee.
3. When the duration of A945 or C945 exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 units occurs 50 minutes after the start time for A945 or C945.
4. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.
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 ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K016 Genetic assessment ..................................................per unit 74.05

Payment rules:
This service is limited to 4 units per patient per day.

Sexually transmitted disease (STD) or potential blood-borne pathogen management
Sexually transmitted disease (STD) or potential blood-borne pathogen management is a time based all-inclusive service for the purpose of providing assessment and counselling to a patient suspected of having a STD or to a patient with a potential blood-borne pathogen (e.g. following a "needle-stick" injury). This service is claimed in units - unit means ½ hour or major part thereof - see the General Preamble GP5, GP37 for definitions and time keeping requirements.

K028 STD management ..................................................per unit 62.75

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

Insulin therapy support (ITS)
ITS is a time-based all-inclusive visit fee per patient per day for the purpose of providing assessment, support and counselling to patients on intensive insulin therapy requiring at least 3 injections per day or using an infusion pump. The service includes any combination of common and specific elements of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP39. ITS rendered same patient same day as any other consultation or visit by the same physician is an insured service payable at nil. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements. Maximum 6 units per patient, per physician, per year.

K029 Insulin therapy support (ITS) ..................................................per unit 62.75
[Commentary:
K029 may be payable for services that include training for patients on insulin who use devices such as glucose meters, insulin pumps and insulin pens and when rendered personally by the physician claiming K029.]
Diabetic management assessment (DMA)

DMA is an all-inclusive service payable to the most responsible physician for providing continuing management and support of a diabetic patient. The service must include an intermediate assessment, a level 2 paediatric assessment or a partial assessment focusing on diabetic target organ systems, relevant counselling and maintenance of a diabetic flow sheet retained on the patient’s permanent medical record. The flow sheet must track lipids, cholesterol, Hgb A1C, urinalysis, blood pressure, fundal examination, peripheral vascular examination, weight and body mass index (BMI) and medication dosage. When DMA is rendered to the same patient same day as any other consultation or visit by the same physician or the above record is not maintained, the DMA is an insured service payable at nil. Maximum 4 per patient per 12 month period.

K030 Diabetic Management Assessment ................................................................. 39.20

Diabetes management incentive (DMI)

DMI is a service rendered by the General/Family Physician most responsible for providing ongoing management of a diabetic patient. The service consists of ongoing management using a planned care approach consistent with the required elements of the Canadian Diabetes Association (CDA) Clinical Practice Guidelines, documenting that all of the CDA required elements have been provided for the previous 12 month period and must include documentation that tracks, at a minimum, the following:

a. Lipids, cholesterol, HbA1C, blood pressure, weight and body mass index (BMI), and medication dosage;
b. Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination;
c. Health promotion counselling and patient self-management support;
d. Albumin to creatinine ratio (ACR);
e. Discussion and offer of referral for dilated eye examination; and
f. Foot examination and neurologic examination.

Q040 Diabetes management incentive ................................................................. 60.00

Payment rules:
Q040 is limited to a maximum of one service per patient per 12 month period.

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.]
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.]
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 15.40

**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, A093, A905, K005, K007, K013, K017, K130, K131, K132, P003, P004, P005, P008, W001, W002, W003, W004, W008, W100, 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.]

**Sexual assault examination**

For investigation of alleged sexual assault and documentation using the evidence kit provided by Ministries of the Attorney General and the Solicitor General.

K018  - female ................................................................................................................ 308.70
K021  - male ................................................................................................................... 243.50

**Ontario Hepatitis C Assistance Program (OHCAP)**

Certification of Medical Eligibility for OHCAP - includes any combination of common and *specific elements* of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and completion of the Application for OHCAP - Physician’s Form. When a physician submits a claim for rendering any other consultation or visit on the same day for which the physician submits a claim for Certification of Medical Eligibility for OHCAP, the Certification service is included (in addition to the common elements) as a specific element of the other service.

K026  Certification of Medical Eligibility for OHCAP .................................................. 54.70
K027  Certification of Medical Eligibility for OHCAP - includes only completion of Application for OHCAP - Physician’s Form without an associated consultation or visit on the same day. ................................................................. 21.85

**Mandatory blood testing act - Physician report**

K031  Completion of Form 1 - Physician report in accordance with the Mandatory Blood Testing Act ................................................................. 102.50
Specific neurocognitive assessment
A specific neurocognitive assessment is an assessment of neurocognitive function rendered personally by the physician where all of the following requirements are met:

a. test of memory, attention, language, visuospatial function and executive function.

b. a minimum of 20 minutes (consecutive or non-consecutive) and must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and

c. the start and stop time(s) must be recorded in the patient's medical record.

K032 Specific neurocognitive assessment................................................................. 62.75

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

Home care application
The service rendered by the most responsible physician for completion and submission of an application for home care to a Community Care Access Centre (CCAC) on behalf of a patient for whom the physician provides on-going medical care. The amount payable for this service is as shown and is in addition to the assessment fee payable, where applicable. The amount payable for completion of the application for home care if completed in whole or in part by a person other than the physician or the physician’s employee is nil.

K070 Application ......................................................................................................... 31.75

Note:
1. K070 is limited to one per home care admission per patient.
2. K070 is not eligible for payment if the patient is currently receiving home care.

Home care supervision
The service rendered by a physician for personally providing medical advice, direction or information to health care staff of a Community Care Access Centre (CCAC) or CCAC contractor on behalf of a patient for whom the physician provides on-going medical care. The date, medical advice, direction or information provided must be recorded in the patient’s medical record. If the information is provided verbally to staff, the name of the staff person must be recorded. The amount payable for home care supervision without the required record of service in the patient's medical record is nil. The amount payable for home care supervision rendered on the same day as a consultation or visit by the same physician with the same patient is nil.

K071 Acute home care supervision (first 8 weeks following admission to home care program) .......................................................................................................................... 21.40
K072 Chronic home care supervision (after the 8th week following admission to the home care program) ...................................................................................................................... 21.40

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

Mandatory reporting of medical condition to the Ontario Ministry of Transportation (MTO)
Mandatory reporting of medical condition to the Ontario Ministry of Transportation (MTO) requires providing to MTO information that satisfies the requirements of the Highway Traffic Act or any applicable regulations, and includes providing any additional information to MTO regarding a previous report related to the same medical condition.

K035 Mandatory reporting of medical condition to the Ontario Ministry of Transportation .................................................................................................................. 36.25

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.
Northern health travel grant application form
K036 Completion of northern health travel grant application form ................................. 10.25

[Commentary:
K036 is payable to both the referring physician and specialist physician.]

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

K038 Completion of Long-Term Care health report form ........................................... 45.15

Immediate telephone reporting - specified reportable disease to the Medical Officer of Health
Telephone reporting of a specified reportable disease to a Medical Officer of Health (MOH) is the service of immediately providing all available information to a MOH in order to comply with the requirements of the Health Protection and Promotion Act and/or any applicable regulations, and includes providing, by any method, any subsequent information to a MOH regarding a previous report related to the same reported disease within the 12 month period.

K034 Telephone reporting - specified reportable disease to a MOH................................. 36.00

Payment rules:
1. K034 is limited to a maximum of one service per physician, per patient, per specified reportable disease, per 12 month period.
2. K034 is only eligible for payment when the telephone report is personally rendered by the physician.
3. K034 is only eligible for payment for the following specified reportable diseases:
   - anthrax, botulism, brucellosis, cholera, cryptosporidiosis, cyclosporiasis, diphtheria, primary viral encephalitis, food poisoning (all causes), symptomatic giardiasis, invasive haemophilus influenzae b disease, hantavirus pulmonary syndrome, hemorrhagic fevers (e.g. ebola, marburg and other viral causes), hepatitis A, lassa fever, legionellosis, listeriosis, measles, acute bacterial meningitis, invasive meningococcal disease, paratyphoid fever, plague, acute poliomyelitis, Q fever, rabies, rubella, Severe Acute Respiratory Syndrome (SARS), shigellosis, smallpox, invasive group A streptococcal infections, tularemia, typhoid fever, verotoxin-producing E. coli infection indicator conditions (e.g. haemolytic-uremic syndrome), west Nile virus illness, and yellow fever.

Medical record requirements:
K034 is only eligible for payment if the patient record demonstrates that the required information of the report related to one of the specified reportable disease has been communicated immediately by telephone to the MOH.

[Commentary:
1. For payment purposes, an immediate telephone report to a MOH includes a report provided to a delegate of a MOH under the regulation.
2. The diseases specified in association with K034 represent a subset of the reportable diseases listed in Regulation 559/91 under the Health Protection and Promotion Act. For payment purposes, the specified list of diseases has been identified as requiring an immediate telephone report.]

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

CLINICAL INTERPRETATION BY AN IMMUNOLOGIST
Clinical Interpretation by an immunologist requires review of clinical data and interpretation of diagnostic tests and the results of related assessments in order to arrive at an opinion as to the nature of the patient’s condition. The physician must submit his/her findings, opinions, and recommendations in writing to the patient’s physician.

K399 Clinical interpretation by an immunologist .......................................................... 29.05

Payment rules:
This service is not eligible for payment when rendered in association with a consultation on the same patient by the same physician.
Addiction medicine – initial assessment – substance abuse
Initial assessment - substance abuse is an assessment where the physician spends a minimum of 50 minutes of personal contact assessing a patient related to substance abuse with or without the patient’s relative(s) or patient’s representative, exclusive of time spent rendering any other service to the patient. This service is only eligible for payment to the physician intending to subsequently render treatment of the patient’s substance abuse.

The elements of the service must include:

i. A complete history of illicit drug use, abuse and dependence, ensuring that a DSM diagnosis is recorded for each problematic drug;
ii. A complete addiction medicine history;
iii. Past medical history;
iv. Family history;
v. Psychosocial history, including education;
vi. Review of systems;
vii. A focused physical examination, when indicated;
viii. Assessment/diagnosis including a DSM diagnosis for each problematic drug;
ix. Review of treatment options;
x. Formulation of a treatment plan;
xi. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
xii. Communication with previous care providers, including family doctors, as necessary.

A680 Initial assessment – substance abuse ................................................................. 144.75

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

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

Medical record requirements:
1. Start and stop times of the service must be recorded in the patient’s permanent medical record or the amount payable for the service will be adjusted to a lesser assessment fee.
2. A DSM diagnosis must be recorded in relation to each problematic substance in the patient’s permanent medical record or the amount payable for the service will be adjusted to a lesser assessment fee.
3. Relevant information obtained in the provision of the all elements of the service must be recorded in the medical record or the amount payable for the service will be adjusted to lesser assessment fee.

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Substance abuse - extended assessment
A substance abuse - extended assessment is the service for providing care to patients receiving therapy for substance abuse. The service has the same specific elements as an assessment.

K680 Substance abuse - extended assessment.......................................................... per unit 62.75

Payment rules:
1. K680 is a time based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP5, GP37 for definitions and time-keeping requirements.
2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K680 to the same patient by the same physician.
3. K680 is not eligible for payment for management of smoking cessation.

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

[Commentary: See K039 – smoking cessation.]

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

Definition/Required elements of service:
Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP) is the one month management and supervision of a patient receiving opioid agonist treatment by the physician most responsible for the management and supervision of that patient when rendered in accordance with the definitions and payment rules described below. The monthly management of a patient in an OAMP is only eligible for payment to a physician who has an active general exemption for methadone maintenance treatment for opioid dependence pursuant to Section 56 of the Controlled Drugs and Substances Act 1996.

This service includes the following specific elements:

a. All medication reviews, adjusting the dose of the opioid agonist therapy, and where appropriate, prescribing additional therapy, and discussions with pharmacists;
b. With the exception of all physician to physician telephone consultation services, discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), in person, by telephone, fax or e-mail on matters related to the service, regardless of identity of person initiating discussion; and
c. All discussions in respect of the patient's opioid dependency, except where the discussion is payable as a separate service.

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

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

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

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

f. A service primarily for the purpose of providing a prescription does not constitute a required service and does not count towards the minimum requirements of K682 or K683.

Payment rules:
1. K682, K683 and K684 are only eligible for payment to the physician most responsible for the patient's OAMP for the applicable month.
2. K684 is only eligible for payment when all required patient encounters are documented in the medical record.
3. K682 is limited to a maximum of six services per patient per 12 month period.
4. A maximum of one of K682 or K683 is eligible for payment per patient per month any physician.
5. In circumstances where the administration of an opioid agonist is delegated to another qualified health professional, K682 and K683 are only eligible for payment if the physician can demonstrate that he/she has received a delegation exemption from the CPSO.

[Commentary:
OAMP monthly management fees may be claimed for a patient enrolled in a treatment program using methadone or buprenorphine.]

Claims submission instructions:
Claims for K683, K682 and K684 are payable only after the minimum requirements have been rendered for the month.

[Commentary:
1. In circumstances where the physician most responsible for the patient's OAMP is temporarily absent and/or the patient is transferred to another physician in any month, the physicians should determine who is the physician most responsible for the purposes of claim submission and payment. In the event that more than one claim is submitted for the same patient for the same month, only the first claim submitted is eligible for payment.
2. The CPSO Methadone Maintenance Treatment Program Standards and Clinical Guidelines may be found at the following internet link: http://www.cpso.on.ca.
3. K683, K682, and K684 will be subject to a joint review by the MOHLTC and the Ontario Medical Association on or before December 31, 2012.]
## CONSULTATIONS AND VISITS

### ANAESTHESIA (01)

#### GENERAL LISTINGS

**Consultation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A015</td>
<td>Consultation</td>
<td>106.80</td>
</tr>
</tbody>
</table>

**Payment rules:**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A016</td>
<td>Repeat consultation</td>
<td>52.15</td>
</tr>
</tbody>
</table>

**Limited consultation for acute pain management**

A limited consultation for acute pain management is a consultation which takes place when a physician is requested by another physician to see a hospital in-patient because of the complexity or severity of the acute pain condition.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A215</td>
<td>Limited consultation for acute pain management in association with special visit to hospital in-patient</td>
<td>47.50</td>
</tr>
</tbody>
</table>

**Note:**

This service is *not eligible for payment*:

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

**[Commentary:]**

P014C - is an anaesthesia service, therefore the pre-anaesthetic evaluation is included in the service and is not payable as a limited consultation for acute pain management or as an assessment.

**Claims submission instructions:**

When providing this service to a hospital in-patient in association with a special visit premium, submit claim using A215 and the appropriate special visit premium beginning with a "C" prefix.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A013</td>
<td>Specific assessment</td>
<td>47.50</td>
</tr>
<tr>
<td>A014</td>
<td>Partial assessment</td>
<td>31.45</td>
</tr>
</tbody>
</table>

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>C015</td>
<td>Consultation - subject to the same conditions as A015</td>
<td>106.80</td>
</tr>
<tr>
<td>C016</td>
<td>Repeat consultation</td>
<td>52.15</td>
</tr>
<tr>
<td>C215</td>
<td>Limited consultation for acute pain management - subject to the same conditions as A215</td>
<td>47.50</td>
</tr>
<tr>
<td>C013</td>
<td>Specific assessment</td>
<td>47.50</td>
</tr>
<tr>
<td>C014</td>
<td>Specific re-assessment</td>
<td>28.00</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

ANAESTHESIA (01)

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

Subsequent visits by the Most Responsible Physician (MRP)
See General Preamble GP29 to GP30 for terms and conditions.
C122 - day following the hospital admission assessment ............................................. 58.80
C123 - second day following the hospital assessment .................................................. 58.80
C124 - day of discharge ............................................................................................. 58.80

Subsequent visits by the MRP following transfer from an intensive care area
See General Preamble GP31 for terms and conditions.
C142 - first subsequent visit by the MRP following transfer from an intensive care area 58.80
C143 - second subsequent visit by the MRP following transfer from an intensive care area .......................................................... 58.80
C121 - Additional visits due to intercurrent illness (see General Preamble GP28) .per visit 31.00
C018 - Concurrent care ............................................................................................ 31.00
C982 - Palliative care (see General Preamble GP34) ................................................... 31.00
CONSULTATIONS AND VISITS

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine section

GENERAL LISTINGS

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

Comprehensive cardiology consultation

This service is a consultation rendered by a specialist in cardiology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A600 Comprehensive cardiology consultation .................................................................. 300.70

Medical record requirements:

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

[Commentary:

1. A600 must satisfy all the elements of a consultation (see page GP12).

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

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.
## CONSULTATIONS AND VISITS

### CARDIOLOGY (60)

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C605</td>
<td>Consultation</td>
<td>$157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>$165.50</td>
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<td>C600</td>
<td>Comprehensive cardiology consultation - subject to the same conditions as A600</td>
<td>$300.70</td>
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<tr>
<td>C675</td>
<td>Limited consultation</td>
<td>$105.25</td>
</tr>
<tr>
<td>C606</td>
<td>Repeat consultation</td>
<td>$105.25</td>
</tr>
<tr>
<td>C603</td>
<td>Medical specific assessment</td>
<td>$79.85</td>
</tr>
<tr>
<td>C604</td>
<td>Medical specific re-assessment</td>
<td>$61.25</td>
</tr>
<tr>
<td>C601</td>
<td>Complex medical specific re-assessment</td>
<td>$70.90</td>
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</table>

**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C602</td>
<td>- first five weeks</td>
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</tr>
<tr>
<td>C607</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>$31.00</td>
</tr>
<tr>
<td>C609</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>$31.00</td>
</tr>
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</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>$58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>$58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>$58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an intensive care area</td>
<td>$58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an intensive care area</td>
<td>$58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>$31.00</td>
</tr>
<tr>
<td>C608</td>
<td>Concurrent care</td>
<td>$31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>$31.00</td>
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</table>
## CONSULTATIONS AND VISITS

### CARDIAC SURGERY (09)

#### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A095</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A096</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
<tr>
<td>A093</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>A094</td>
<td>Partial assessment</td>
<td>24.10</td>
</tr>
</tbody>
</table>

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
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<tr>
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<td>160.00</td>
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<tr>
<td>C096</td>
<td>Repeat consultation</td>
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<tr>
<td>C093</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>C094</td>
<td>Specific re-assessment</td>
<td>25.95</td>
</tr>
</tbody>
</table>

#### Subsequent visits

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

#### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28) .per visit</td>
<td>31.00</td>
</tr>
<tr>
<td>C098</td>
<td>Concurrent care ......................................................... per visit</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34) ............... per visit</td>
<td>31.00</td>
</tr>
</tbody>
</table>

#### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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<tr>
<td>W095</td>
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<td>90.30</td>
</tr>
<tr>
<td>W096</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
</tbody>
</table>
For Services not listed, refer to Internal Medicine Section.

**GENERAL LISTINGS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
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<tbody>
<tr>
<td>A625</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>A525</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A626</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A623</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A624</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A621</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A628</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
</tbody>
</table>

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

**EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)**

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C625</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C525</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C626</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C623</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C624</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C621</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
</tbody>
</table>

Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C622</td>
<td>first five weeks per visit</td>
<td>31.00</td>
</tr>
<tr>
<td>C627</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week) per visit</td>
<td>31.00</td>
</tr>
<tr>
<td>C629</td>
<td>after thirteenth week (maximum 6 per patient per month) per visit</td>
<td>31.00</td>
</tr>
</tbody>
</table>

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28) per visit</td>
<td>31.00</td>
</tr>
<tr>
<td>C628</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care</td>
<td>31.00</td>
</tr>
</tbody>
</table>
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 GP12).
2. The calculation of the 50 and 75 minute minimum time for special and comprehensive community medicine consultations respectively excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]
A405  Limited consultation ................................................................................................. 84.20
A056  Repeat consultation ................................................................................................. 84.20
A053  Medical specific assessment ...................................................................................... 79.85
A054  Medical specific re-assessment ............................................................................... 61.25
A051  Complex medical specific re-assessment ................................................................. 70.90
A058  Partial assessment ................................................................................................. 38.05

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)
Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES
See General Preamble GP26 to GP32. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.
C055  Consultation ............................................................................................................. 125.60
C050  Special community medicine consultation – subject to the same conditions as A050 .......................................................................................................................... 144.75
C400  Comprehensive community medicine consultation – subject to the same conditions as A400 ...................................................................................................................... 240.55
C405  Limited consultation ................................................................................................. 84.20
C056  Repeat consultation ................................................................................................. 84.20
C053  Medical specific assessment ...................................................................................... 79.85
C054  Medical specific re-assessment ............................................................................... 61.25
C051  Complex medical specific re-assessment ................................................................. 70.90
**CONSULTATIONS AND VISITS**

### COMMUNITY MEDICINE (05)

#### Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>C052</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C057</td>
<td>- sixth to thirteenth week (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C059</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
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</table>

#### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
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</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C058</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

#### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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</thead>
<tbody>
<tr>
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</tr>
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<td>Special community medicine consultation – subject to the same conditions as A050</td>
<td>144.75</td>
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<tr>
<td>W400</td>
<td>Comprehensive community medicine consultation – subject to the same conditions as A400</td>
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<td>W405</td>
<td>Limited consultation</td>
<td>84.20</td>
</tr>
<tr>
<td>W056</td>
<td>Repeat consultation</td>
<td>84.20</td>
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</table>

#### Admission assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Per Visit</th>
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<tbody>
<tr>
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<td>- Type 1</td>
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</tr>
<tr>
<td>W404</td>
<td>- Type 2</td>
<td>20.60</td>
</tr>
<tr>
<td>W407</td>
<td>- Type 3</td>
<td>30.70</td>
</tr>
<tr>
<td>W409</td>
<td>Periodic health visit</td>
<td>65.05</td>
</tr>
<tr>
<td>W054</td>
<td>General re-assessment of patient in nursing home (as per the Nursing Homes Act)*</td>
<td>20.60</td>
</tr>
</tbody>
</table>

**Note:**

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

#### Subsequent visits (see General Preamble GP33)

**Chronic care or convalescent hospital**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>W052</td>
<td>- first 4 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W051</td>
<td>- additional subsequent visits (maximum 6 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W982</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
</tbody>
</table>

**Nursing home or home for the aged**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>W053</td>
<td>- first 2 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W058</td>
<td>- additional subsequent visits (maximum 3 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W972</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
<tr>
<td>W121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP33)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
## GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A025</td>
<td>Consultation</td>
<td>72.15</td>
</tr>
<tr>
<td>A027</td>
<td>Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient</td>
<td>147.30</td>
</tr>
</tbody>
</table>

### Claims submission instructions:
Submit claim using A027 and the appropriate special visit premium beginning with "C" prefix for a hospital in-patient, "W" prefix for a long-term care in-patient or "K" prefix for an emergency department patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A026</td>
<td>Repeat consultation</td>
<td>44.45</td>
</tr>
<tr>
<td>A023</td>
<td>Specific assessment</td>
<td>38.70</td>
</tr>
<tr>
<td>A024</td>
<td>Partial assessment</td>
<td>21.90</td>
</tr>
<tr>
<td>U025</td>
<td>Initial e-assessment</td>
<td>44.45</td>
</tr>
<tr>
<td>U023</td>
<td>Repeat e-assessment</td>
<td>29.00</td>
</tr>
<tr>
<td>U026</td>
<td>Follow-up e-assessment</td>
<td>21.90</td>
</tr>
<tr>
<td>U021</td>
<td>Minor e-assessment</td>
<td>11.00</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

DERMATOLOGY (02)

Complex dermatology assessment
This service is an assessment for the ongoing management of any of the following diseases where the complexity of the condition requires the continuing management by a dermatology specialist.

a. Complex systemic disease with skin manifestations for at least one of the following:
   i. sarcoidosis;
   ii. systemic lupus erythematosus;
   iii. dermatomyositis;
   iv. scleroderma;
   v. relapsing polychondritis;
   vi. inflammatory bowel disease related diseases (i.e. pyoderma gangrenosum, Sweet’s syndrome, erythema nodosum);
   vii. porphyria;
   viii. autoimmune blistering diseases (e.g. pemphigus, pemphigoid, linear IgA);
   ix. paraneoplastic syndromes involving the skin;
   x. vasculitis (including Behcet’s disease); or
   xi. cutaneous lymphomas (including lymphomatoid papulosis).

or

b. Chronic pruritus with or without skin manifestations (i.e. prurigo nodularis).

or

c. Complex systemic drug reactions for at least one of the following:
   i. drug hypersensitivity syndrome;
   ii. erythema multiforme major; or
   iii. toxic epidermal necrolysis.

or

d. "Complex psoriasis" or "complex dermatitis" as defined by at least one of the following criteria:
   i. involvement of body surface area of greater than 30%;
   ii. treatment with systemic therapy (e.g. methotrexate, acitretin, cyclosporine, biologics); or
   iii. a visit that requires at least 15 minutes of direct patient encounter time.

A020 Complex dermatology assessment................................................................. 49.95

Payment rules:
1. A complex dermatology assessment must include all the elements of a specific assessment or the amount payable will be adjusted to lesser assessment fee.
2. Complex dermatology assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.
CONSULTATIONS AND VISITS

DERMATOLOGY (02)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing home or home for the aged

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

H055 Consultation (see General Preamble GP13) .............................................................................. 97.60

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

This service is a consultation rendered by a specialist in endocrinology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A150</td>
<td>Comprehensive endocrinology consultation</td>
<td>300.70</td>
</tr>
</tbody>
</table>

**Medical record requirements:**
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

**[Commentary:]**
1. A150 must satisfy all the elements of a consultation (see page GP12).
2. The calculation of the 75 minute minimum time for comprehensive endocrinology consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.

### Complex endocrine neoplastic disease assessment

This service is an assessment in relation to one or more of the following diseases where the complexity of the condition requires the ongoing management by an endocrinologist:

- a. thyroid neoplasm;
- b. parathyroid neoplasm;
- c. pituitary neoplasm; or
- d. adrenal neoplasm.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A760</td>
<td>Complex endocrine neoplastic disease assessment</td>
<td>89.85</td>
</tr>
</tbody>
</table>

**Payment rules:**
1. A760 must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.
2. A760 is limited to 6 per patient, per physician, per 12 month period and up to 12 per patient per physician for 24 consecutive months. Services in excess of this limit will be adjusted to a lesser assessment fee.
3. E078 is not eligible for payment with A760.

**[Commentary:]**
A760 is not payable for the evaluation and/or management of uncomplicated endocrine disorders.
DIABETES MANAGEMENT BY A SPECIALIST

Definition/Required elements of service:
Diabetes Management by a specialist is a service rendered by a specialist in Endocrinology, Internal Medicine or Paediatrics who is most responsible for providing ongoing management of a diabetic patient. This service includes all services related to the coordination, provision and documentation of ongoing management using a planned care approach consistent with the required elements of the current Canadian Diabetes Association (CDA) Clinical Practice Guidelines. The medical record must document that all of the CDA required elements have been provided for the previous 12 month period and include, at a minimum, the following:

- Lipids, cholesterol, HbA1C, blood pressure, weight and body mass index (BMI), and medication dosage;
- Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination;
- Health promotion counselling and patient self-management support;
- Albumin to creatinine ratio (ACR);
- Discussion and offer of referral for dilated eye examination; and
- Foot examination and neurologic examination.

K045 Diabetes management by a specialist .............................................................. 75.00

Payment rules:
1. K045 is limited to a maximum of one service per patient per 12 month period.
2. K045 is only eligible for payment if the physician has rendered a minimum of 4 of any of the following: consultations/assessments, K013, K033, K029, K002, K003 to the same patient in the 12 month period for which K045 is claimed.
3. K045 is only eligible for payment when the physician has greater than 100 patients per year with diabetes.
4. K045 is eligible for payment to a physician from one of the following specialties: Internal Medicine (13), Endocrinology (15) or Paediatrics (26).

Medical record requirements:
K045 is only eligible for payment if the flow sheet and/or a diabetic registry record has been completed for the previous 12 month period including the above listed requirements and is maintained in the patient’s permanent medical record.

Claims submission instructions:
Claims for K045 may only be submitted when the required elements of the service have been completed for the previous 12 month period.

[Commentary:
A copy of a flow sheet meeting the medical record requirements and CDA Clinical Practice Guidelines may be found at www.oma.org or www.diabetes.ca/for-professionals/resources/2008-cpg]
DIABETES TEAM MANAGEMENT (DTM)

Definition/Required elements of service:
This is an annual fee payable to a specialist in internal medicine or endocrinology for the comprehensive team-based care of a patient with diabetes.

The diabetes management team must include the specialist most responsible for the diabetes management of the patient and at least one or more Certified Diabetes Educators (CDE). DTM includes all services related to the coordination, provision and documentation of all required elements of ongoing care, as necessary, by the physician and/or the CDE.

K046 Diabetes team management................................................................. 115.00

Payment rules:
1. A maximum of one K046 is eligible for payment per patient per 12 month period.
2. K046 is only eligible for payment if all of the following requirements are fulfilled:
   a. the physician has rendered a minimum of 4 of any combination of consultations/assessments or K013, K033, K029, K002, K003 to the same patient in the 12 month period for which K046 is claimed;
   b. the CDE is an employee of the physician;
   c. when the physician has treated more than 100 patients with diabetes during the period for which K046 is claimed; and
   d. the physician is from one of the following specialties: Internal Medicine (13) or Endocrinology (15).
3. K046 is not eligible for payment unless the physician documents the services rendered by the CDE. The physician must provide such documentation to the ministry, if requested.
4. The CDE must have current certification by the Canadian Diabetes Educator Certification Board at the time the CDE renders services to the patient.

Medical record requirements:
1. K046 is only eligible for payment when the record includes a flow sheet and/or a diabetic registry record meeting the published Standards of Care as defined in the Canadian Diabetes Association Clinical Practice Guidelines. The minimum required elements of the diabetes flow sheet include:
   a. Laboratory parameters including:
      i. Lipid profile (cholesterol, triglycerides);
      ii. glycated haemoglobin (HgbA1C);
      iii. albumin to creatinine ratio (ACR); and
      iv. estimated glomerular filtration rate (eGFR) or Creatinine Clearance (CrCl)
   b. Blood pressure;
   c. Height, weight and body mass index (BMI);
   d. Medications (including dosage);
   e. Services related to prevention of diabetic complications;
   f. Health promotion counselling and patient self-management support;
   g. Evaluation and referral, as necessary, for dilated eye examination;
   h. Foot examination; and
   i. Neurological examination
2. K046 is not eligible for payment unless the record identifies any CDE performing the elements of the flow sheet.

[Commentary:
1. In circumstances where the CDE is employed by facilities, organizations or persons other than the physician, such as public hospitals, public health units, Independent Health Facilities (IHFs), industrial clinics or long-term care facilities, K046 is not eligible for payment.
2. For payment purposes, services rendered by the Certified Diabetic Educator (CDE) do not require the physical presence of a physician for direct supervision. It is required that the CDE performing services has the appropriate authorization from the applicable regulatory college, the CDE reports to the physician, and the services are rendered in accordance with accepted professional standards and practice.
3. K046 is payable in addition to K045.]

Claims submission instructions:
Claims for K046 may only be submitted when the required elements of the service have been completed for the previous 12 month period.
**CONSULTATIONS AND VISITS**

**ENDOCRINOLOGY & METABOLISM (15)**

**EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)**

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C155</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C150</td>
<td>Comprehensive endocrinology consultation - subject to the same conditions as A150</td>
<td>300.70</td>
</tr>
<tr>
<td>C255</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C156</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C153</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C154</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C151</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>C760</td>
<td>Complex endocrine neoplastic disease assessment - subject to the same conditions as A760</td>
<td>89.85</td>
</tr>
</tbody>
</table>

**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C152</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C157</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C159</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C158</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care</td>
<td>31.00</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

ENDOCRINOLOGY & METABOLISM (15)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment
W252 - Type 1................................................................................................................ 69.35
W254 - Type 2................................................................................................................ 20.60
W257 - Type 3................................................................................................................ 30.70
W259 Periodic health visit........................................................................................................... 65.05
W154 General re-assessment of patient in nursing home (as per the Nursing Homes Act)* 20.60

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

Subsequent visits (see General Preamble GP33)

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

Nursing home or home for the aged
W153 - first 2 subsequent visits per patient per month ........................................ per visit 32.20
W158 - subsequent visits per month (maximum of 3 per patient per month)..... per visit 21.20
W972 - palliative care (see General Preamble GP34) ........................................ per visit 32.20
W121 Additional visits due to intercurrent illness (see General Preamble GP33) .per visit 31.00
## CONSULTATIONS AND VISITS

### GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine section.

### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A415</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>A545</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A416</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A413</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A414</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A411</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A418</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
<tr>
<td>A120</td>
<td>Colonoscopy assessment, same day as colonoscopy</td>
<td>18.85</td>
</tr>
</tbody>
</table>

**Note:**
1. A120 is the only assessment service eligible for payment on the same day as a colonoscopy if a major pre-operative visit has been rendered by any physician in the 12 month period prior to the date of the colonoscopy service.
2. A120 is **not eligible for payment** if a major pre-operative visit is eligible for payment on the same day as colonoscopy.
3. A120 is **only eligible for payment** to physicians in the following specialties: Internal Medicine (13) and Gastroenterology (41).

**Commentary:**
For the definition of major pre-operative visit, see the definition page A4.

### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C415</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C545</td>
<td>Limited consultation</td>
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<td>C416</td>
<td>Repeat consultation</td>
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</tr>
<tr>
<td>C414</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C411</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
</tbody>
</table>
### Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost (per visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C412</td>
<td>first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C417</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C419</td>
<td>after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost (per visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost (per visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an intensive care area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C418</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
## CONSULTATIONS AND VISITS

### GENERAL LISTINGS

| Code  | Description                                                                 | Amount  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A035</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A036</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
<tr>
<td>A033</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>A034</td>
<td>Partial assessment</td>
<td>24.10</td>
</tr>
</tbody>
</table>

### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

| Code  | Description                                                                 | Amount  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C035</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>C935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>C036</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
<tr>
<td>C033</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>C034</td>
<td>Specific re-assessment</td>
<td>25.95</td>
</tr>
</tbody>
</table>

#### Subsequent visits

| Code  | Description                                                                 | Amount  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C032</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C037</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C039</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

#### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

| Code  | Description                                                                 | Amount  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

| Code  | Description                                                                 | Amount  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C038</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
## CONSULTATIONS AND VISITS

### GENERAL SURGERY (03)

**NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES**

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W035</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>W036</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
</tbody>
</table>

### Subsequent visits (see General Preamble GP33)

**Chronic care or convalescent hospital**

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

**Nursing home or home for the aged**

- W033 - first 2 subsequent visits per patient per month per visit 32.20
- W038 - subsequent visits per month (maximum of 3 per patient per month) per visit 21.20
- W972 - palliative care (see General Preamble GP34) per visit 32.20

**W121 Additional visits due to intercurrent illness** (see General Preamble GP33) per visit 31.00
# CONSULTATIONS AND VISITS

## GENERAL THORACIC SURGERY (64)

### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A645</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A646</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
<tr>
<td>A643</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>A644</td>
<td>Partial assessment</td>
<td>24.10</td>
</tr>
</tbody>
</table>

### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C645</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>C935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>C646</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
<tr>
<td>C643</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>C644</td>
<td>Specific re-assessment</td>
<td>25.95</td>
</tr>
</tbody>
</table>

**Subsequent visits**

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

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W645</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>W646</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
</tbody>
</table>
These listings may also be used by specialists with FCCMG designation (Fellow of the Canadian College of Medical Geneticists).

**GENERAL LISTINGS**

A225 Consultation* ........................................................................................................... 165.00

Special genetic consultation
Special genetic consultation is a consultation in which the physician provides all the elements of a consultation (A225) and spends a minimum of 75 minutes of direct contact with the patient *with or without* family.

A220 Special genetic consultation* .................................................................................. 300.70

**Medical record requirements:**
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Extended special genetic consultation
Extended special genetic consultation is a consultation in which the physician provides all the elements of a consultation (A225) and spends a minimum of 90 minutes of direct contact with the patient *with or without* family.

A223 Extended special genetic consultation* ........................................................... 395.65

**Medical record requirements:**
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

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

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

K016 Genetic assessment, patient or family ................................................................. per unit 74.05

**Payment rules:**
This service is limited to 4 units per patient per day.
CONSULTATIONS AND VISITS

GENETICS (22)

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

A800  Midwife-requested genetic assessment................................................................. 165.00

Payment rules:
1. This service is limited to one per patient, per physician, per 12 month period.
2. The geneticist must submit his/her findings, opinions and recommendations in writing to both the midwife and the patient's primary care physician, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Medical record requirements:
The written request from the midwife must be retained on the patient’s permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

Comprehensive midwife-requested genetic assessment
This service is an assessment provided by a geneticist upon the written request of a midwife because of the complex, obscure or serious nature of the patient’s problem. This service includes the specific elements of an assessment and the physician must spend a minimum of 75 minutes of direct contact with the patient.

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

Medical record requirements:
1. The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.
2. The written request from the midwife must be retained on the patient’s permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

Extended midwife-requested genetic assessment
This service is the assessment provided by a geneticist upon the written request of a midwife because of the complex, obscure or serious nature of the patient’s problem. This service includes the specific elements of an assessment and the physician must spend a minimum of 90 minutes of direct contact with the patient.

A802  Extended midwife-requested genetic assessment ............................................... 395.65

Medical record requirements:
1. The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.
2. The written request from the midwife must be retained on the patient’s permanent medical record, or the amount payable for the service will be reduced to a lesser fee.
CONSULTATIONS AND VISITS

GENETICS (22)

Genetic care
Genetic care is a time based service payable for rendering a genetic assessment. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K222 Genetic care, patient or family ................................................................. per unit 74.70

Payment rules:
This service is limited to 4 units per patient, per day.

Clinical interpretation by a geneticist
Clinical interpretation by a Geneticist requires interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports. The service must be requested in writing by a physician who is participating in the patient’s care and the geneticist must submit his/her findings, opinions, and recommendations in writing to the referring physician.

K223 Clinical interpretation ................................................................. 37.65

Payment rules:
This service is not eligible for payment when rendered in association with a consultation on the same patient.

Clinical interpretation by a geneticist requested by a midwife
This service is the interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports. The service must be requested in writing by a midwife who is participating in the patient’s care and the geneticist must submit his/her findings, opinions, and recommendations in writing to both the midwife and the patient’s primary care physician, if applicable, or the amount payable for the service will be reduced to a lesser fee.

K224 Clinical interpretation requested by a midwife ........................................ 37.65

Genetic family counselling
Genetic family counselling is counselling dedicated to an educational dialogue between the physician and one or more family members, guardians of a genetic patient or patient’s representative for the purpose of providing information regarding treatment options and prognosis. The claim is submitted under the genetic patient’s health number.

K044 Genetic family counselling........................................................................... per unit 62.75

Note:
Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time keeping requirements.
CONSULTATIONS AND VISITS

GENETICS (22)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

C225 Consultation* ........................................................................................................... 165.00
C220 Special genetic consultation* - subject to the same conditions as A220................. 300.70
C223 Extended special genetic consultation* - subject to the same conditions as A223 .. 395.65
C235 Limited consultation.................................................................................................. 105.25
C226 Repeat consultation .................................................................................................. 105.25
C800 Midwife-requested genetic assessment – subject to the same conditions as A800 165.00
C801 Comprehensive midwife-requested genetic assessment – subject to the same conditions as A801 .............................................................................................................. 300.70
C802 Extended midwife-requested genetic assessment – subject to the same conditions as A802.............................................................................................................. 395.65

Subsequent visits

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing home or home for the aged

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

GERIATRICS (07)

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

Claims submission instructions:
Submit claim using A070 and the appropriate special visit premium beginning with "C" prefix for a hospital in-patient, "W" prefix for a long-term care in-patient or "K" prefix for an emergency department patient.

Comprehensive geriatric consultation
A comprehensive geriatric consultation is a consultation performed by a physician with a certificate of special competence in Geriatrics on a patient:
a. at least 65 years of age; or
b. when the consultation is for the assessment of dementia; and
where the physician spends at least 75 minutes with the patient exclusive of time spent rendering any other service to the patient.
A775 Comprehensive geriatric consultation........................................................... 300.70

[Commentary:
A775 is eligible for payment when the consultation is for the assessment of dementia regardless of the patient's age.]

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Payment rules:
1. The consultation must be scheduled at least one day before the service is rendered.
2. A comprehensive geriatric consultation is only eligible for payment if this service has not been rendered on the same patient by the same consultant within the previous 2 years.

Extended comprehensive geriatric consultation
An extended comprehensive geriatric consultation is a consultation performed by a physician with a certificate of special competence in geriatrics on a patient:
a. at least 65 years of age; or
b. when the consultation is for the assessment of dementia; and
where the physician spends at least 90 minutes with the patient exclusive of time spent rendering any other service to the patient.
A770 Extended comprehensive geriatric consultation ..................................................... 395.65

[Commentary:
A770 is eligible for payment when the consultation is for the assessment of dementia regardless of the patient's age.]

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Payment rules:
An extended comprehensive geriatric consultation is only eligible for payment if this service has not been rendered on the same patient by the same consultant within the previous 2 years.
**CONSULTATIONS AND VISITS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A375</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A076</td>
<td>Repeat consultation</td>
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<tr>
<td>A073</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A074</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
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<tr>
<td>A071</td>
<td>Complex medical specific re-assessment</td>
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<td>A078</td>
<td>Partial assessment</td>
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<tr>
<td>E078</td>
<td>- chronic disease assessment premium (see General Preamble GP16) add 50%</td>
<td></td>
</tr>
</tbody>
</table>

**Geriatric telephone support**

This is the service initiated by a caregiver where a physician provides telephone support to a caregiver(s) for a patient with an established diagnosis of dementia.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>K077</td>
<td>Geriatric telephone support</td>
<td>35.45</td>
</tr>
</tbody>
</table>

**Payment rules:**

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

2. A maximum of eight (8) K077 units are eligible for payment per patient per 12 month period.

3. K077 is only eligible for payment where:
   a. there is a minimum of 10 minutes of patient-related discussion; and
   b. the physician:
      i. is a specialist in Geriatrics (07); or
      ii. has a certificate of special competence in Geriatrics; or
      iii. has an exemption to access bonus impact in Care of the Elderly from the MOHLTC.

4. In circumstances where a physician receives compensation, other than by fee-for-service under this Schedule, for the provision of telephone support for caregivers, this service is not eligible for payment to that physician.

[Commentary:

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

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

**Medical record requirements:**

K077 is only eligible for payment where the following elements are included in the medical record:

1. patient’s name and health number;
2. start and stop times of the discussion;
3. reason for the telephone support; and
4. the opinion, advice and/or recommendations of the physician.
CONSULTATIONS AND VISITS

GERIATRICS (07)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>C075</td>
<td>Consultation</td>
<td>185.00</td>
</tr>
<tr>
<td>C775</td>
<td>Comprehensive geriatric consultation - subject to the same conditions as A775...</td>
<td>300.70</td>
</tr>
<tr>
<td>C770</td>
<td>Extended comprehensive geriatric consultation - subject to the same conditions as A770...</td>
<td>395.65</td>
</tr>
<tr>
<td>C375</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C076</td>
<td>Repeat consultation</td>
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<tr>
<td>C074</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C071</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
</tbody>
</table>

Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C072</td>
<td>First five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C077</td>
<td>Sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C079</td>
<td>After thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>Day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>Second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>Day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>First subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>Second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C078</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment
W272 - Type 1................................................................................................................. 69.35
W274 - Type 2................................................................................................................. 20.60
W277 - Type 3................................................................................................................. 30.70
W279 Periodic health visit ................................................................................................. 65.05
W074 General reassessment of patient in nursing home (as per the Nursing Homes Act)* 20.60

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

Subsequent visits (see General Preamble GP33)

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

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

Monthly Management of a Nursing Home or Home for the Aged Patient
W010 Monthly management fee (per patient per month) (see General Preamble GP35 to GP36)................................................................................................. 108.85
For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A615 Consultation ................................................................. 157.00
A765 Consultation, patient 16 years of age and under ..................... 165.50
A655 Limited consultation ...................................................... 105.25
A616 Repeat consultation ...................................................... 105.25
A613 Medical specific assessment ........................................... 79.85
A614 Medical specific re-assessment ....................................... 61.25
A611 Complex medical specific re-assessment ............................ 70.90
A618 Partial assessment ...................................................... 38.05
E078 chronic disease assessment premium (see General Preamble GP16) add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

### INFECTIOUS DISEASE (46)

#### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A465</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
</tbody>
</table>

**Comprehensive infectious disease consultation**

This service is a consultation rendered by a *specialist* in infectious disease who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A460</td>
<td>Comprehensive infectious disease consultation</td>
<td>300.70</td>
</tr>
</tbody>
</table>

**Medical record requirements:**

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

*[Commentary]*:

1. A460 must satisfy all the elements of a consultation (see page GP12).
2. The calculation of the 75 minute minimum time for comprehensive infectious disease consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A275</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A466</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A463</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A464</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A461</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A468</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
<tr>
<td>E078</td>
<td>- chronic disease assessment premium (see General Preamble GP16)</td>
<td></td>
</tr>
</tbody>
</table>

**EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)**

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>C465</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C460</td>
<td>Comprehensive infectious disease consultation - subject to the same conditions as A460</td>
<td>300.70</td>
</tr>
<tr>
<td>C275</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C466</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C463</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C464</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C461</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
</tbody>
</table>
Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment

W292 - Type 1 ......................................................................................... 69.35
W294 - Type 2 ......................................................................................... 20.60
W297 - Type 3 ......................................................................................... 30.70
W299 Periodic health visit ........................................................................... 65.05
W464 General re-assessment of patient in nursing home (as per the Nursing Homes Act)* 20.60

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing home or home for the aged

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

## INTERNAL AND OCCUPATIONAL MEDICINE (13)

### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A135</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
</tbody>
</table>

**Comprehensive internal medicine consultation**

This service is a consultation rendered by a specialist in internal medicine who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A130</td>
<td>Comprehensive internal medicine consultation</td>
<td>300.70</td>
</tr>
</tbody>
</table>

**Medical record requirements:**

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

[**Commentary:**

1. A130 must satisfy all the elements of a consultation (see page GP12).

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A435</td>
<td>Limited consultation</td>
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<tr>
<td>A136</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A133</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A134</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A131</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A138</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
<tr>
<td>A120</td>
<td>Colonoscopy assessment, same day as colonoscopy</td>
<td>18.85</td>
</tr>
</tbody>
</table>

**Note:**

1. A120 is the only assessment service eligible for payment on the same day as a colonoscopy if a major pre-operative visit has been rendered by any physician in the 12 month period prior to the date of the colonoscopy service.

2. A120 is *not eligible for payment* if a major pre-operative visit is eligible for payment on the same day as colonoscopy.

3. A120 is *only eligible for payment* to physicians in the following specialties: Internal Medicine (13) and Gastroenterology (41).

[**Commentary:**

For the definition of major pre-operative visit, see the definition page A4.]

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>K045</td>
<td>Diabetes management by a specialist</td>
<td>75.00</td>
</tr>
<tr>
<td>K046</td>
<td>Diabetes team management</td>
<td>115.00</td>
</tr>
</tbody>
</table>

[**Commentary:**

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

INTERNAL AND OCCUPATIONAL MEDICINE (13)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

INTERNAL AND OCCUPATIONAL MEDICINE (13)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment

W232 - Type 1.................................................................................. 69.35
W234 - Type 2.................................................................................. 20.60
W237 - Type 3.................................................................................. 30.70
W239 Periodic health visit ................................................................. 65.05
W134 General re-assessment of patient in nursing home (as per the Nursing Homes Act)* ............................................................... 20.60

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing home or home for the aged

W133 - first 2 subsequent visits per patient per month ...................... per visit 32.20
W138 - subsequent visits per month (maximum of 3 per patient per month) ....per visit 21.20
W972 - palliative care (see General Preamble GP34) ........................................ per visit 32.20
W121 Additional visits due to intercurrent illness (see General Preamble GP33). per visit 31.00
The following fees are applicable to specialists in Haematopathology, Neuropathology, Medical Biochemistry, Medical Microbiology, Anatomic and General Pathology.

**GENERAL LISTINGS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A285</td>
<td>Consultation</td>
<td>102.00</td>
</tr>
<tr>
<td>A286</td>
<td>Limited consultation</td>
<td>71.20</td>
</tr>
<tr>
<td>A586</td>
<td>Repeat consultation</td>
<td>71.20</td>
</tr>
<tr>
<td>A283</td>
<td>Medical specific assessment</td>
<td>55.55</td>
</tr>
<tr>
<td>A284</td>
<td>Partial assessment</td>
<td>30.60</td>
</tr>
<tr>
<td>E078</td>
<td>- chronic disease assessment premium (see General Preamble GP16)</td>
<td>add 50%</td>
</tr>
</tbody>
</table>

**Diagnostic consultation**

A diagnostic laboratory medicine consultation is the service rendered when tissue, slides, specimens and/or laboratory results prepared in one licensed laboratory are referred to a laboratory medicine physician not in the same licensed laboratory for a written opinion. The specific elements are the same as for the L800 series of codes (see page J47 to J48).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A585</td>
<td>Diagnostic consultation</td>
<td>64.70</td>
</tr>
</tbody>
</table>

**Payment rules:**

1. A diagnostic laboratory medicine consultation is **not eligible for payment** when tissues, slides, specimens and/or laboratory results from a different licensed laboratory are used for comparison purposes with tissues, slides, specimens and/or laboratory results done in the consultant’s licensed laboratory.

2. With the exception of those services set out in the section, “Special Procedures and Interpretation – Histology or Cytology”, any other services rendered by the physician in association with a diagnostic laboratory medicine consultation are **not eligible for payment**.

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C285</td>
<td>Consultation</td>
<td>102.00</td>
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<tr>
<td>C286</td>
<td>Limited consultation</td>
<td>71.20</td>
</tr>
<tr>
<td>C586</td>
<td>Repeat consultation</td>
<td>71.20</td>
</tr>
<tr>
<td>C283</td>
<td>Medical specific assessment</td>
<td>55.55</td>
</tr>
<tr>
<td>C585</td>
<td>Diagnostic consultation - subject to the same conditions as A585</td>
<td>64.70</td>
</tr>
<tr>
<td>C288</td>
<td>Concurrent care</td>
<td>30.10</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Fee</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>A445</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>A845</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A446</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A443</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A444</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A441</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A448</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
<tr>
<td>E078</td>
<td>- chronic disease assessment premium (see General Preamble GP16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>add 50%</td>
</tr>
</tbody>
</table>

**EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)**

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C445</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C845</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C446</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C443</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C444</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C441</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
</tbody>
</table>

**Subsequent visits**

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

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
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</tbody>
</table>
### CONSULTATIONS AND VISITS

**MEDICAL ONCOLOGY (44)**

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28) per visit</td>
<td>31.00</td>
</tr>
<tr>
<td>C448</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

#### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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</thead>
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<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>W765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>167.00</td>
</tr>
<tr>
<td>W845</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>W446</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
</tbody>
</table>

#### Admission assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W842</td>
<td>- Type 1</td>
<td>69.35</td>
</tr>
<tr>
<td>W844</td>
<td>- Type 2</td>
<td>20.60</td>
</tr>
<tr>
<td>W847</td>
<td>- Type 3</td>
<td>30.70</td>
</tr>
<tr>
<td>W849</td>
<td>Periodic health visit</td>
<td>65.05</td>
</tr>
<tr>
<td>W444</td>
<td>General re-assessment of patient in nursing home (as per the Nursing Homes Act)*</td>
<td>20.60</td>
</tr>
</tbody>
</table>

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

#### Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W442</td>
<td>- first 4 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W441</td>
<td>- additional subsequent visits (maximum of 6 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W982</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
</tbody>
</table>

Nursing home or home for the aged

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>W443</td>
<td>- first 2 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W448</td>
<td>- subsequent visits per month (maximum of 3 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W972</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
<tr>
<td>W121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP33). per visit</td>
<td>31.00</td>
</tr>
</tbody>
</table>
### Consultations and Visits

**NEPHROLOGY (16)**

### General Listings

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A165</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
</tbody>
</table>

**Comprehensive nephrology consultation**

This service is a consultation rendered by a specialist in nephrology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A160</td>
<td>Comprehensive nephrology consultation</td>
<td>300.70</td>
</tr>
</tbody>
</table>

**Medical record requirements:**

For A160, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

**Commentary:**

1. A160 must satisfy all the elements of a consultation (see page GP12).

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A865</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A166</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>A163</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A164</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A161</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A168</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
</tbody>
</table>

### Emergency or Out-Patient Department (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

### Non-Emergency Hospital In-Patient Services

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C165</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C160</td>
<td>Comprehensive nephrology consultation - subject to the same conditions as A160</td>
<td>300.70</td>
</tr>
<tr>
<td>C865</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C166</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C163</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C164</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>C161</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

NEPHROLOGY (16)

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment

W862 - Type 1 .......................................................................................... 69.35
W864 - Type 2 .......................................................................................... 20.60
W867 - Type 3 .......................................................................................... 30.70
W869 - Periodic health visit .......................................................................... 65.05
W164 - General re-assessment of patient in nursing home (as per the Nursing Homes Act)* 20.60

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing home or home for the aged

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

### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A185</td>
<td>Consultation</td>
<td>176.35</td>
</tr>
</tbody>
</table>

**Special neurology consultation**

Special neurology consultation is a consultation in which the physician provides all the elements of a consultation (A185) and spends a minimum of 75 minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A180</td>
<td>Special neurology consultation</td>
<td>300.70</td>
</tr>
</tbody>
</table>

**Medical record requirements:**

The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A385</td>
<td>Limited consultation</td>
<td>84.95</td>
</tr>
<tr>
<td>A186</td>
<td>Repeat consultation</td>
<td>84.95</td>
</tr>
<tr>
<td>A183</td>
<td>Medical specific assessment</td>
<td>78.80</td>
</tr>
<tr>
<td>A184</td>
<td>Medical specific re-assessment</td>
<td>62.10</td>
</tr>
<tr>
<td>A181</td>
<td>Complex medical specific re-assessment</td>
<td>71.90</td>
</tr>
<tr>
<td>A188</td>
<td>Partial assessment</td>
<td>37.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>E078</td>
<td>- chronic disease assessment premium (see General Preamble GP16) add 50%</td>
<td>89.85</td>
</tr>
</tbody>
</table>

**Complex neuromuscular assessment**

A complex neuromuscular assessment is an assessment for the ongoing management of the following diseases of the neuromuscular system where the complexity of the condition requires the continuing management by a neurologist:

- generalized peripheral neuropathies;
- myopathies;
- diseases of the neuromuscular junction; or
- diseases of the motor neurone.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A113</td>
<td>Complex neuromuscular assessment</td>
<td>89.85</td>
</tr>
</tbody>
</table>

**Payment rules:**

1. A complex neuromuscular assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee.
2. This service is not eligible for payment to a physician for the initial evaluation of the patient by that physician.
3. Complex neuromuscular assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.
4. E078 is not eligible for payment with A113.

**Commentary:**

1. A complex neuromuscular assessment is for the ongoing management of complex neuromuscular disorders, where the complexity of the condition requires the continuing management by a neurologist. It is not intended for the evaluation and/or management of uncomplicated neuromuscular disorders (e.g. carpal tunnel syndrome, Bell’s palsy, asymptomatic diabetic neuropathy).
2. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex neuromuscular assessment is for the ongoing management of a patient with a complex neuromuscular disorder.]
**CONSULTATIONS AND VISITS**

**NEUROLOGY (18)**

**EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)**

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

**NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES**

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

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<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C185</td>
<td>Consultation</td>
<td>176.35</td>
</tr>
<tr>
<td>C180</td>
<td>Special neurology consultation - subject to the same conditions as A180</td>
<td>300.70</td>
</tr>
<tr>
<td>C385</td>
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<td>Medical specific assessment</td>
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<td>C184</td>
<td>Medical specific re-assessment</td>
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<td>89.85</td>
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</table>

**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C182</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C187</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C189</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

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<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
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<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
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</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C188</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
### CONSULTATIONS AND VISITS

#### NEUROLOGY (18)

**NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES**

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W185</td>
<td>Consultation</td>
<td>176.35</td>
</tr>
<tr>
<td>W180</td>
<td>Special neurology consultation - subject to the same conditions as A180</td>
<td>300.70</td>
</tr>
<tr>
<td>W385</td>
<td>Limited consultation</td>
<td>84.95</td>
</tr>
<tr>
<td>W186</td>
<td>Repeat consultation</td>
<td>84.95</td>
</tr>
<tr>
<td>W113</td>
<td>Complex neuromuscular assessment - subject to the same conditions as A113</td>
<td>89.85</td>
</tr>
<tr>
<td>W184</td>
<td>General re-assessment of patient in nursing home (as per the Nursing Homes Act)*</td>
<td>20.60</td>
</tr>
</tbody>
</table>

**Note:**

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

**Subsequent visits (see General Preamble GP33)**

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

- Nursing home or home for the aged
  - W183 - first 2 subsequent visits per patient per month ......................................... per visit 32.20
  - W188 - subsequent visits per month (maximum of 3 per patient per month)................ per visit 21.20
  - W972 - palliative care (see General Preamble GP34) ............................................. per visit 32.20
  - W121 - Additional visits due to intercurrent illness (see General Preamble GP33)....... per visit 31.00
## GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A045</td>
<td>Consultation</td>
<td>121.10</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A046</td>
<td>Repeat consultation</td>
<td>58.25</td>
</tr>
<tr>
<td>A043</td>
<td>Specific assessment</td>
<td>58.25</td>
</tr>
<tr>
<td>A044</td>
<td>Partial assessment</td>
<td>30.00</td>
</tr>
</tbody>
</table>

## EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

## NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>C045</td>
<td>Consultation</td>
<td>121.10</td>
</tr>
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<td>C935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>C046</td>
<td>Repeat consultation</td>
<td>58.25</td>
</tr>
<tr>
<td>C043</td>
<td>Specific assessment</td>
<td>58.25</td>
</tr>
<tr>
<td>C044</td>
<td>Specific re-assessment</td>
<td>30.00</td>
</tr>
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</table>

**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
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<tbody>
<tr>
<td>C042</td>
<td>first five weeks</td>
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</tr>
<tr>
<td>C047</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C049</td>
<td>after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C048</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

## NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W045</td>
<td>Consultation</td>
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</tr>
<tr>
<td>W046</td>
<td>Repeat consultation</td>
<td>51.45</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

NUCLEAR MEDICINE (63)

GENERAL LISTINGS

A635 Consultation ............................................................................................................. 82.40

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

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

Payment rules:
When a nuclear medicine consultation or repeat consultation is rendered in conjunction with a nuclear medicine study, only the P2 professional fee is payable for the study (rather than the P1 professional fee).

Diagnostic consultation
A diagnostic nuclear medicine consultation is the service rendered:

a. when nuclear medicine studies rendered at one institution or facility are referred to a nuclear medicine specialist in a different institution or facility for a written opinion. In this case, the specific elements are the same as the nuclear medicine professional component P2 (see page B1); or

b. when a nuclear medicine specialist is required to make a special visit at evening or night (17:00h to 07:00h) or on a Saturday, Sunday, or holiday to consult on the advisability of performing a nuclear medicine procedure, which eventually is not done. In this case, the specific elements are the same as for consultations.

A735 Diagnostic consultation .......................................................................................... 33.70

Payment rules:
A diagnostic nuclear medicine consultation is not eligible for payment when studies rendered in a different institution or facility are used for comparison purposes with nuclear medicine studies rendered in the consultant’s institution or facility.

A636 Repeat consultation .............................................................................................. 57.25
A638 Partial assessment ................................................................................................. 35.35

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

**OBSTETRICS AND GYNAECOLOGY (20)**

### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>A205</td>
<td>Consultation*</td>
<td>101.70</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A206</td>
<td>Repeat consultation*</td>
<td>54.10</td>
</tr>
<tr>
<td>A203</td>
<td>Specific assessment*</td>
<td>47.45</td>
</tr>
<tr>
<td>A204</td>
<td>Partial assessment</td>
<td>26.35</td>
</tr>
</tbody>
</table>

**Note:**
The Papanicolaou smear is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), or routine post-natal visit when pelvic examination is normal part of the foregoing services. However, the add-on codes E430 or E431 can be billed in addition to these services when a papanicolaou smear is performed outside hospital.

### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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<td>Specific assessment*</td>
<td>47.45</td>
</tr>
<tr>
<td>C204</td>
<td>Specific re-assessment*</td>
<td>29.65</td>
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</table>

#### Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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<tbody>
<tr>
<td>C202</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C207</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C209</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
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#### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
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#### Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP31 for terms and conditions.

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<thead>
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</tr>
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<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C208</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
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### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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<tr>
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<th>Description</th>
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</thead>
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<tr>
<td>W305</td>
<td>Consultation*</td>
<td>101.70</td>
</tr>
<tr>
<td>W306</td>
<td>Repeat consultation*</td>
<td>54.10</td>
</tr>
</tbody>
</table>

**Note:**
*Includes (where indicated) biopsy of cervix, papanicolaou smear, examination of trichomonas suspension.
CONSULTATIONS AND VISITS

OPHTHALMOLOGY (23)

Note:
Ophthalmology consultations and visits may include retinal photography as a specific element of the insured service, where medically necessary.

GENERAL LISTINGS

A235 Consultation .......................................................... 82.30
A935 Special surgical consultation (see General Preamble GP13) ........................................ 160.00
A236 Repeat consultation .......................................................... 45.85
A231 Neuro-ophthalmology consultation .......................................................... 120.00

Payment rules:
1. A231 is only eligible for payment when at least four of the following are documented as a part of the examination:
   a. Detailed pupillary examination (includes pharmacological testing as applicable)
   b. Detailed extraocular motility examination
   c. Ocular alignment testing
   d. Partial or complete neurological examination
   e. Detailed examination of the fundus
   f. Analysis of formal visual field test(s)
   g. Analysis of pertinent diagnostic imaging studies
2. A231 is only eligible for payment to an ophthalmologist with fellowship training in Neuro-ophthalmology.
3. A231 is only eligible for payment for the consultation of a patient with a neuro-ophthalmological disorder.

[Commentary:
In circumstances where a neuro-ophthalmologist renders a consultation service to a patient who is not referred for a neuro-ophthalmology consultation or, where the patient does not have a neuro-ophthalmological disorder, see general listings.]

A233 Specific assessment .......................................................... 57.70
A234 Partial assessment .......................................................... 28.95

Manual cycloplegic refraction is the service rendered personally by an ophthalmologist for evaluation of patients up to and including 15 years of age for the evaluation of strabismus and/or amblyopia requiring glasses or contact lenses.

E423 - manual cycloplegic refraction, to A233 or A234 ........................................... add 25.00

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

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

Periodic oculo-visual assessment

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

Note:
See General Preamble GP19 for definitions and conditions.
## Ophthalmology (23)

### Major eye examination

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A115</td>
<td>Major eye examination (see page A7)</td>
<td>51.10</td>
</tr>
</tbody>
</table>

#### Orthoptic assessment

Orthoptic assessment must include quantitative measurement of all cardinal positions of gaze (straight ahead, left, right, up, down, tilt right and tilt left), sensory testing for binocular vision suppression, cyclodeviation and retinal correspondence. An orthoptic assessment is eligible for payment in addition to an ophthalmology consultation or visit.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>A230</td>
<td>Orthoptic assessment</td>
<td>25.00</td>
</tr>
</tbody>
</table>

**Note:**

A230 is only eligible for payment when all tests described under orthoptic assessment are rendered personally and interpreted personally by the physician and results and measurements are documented in the patient’s permanent medical record.

**[Commentary:]**

If a certified orthoptist is rendering the examination, G814 may be eligible for payment (page J74).

### Retinopathy of prematurity (ROP) assessment

Retinopathy of Prematurity (ROP) assessment is the service rendered by an ophthalmologist for initial assessment or follow-up assessment(s) of a patient with ROP who is either:

a. 9 months of age or younger; or

b. aged 10 months to 16 years with minimum stage 3 ROP disease.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A250</td>
<td>Retinopathy of prematurity assessment</td>
<td>120.00</td>
</tr>
</tbody>
</table>

**Payment rules:**

No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A250.
Vision Rehabilitation – Initial assessment and follow-up assessment

Definitions
The following phrases have the following meanings for the purpose of fee schedule codes A252 and A254.

**Low visual acuity** - best corrected visual acuity of 20/50 (6/15) or less in the better eye and not amenable to further medical and/or surgical treatment.

**Significant oculomotor dysfunction** - nerve palsy or nystagmus resulting in low visual acuity or visual field defects as defined and not amenable to further medical and/or surgical treatment.

**Visual field defect** - splitting of fixation, scotomata, quadranopic or hemianopic field defects not amenable to further medical and/or surgical treatment.

Initial vision rehabilitation assessment
Initial vision rehabilitation assessment by an ophthalmologist of a patient with either low visual acuity, visual field defect, or significant oculomotor dysfunction subject to the conditions below.

This service is only payable when a minimum of four (4) of the following eight (8) listed components are rendered during the same visit:

2. Assessment of residual visual function to include at least two of the following tests: visual acuity tested with ETDRS charts, macular perimetry, contrast sensitivity tested at 5 spatial frequencies and fixation instability.
3. Assessment of eccentric preferred retinal loci.
4. Assessment of near functional visual acuity with ETDRS charts.
5. Assessment of reading skills.

[Commentary:
For example, using MNRead or Colenbrander charts.]

6. Prescribing of low vision devices aimed to improve residual visual function.
7. Preparation of a vision rehabilitation plan and/or discussion of the plan with the patient.
8. Supervised training of the patient, in accordance with recognized programs, for use of low vision devices and/or training for rehabilitation of skills dependent on vision.

A252 Initial vision rehabilitation assessment ........................................................... 240.00

Follow-up vision rehabilitation assessment
This service is only payable when a minimum of three (3) of the eight (8) components listed above are rendered in the same visit.

A254 Follow-up vision rehabilitation assessment ........................................................ 120.00

Payment rules:
For A252 and A254:

1. No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A252 or A254.
2. A252 is limited to two (2) per patient per five (5) year period per physician.
3. A254 is only payable when the patient has received an A252.
4. A254 is limited to ten (10) per patient per five (5) year period from the date of the most recent A252.
5. If the minimum required number of components for A252 or A254 are not rendered, the amount payable for the service will be reduced to a lesser fee.

[Commentary:
Diagnostic services (e.g. visual field testing), when rendered, are eligible for payment with these services.]
CONSULTATIONS AND VISITS

OPHTHALMOLOGY (23)

Optometrist-requested assessment (ORA)
Optometrist-requested assessment (ORA) is an assessment of a patient provided by an ophthalmologist upon the written request of an optometrist because of the complex, obscure or serious nature of the patient's problem. Urgent or emergency requests may be initiated verbally but must also be documented in writing. The ORA includes the common and specific elements of a specific assessment.

A253 Optometrist-Requested Assessment (ORA) ................................................................. 82.30

Payment rules:
1. This service is limited to one per patient, per physician, per 12 month period.
2. The ophthalmologist must submit his/her findings, opinions and recommendations in writing to both the optometrist and the patient’s primary care physician, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Medical record requirements:
The written request from the optometrist must be retained on the patient’s permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

Special optometrist-requested assessment
A Special Optometrist-Requested Assessment is an assessment in which the ophthalmologist provides all the elements of an Optometrist-Requested Assessment (A253) and spends a minimum of 50 minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A256 Special optometrist-requested assessment ............................................................. 144.75

Payment rules:
This service is limited to one per patient, per physician, per 12 month period.

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient’s permanent medical record.

Special ophthalmologic assessment
Special ophthalmologic assessment is a complete ophthalmologic assessment, rendered by an ophthalmologist, to a person with a psychological problem, developmental delay, learning disability, or significant physical disability which so limits the person’s participation in the assessment that the physician is required to spend a minimum of 20 minutes in direct contact with the patient, family, and/or legal representative.

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

a. the development of a continuing comprehensive vision care plan;

b. provision of appropriate information to the patient’s health care team regarding the patient’s vision to allow them to better prepare both general and academic plans; and

c. reporting the findings, opinions or recommendations in writing to other health care team members regarding this evaluation and future planning.

A251 Special ophthalmologic assessment ................................................................. 120.00

Payment rules:
1. No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A251.
2. This service is limited to a maximum of 2 services per patient per physician per 12 month period.

Medical record requirements:
1. The start/stop time of the service must be documented in the patient’s medical record or the amount payable for the service will be reduced to a lesser fee.
2. A statement of the medical condition and how it limits the patient’s ability to participate in the assessment with the physician must be documented in the patient's medical record or the amount payable for the service will be reduced to a lesser fee.
3. A copy of the letter to other health care team members must be maintained in the patient’s medical record or the service will be reduced to a lesser fee.

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

OPHTHALMOLOGY (23)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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</thead>
<tbody>
<tr>
<td>C235</td>
<td>Consultation</td>
<td>82.30</td>
</tr>
<tr>
<td>C236</td>
<td>Repeat consultation</td>
<td>45.85</td>
</tr>
<tr>
<td>C231</td>
<td>Neuro-Ophthalmology Consultation – subject to the same conditions as A231</td>
<td>120.00</td>
</tr>
<tr>
<td>C233</td>
<td>Specific assessment</td>
<td>57.70</td>
</tr>
<tr>
<td>C234</td>
<td>Specific re-assessment</td>
<td>29.35</td>
</tr>
<tr>
<td>C250</td>
<td>Retinopathy of prematurity assessment - subject to the same conditions as A250</td>
<td>120.00</td>
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</table>

Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
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<tbody>
<tr>
<td>C232</td>
<td>first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C237</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C239</td>
<td>after thirteenth week (maximum 6 per patient per month)</td>
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Subsequent visits by the Most Responsible Physician (MRP)

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<td>58.80</td>
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<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
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<td>day of discharge</td>
<td>58.80</td>
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Subsequent visits by the MRP following transfer from an Intensive Care Area

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<td>C238</td>
<td>Concurrent care</td>
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</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
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<tr>
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<td>Consultation</td>
<td>82.30</td>
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<tr>
<td>W536</td>
<td>Repeat consultation</td>
<td>45.85</td>
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<tr>
<td>W231</td>
<td>Neuro-Ophthalmology Consultation – subject to the same conditions as A231</td>
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</table>
### CONSULTATIONS AND VISITS

#### ORTHOPAEDIC SURGERY (06)

#### GENERAL LISTINGS

<table>
<thead>
<tr>
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<th>Description</th>
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</tr>
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<tbody>
<tr>
<td>A065</td>
<td>Consultation</td>
<td>83.10</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A066</td>
<td>Repeat consultation</td>
<td>51.70</td>
</tr>
<tr>
<td>A063</td>
<td>Specific assessment</td>
<td>42.55</td>
</tr>
<tr>
<td>A064</td>
<td>Partial assessment</td>
<td>24.05</td>
</tr>
</tbody>
</table>

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>C065</td>
<td>Consultation</td>
<td>83.10</td>
</tr>
<tr>
<td>C935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
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<tr>
<td>C066</td>
<td>Repeat consultation</td>
<td>51.70</td>
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<tr>
<td>C063</td>
<td>Specific assessment</td>
<td>42.55</td>
</tr>
<tr>
<td>C064</td>
<td>Specific re-assessment</td>
<td>25.50</td>
</tr>
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**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>C062</td>
<td>first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C067</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C069</td>
<td>after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
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</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
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</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness</td>
<td>31.00</td>
</tr>
<tr>
<td>C068</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
### CONSULTATIONS AND VISITS

**ORTHOPAEDIC SURGERY (06)**

**NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES**

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>W065</td>
<td>Consultation</td>
<td>83.10</td>
</tr>
<tr>
<td>W066</td>
<td>Repeat consultation</td>
<td>51.70</td>
</tr>
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</table>

**Subsequent visits (see General Preamble GP33)**

**Chronic care or convalescent hospital**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>W062</td>
<td>- first 4 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W061</td>
<td>- additional subsequent visits (maximum of 6 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W982</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
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**Nursing home or home for the aged**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>W063</td>
<td>- first 2 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W068</td>
<td>- subsequent visits per month (maximum of 3 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W972</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
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</table>

W121  Additional visits due to intercurrent illness (see General Preamble GP33) | 31.00 |
CONSULTATIONS AND VISITS

OTOLARYNGOLOGY (24)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C242  - first five weeks ................................................................................................. 31.00
C247  - sixth to thirteenth week inclusive (maximum 3 per patient per week) .......... 31.00
C249  - after thirteenth week (maximum 6 per patient per month) ......................... 31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W345  Consultation............................................................................................................. 77.90
W346  Repeat consultation ............................................................................................ 48.85
CONSULTATIONS AND VISITS

PAEDIATRICS (26)

GENERAL LISTINGS

Services rendered by a physician with a specialty designation in Paediatrics (26) (i.e. “paediatrician”) are eligible for payment for an adult patient where:

1. the paediatrician has rendered at least one consultation, assessment or visit from the general listings for Paediatrics in the Consultation and Visits section of this Schedule for the same patient in the 12 month period prior to the patient's eighteenth birthday; and ongoing management of the patient with a chronic condition by the paediatrician is necessary; and the patient is less than 22 years of age; or

2. the paediatrician has obtained written prior approval from the MOHLTC by demonstrating that the continuation of treatment is generally accepted and necessary for the patient under the circumstances.

A265 Consultation ............................................................................................................... 167.00

Special paediatric consultation

Special paediatric consultation is a consultation in which the physician provides all the elements of a consultation (A265) and spends a minimum of 75 minutes of direct contact with the patient.

A260 Special paediatric consultation .................................................................................. 300.70

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Extended special paediatric consultation

Extended special paediatric consultation is a consultation in which the physician provides all the elements of a consultation (A265) and spends a minimum of 90 minutes of direct contact with the patient.

A662 Extended special paediatric consultation ................................................................. 395.65

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Neurodevelopmental consultation

Neurodevelopmental consultation is a consultation in which the physician provides all the elements of a consultation (A265) for an infant, child or adolescent with complex neurodevelopmental conditions (e.g. autism, global development disorders etc.) and spends a minimum of 90 minutes of direct contact with the patient and caregiver.

A667 Neurodevelopmental consultation ............................................................................. 395.65

Payment rules:
This service is limited to a maximum of one per patient, per physician, per 12 month period.

Medical record requirements:
The start and stop time must be recorded in the patient's permanent medical record or the payment for this service will be reduced to a lesser fee.

[Commentary:
Neurodevelopmental consultations for less complex conditions, e.g. attention deficit disorder, are payable at a lesser fee.]
Prenatal consultation
A prenatal consultation is the service rendered by a paediatrician upon request of a physician who considers a fetus of greater than 20 weeks gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or fetal distress.

[Commentary:
A prenatal consultation by a paediatrician does not preclude the paediatrician from claiming a post-natal consultation on the infant.]

A665 Prenatal consultation ................................................................................................. 91.35
A565 Limited consultation ................................................................................................. 91.35
A266 Repeat consultation .................................................................................................. 91.35
A263 Medical specific assessment ...................................................................................... 77.70
A264 Medical specific re-assessment .................................................................................. 59.45
A661 Complex medical specific re-assessment ................................................................... 68.80
A268 Enhanced 18 month well baby visit (see General Preamble GP22) ....................... 62.40
A261 Level 1 - Paediatric assessment ............................................................................... 21.50
A262 Level 2 - Paediatric assessment ............................................................................... 42.15
E078 - chronic disease assessment premium (see General Preamble GP16) ....................add 50%
K045 Diabetes management by a specialist ..................................................................... 75.00

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

Periodic health visit
K267 - 2 - 11 years of age .................................................................................................. 41.60
K269 - 12 - 17 years of age ............................................................................................... 77.20

Note:
1. For definitions and payment rules - see General Preamble GP14.
2. Diagnostic interview and/or counselling with child and/or parent - see listings in Family Practice & Practice in General.

Paediatric Developmental Assessment Incentive (PDAI)
PDAI is the service rendered by a paediatrician most responsible for providing ongoing management of a paediatric patient at developmental risk. The service is for ongoing management using a developmental surveillance approach and documenting the indicators of the child’s development three times in a 12 month period.

K119 Paediatric developmental assessment incentive ..................................................... 100.00

Payment rules:
1. K119 is limited to a maximum of one service per patient per 12 month period.
2. K119 is limited to a maximum of six services per patient per lifetime.
3. K119 is only eligible for payment for a service rendered to a person under six years of age.
4. K119 is only eligible for payment if the physician has rendered a minimum of three consultations or assessments or visits to the patient in the immediately preceding 12 month period.
5. K119 is only eligible for payment to a specialist in Paediatrics (26).

Medical record requirements:
K119 is only eligible for payment if a standardized developmental screening tool has been completed three times for the previous 12 month period and is maintained in the patient’s permanent medical record.

Claims submission instructions:
Claims for K119 should only be submitted when the required elements of the service have been completed for the previous 12 month period.
**Developmental and/or behavioural care**

Developmental and/or behavioural care are services encompassing any combination or form of assessment and treatment by a paediatrician for mental illness, behavioural maladaptations, developmental disorders, and/or other problems that are assumed to be of a developmental or emotional nature where there is consideration of the patient's biological and psychosocial functioning. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>K122</td>
<td>individual developmental and/or behavioural care</td>
<td>80.30</td>
</tr>
<tr>
<td>K123</td>
<td>family developmental and/or behavioural care</td>
<td>91.10</td>
</tr>
</tbody>
</table>

**Payment rules:**

These services are only payable to paediatricians who satisfy one of the following criteria:

- **a.** 35% or more of the dollar value of the annual fee-for-service claims in any 12 month period consist of K122 and/or K123;
- **b.** 35% or more of the dollar value of the annual fee-for-service claims in any 12 month period consist of any combination of K005, K007, K019, K020, K012, K024, K025, K010, K004, K006, or K008; or
- **c.** additional residency or fellowship training in paediatrics or psychiatry. Residency or fellowship training includes either completion of training in paediatric or adolescent developmental and/or behavioural medicine within a recognized paediatric residency training programme of at least one-year duration following completion of the first three years of residency, or a post residency fellowship or other equivalent programme in paediatrics, adolescent medicine or psychiatry. Documentation of additional residency or fellowship training must be provided if requested by the ministry.

**Commentary:**

Paediatricians who do not meet the criteria listed above but believe they have appropriate training and/or experience to permit them to provide paediatric or adolescent developmental and/or behavioural care may contact the ministry to determine whether their training and/or experience constitute an equivalent residency, training or programme.

Services rendered by physicians who do not meet these requirements are still insured but eligible for payment under another fee schedule code e.g. primary mental health care (K005), counselling (K013/K033) or group counselling (K040/K041).
CONSULTATIONS AND VISITS

PAEDIATRICS (26)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)
Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

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

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

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

Subsequent visits by the Most Responsible Physician (MRP)
See General Preamble GP29 to GP30 for terms and conditions.
C122 - day following the hospital admission assessment ............................................. 58.80
C123 - second day following the hospital assessment ................................................. 58.80
C124 - day of discharge .............................................................................................. 58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area
See General Preamble GP31 for terms and conditions.
C142 - first subsequent visit by the MRP following transfer from an Intensive Care Area 58.80
C143 - second subsequent visit by the MRP following transfer from an Intensive Care Area .............................................................................................................. 58.80
C121 Additional visits due to intercurrent illness (see General Preamble GP28) .per visit 31.00
C268 Concurrent care .................................................................................................per visit 31.00
C982 Palliative care (see General Preamble GP34) .....................................................per visit 31.00
Attendance at maternal delivery

Attendance at maternal delivery requires constant attendance at the delivery of a baby expected to be at risk by a paediatrician, and includes an assessment of the newborn.

H267 Attendance at maternal delivery ................................................................. 63.45

Payment rules:
This service is not eligible for payment if any other service is rendered by the same physician at the time of the delivery unless the newborn is sick in which case a medical specific assessment (C263) is payable in addition to attendance at maternal delivery if rendered.

H261 Newborn care in hospital or home.............................................................. 57.90

Low birth weight newborn uncomplicated care

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

Admission assessment

W562 - Type 1 ....................................................................................... 69.35
W564 - Type 2 ....................................................................................... 20.60
W567 - Type 3 ....................................................................................... 30.70
W269 Periodic health visit ........................................................................ 30.70

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Note:
In surgical cases requiring medical direction, standard in-hospital medical fees are to be claimed in addition to the surgical fee. This includes all operations on babies under one year of age, and all other older children who require medical supervision.
CONSULTATIONS AND VISITS

PHYSICAL MEDICINE & REHABILITATION (31)

GENERAL LISTINGS

A315 Consultation................................................................. 172.85

**Comprehensive physical medicine and rehabilitation consultation**

A comprehensive physical medicine and rehabilitation consultation is a consultation in which the physician provides all the elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient.

A425 Comprehensive physical medicine and rehabilitation consultation.......................... 300.70

**Payment rules:**

A comprehensive physical medicine and rehabilitation consultation is limited to one every 2 years by the same physician.

**Medical record requirements:**

The start and stop time must be recorded in the patient's permanent medical record or the payment for the service will be reduced to a lesser fee.

A515 Limited consultation .............................................................. 91.35
A316 Repeat consultation ............................................................. 91.35
A313 Medical specific assessment .................................................. 74.00
A310 Medical specific re-assessment ............................................. 65.00
A311 Complex medical specific re-assessment ................................ 70.90
A318 Partial assessment .............................................................. 38.05

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

A complex neuromuscular assessment is an assessment for the ongoing management of the following diseases of the neuromuscular system where the complexity of the condition requires the continuing management by a physical medicine and rehabilitation specialist:

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

Payment rules:
1. A complex neuromuscular assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee.
2. This service is not eligible for payment to a physician for the initial evaluation of the patient by that physician.
3. Complex neuromuscular assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.
4. E078 is not eligible for payment with A510.

[Commentary:
1. A complex neuromuscular assessment is for the ongoing management of complex neuromuscular disorders, where the complexity of the condition requires the continuing management by a physical medicine and rehabilitation specialist. It is not intended for the evaluation and/or management of uncomplicated neuromuscular disorders (e.g. carpal tunnel syndrome, Bell’s palsy, asymptomatic diabetic neuropathy).
2. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex neuromuscular assessment is for the ongoing management of a patient with a complex neuromuscular disorder.]

Complex physiatry assessment

This service is an assessment in relation to the following diseases where the complexity of the condition requires the ongoing management by a physical medicine and rehabilitation specialist:

a. traumatic brain injury;
b. stroke (hemorrhagic and ischemic); or
c. spinal cord injury.

Payment rules:
1. A complex physiatry assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.
2. Complex physiatry assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.
3. E078 is not eligible for payment with A511.

[Commentary:
A complex physiatry assessment is not intended for the evaluation and/or management of uncomplicated physiatric disorders (e.g. transient ischemic attacks, uncomplicated concussion, uncomplicated spinal cord injury e.g. American Spinal Injury Association level E-normal motor and sensory function.]
## CONSULTATIONS AND VISITS

### PHYSICAL MEDICINE & REHABILITATION (31)

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
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<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>C315</td>
<td>Consultation</td>
<td>182.85</td>
</tr>
<tr>
<td>C425</td>
<td>Comprehensive physical medicine and rehabilitation consultation – subject to the same conditions as A425</td>
<td>300.70</td>
</tr>
<tr>
<td>C515</td>
<td>Limited consultation</td>
<td>91.35</td>
</tr>
<tr>
<td>C316</td>
<td>Repeat consultation</td>
<td>91.35</td>
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<tr>
<td>C313</td>
<td>Medical specific assessment</td>
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<td>C314</td>
<td>Medical specific re-assessment</td>
<td>65.00</td>
</tr>
<tr>
<td>C511</td>
<td>Complex physiatry assessment - subject to the same conditions as A511</td>
<td>89.85</td>
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### Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
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<th>Fee</th>
</tr>
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<tbody>
<tr>
<td>C312</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C317</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C319</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C318</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
## CONSULTATIONS AND VISITS

### PHYSICAL MEDICINE & REHABILITATION (31)

### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W515</td>
<td>Consultation</td>
<td>182.85</td>
</tr>
<tr>
<td>W425</td>
<td>Comprehensive physical medicine and rehabilitation consultation - subject to the same conditions as A425</td>
<td>300.70</td>
</tr>
<tr>
<td>W310</td>
<td>Limited consultation</td>
<td>91.35</td>
</tr>
<tr>
<td>W516</td>
<td>Repeat consultation</td>
<td>91.35</td>
</tr>
<tr>
<td>W510</td>
<td>Complex neuromuscular assessment - subject to the same conditions as A510</td>
<td>89.85</td>
</tr>
<tr>
<td>W511</td>
<td>Complex physiatry assessment - subject to the same conditions as A511</td>
<td>89.85</td>
</tr>
</tbody>
</table>

#### Admission assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W512</td>
<td>- Type 1</td>
<td>69.35</td>
</tr>
<tr>
<td>W514</td>
<td>- Type 2</td>
<td>20.60</td>
</tr>
<tr>
<td>W517</td>
<td>- Type 3</td>
<td>30.70</td>
</tr>
<tr>
<td>W419</td>
<td>Periodic health visit</td>
<td>65.05</td>
</tr>
<tr>
<td>W314</td>
<td>General re-assessment of patient in nursing home*</td>
<td>20.60</td>
</tr>
</tbody>
</table>

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

#### Subsequent visits (see General Preamble GP33)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W312</td>
<td>- first 4 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W311</td>
<td>- additional subsequent visits (maximum of 6 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W982</td>
<td>palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
</tbody>
</table>

#### Nursing home or home for the aged

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W313</td>
<td>- first 2 subsequent visits per patient per month</td>
<td>32.20</td>
</tr>
<tr>
<td>W318</td>
<td>- subsequent visits per month (maximum of 3 per patient per month)</td>
<td>21.20</td>
</tr>
<tr>
<td>W972</td>
<td>- palliative care (see General Preamble GP34)</td>
<td>32.20</td>
</tr>
<tr>
<td>W121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP33)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
**Team management in a Rehabilitation Unit**

Team management in a Rehabilitation Unit active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to fee codes H312, H317 and H319 means when this service is rendered by one physiatrist even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit, the weekly and monthly limitations under the following fee codes apply to the total rehabilitation care rendered. In other words, it is not possible to claim the maximum fees allowed under C312, C317 and C319 and then start claiming de novo under H312, H317 and H319 under the above circumstances.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H312</td>
<td>first twelve weeks</td>
<td>39.00</td>
</tr>
<tr>
<td>H317</td>
<td>from thirteenth to twenty-sixth week (maximum 3 per patient per week)</td>
<td>39.00</td>
</tr>
<tr>
<td>H319</td>
<td>twenty-seventh week onwards (maximum 6 per patient per month)</td>
<td>39.00</td>
</tr>
</tbody>
</table>

**Rehabilitation counselling**

Rehabilitation counselling one or more persons. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H313</td>
<td>Rehabilitation counselling</td>
<td>76.95</td>
</tr>
</tbody>
</table>

**Physiatric management**

Physiatric management is the service rendered by physiatrists for regulation, management and supervision of the active, regular, and ongoing treatment of a patient in a rehabilitation department by physical or other (e.g. occupational, speech) therapists. The service also includes making arrangements for any related assessments, procedures or therapy and making arrangements for follow-up care as required.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>K313</td>
<td>Physiatric management</td>
<td>8.10</td>
</tr>
</tbody>
</table>

**Payment rules:**

1. Physiatric management is *not eligible for payment* if any other service is rendered by the same physician on the same day to the same patient.

2. This service is *only eligible for payment* on days when rehabilitation services are provided to patients seen previously by the physiatrist for consultation or assessment.

**[Commentary:**

1. The fee is not meant as an administrative fee for supervising a department of rehabilitation.

2. This fee applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services or physical therapy, occupational therapy, speech therapy and discharge planning.]
## CONSULTATIONS AND VISITS

### PLASTIC SURGERY (08)

#### GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A085</td>
<td>Consultation</td>
<td>81.10</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A086</td>
<td>Repeat consultation</td>
<td>47.95</td>
</tr>
<tr>
<td>A083</td>
<td>Specific assessment</td>
<td>41.55</td>
</tr>
<tr>
<td>A084</td>
<td>Partial assessment</td>
<td>26.55</td>
</tr>
</tbody>
</table>

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>C085</td>
<td>Consultation</td>
<td>81.10</td>
</tr>
<tr>
<td>C935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
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<tr>
<td>C086</td>
<td>Repeat consultation</td>
<td>47.95</td>
</tr>
<tr>
<td>C083</td>
<td>Specific assessment</td>
<td>41.55</td>
</tr>
<tr>
<td>C084</td>
<td>Specific re-assessment</td>
<td>27.80</td>
</tr>
</tbody>
</table>

**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C082</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C087</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C089</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C088</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

#### NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>W085</td>
<td>Consultation</td>
<td>81.10</td>
</tr>
<tr>
<td>W086</td>
<td>Repeat consultation</td>
<td>47.95</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

GENERAL LISTINGS

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

Claims submission instructions:
Submit claim using A895 and the appropriate special visit premium beginning with “C” prefix for a hospital in-patient, “W” prefix for a long-term care in-patient or “K” prefix for an emergency department patient.

Special psychiatric consultation
Special psychiatric consultation is a consultation in which the physician provides all the elements of a consultation (A195) and spends a minimum of 75 minutes of direct contact with the patient.

A190 Special psychiatric consultation ............................................................................... 300.70

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient’s permanent medical record.

Geriatric psychiatric consultation
Geriatric psychiatric consultation is payable to a psychiatrist for a patient aged 75 years or older and must include all the elements of A195 and a minimum of 75 minutes of direct contact with the patient exclusive of discussion with caregivers or any separately payable services. The consultation must be scheduled a minimum of 24 hours prior to the visit. The start and stop time must be recorded in the patient’s permanent medical record. Maximum one per patient per physician every 5 years. Geriatric psychiatric consultations that do not conform with the above or are delegated in a clinic teaching unit to an intern, resident or fellow are payable as a lesser consultation or visit.

A795 Geriatric psychiatric consultation ........................................................................... 300.70

Neurodevelopmental consultation
Neurodevelopmental consultation is payable when the physician provides all the elements of A195 for an adult with complex neurodevelopmental conditions e.g. autism, global developmental disorders etc., and must include a minimum of 90 minutes of direct contact with the patient and caregiver. The start and stop times must be recorded in the patient’s permanent medical record. Maximum one per patient per physician every 5 years.

A695 Neurodevelopmental consultation ........................................................................... 395.65

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

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

Consultative interview on behalf of disturbed patient (including report)

A197 - consultative interview with parent(s) or patient representative(s) of patient less than age 22 .............................................................................................................. 212.65
A198 - consultative interview with patient less than age 22 ........................................ 212.65
A191 - consultative interview with caregiver(s) of a patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia ............................................. 212.65
A192 - consultative interview with patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia ............................................................. 212.65

Note:
1. A191, A192, A197 and A198 are consultations.
2. A191, A192, A197, A198 are not eligible for payment for the same patient, same day as family psychiatric care or family psychotherapy (K191, K193, K195, K196).

[Commentary:
For psychiatric consultation extension with parents or caregivers, see K630.]
**Psychiatric consultation extension**

This service is eligible for payment for an extension to the consultations listed in the table below when the physician is required to spend an additional period of consecutive or non-consecutive time on the same day with the patient and/or patient's relative(s), patient’s representative or other caregivers.

**Note:**
The time unit measured excludes time spent on separately billable interventions.

<table>
<thead>
<tr>
<th>Consultation</th>
<th>Minimum time with the patient before the start time for the first unit of K630</th>
<th>Minimum time required for consultation service + 1 unit of K630 to be payable</th>
<th>[Commentary: Minimum time required for consultation service + 2 units of K630 to be payable]</th>
</tr>
</thead>
<tbody>
<tr>
<td>A190, C190, W190</td>
<td>90 minutes</td>
<td>106 minutes</td>
<td>136 minutes</td>
</tr>
<tr>
<td>A195</td>
<td>60 min</td>
<td>76 min</td>
<td>106 min</td>
</tr>
<tr>
<td>A197 – sole service</td>
<td>60 min</td>
<td>76 min</td>
<td>106 min</td>
</tr>
<tr>
<td>A198 – sole service</td>
<td>60 min</td>
<td>76 min</td>
<td>106 min</td>
</tr>
<tr>
<td>A197 + A198 same patient same day</td>
<td>120 min</td>
<td>136 min</td>
<td>166 min</td>
</tr>
<tr>
<td>A695, C695, W695</td>
<td>120 min</td>
<td>136 min</td>
<td>166 min</td>
</tr>
<tr>
<td>A795, C795, W795</td>
<td>90 min</td>
<td>106 min</td>
<td>136 min</td>
</tr>
<tr>
<td>A895, C895, W895</td>
<td>60 min</td>
<td>76 min</td>
<td>106 min</td>
</tr>
<tr>
<td>A191</td>
<td>60 min</td>
<td>76 min</td>
<td>106 min</td>
</tr>
<tr>
<td>A192</td>
<td>60 min</td>
<td>76 min</td>
<td>106 min</td>
</tr>
<tr>
<td>A191+ A192 same patient same day</td>
<td>120 min</td>
<td>136 min</td>
<td>166 min</td>
</tr>
</tbody>
</table>
CONSULTATIONS AND VISITS

**PSYCHIATRY (19)**

**EMERGENCY OR OUT-PATIENT DEPARTMENT (ODP)**
Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C895</td>
<td>Consultation</td>
<td>232.70</td>
</tr>
<tr>
<td>C190</td>
<td>Special psychiatric consultation - subject to the same conditions as A190</td>
<td>300.70</td>
</tr>
<tr>
<td>C395</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C196</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C795</td>
<td>Geriatric psychiatric consultation - subject to same conditions as A795</td>
<td>300.70</td>
</tr>
<tr>
<td>C695</td>
<td>Neurodevelopmental consultation - subject to same conditions as A695</td>
<td>395.65</td>
</tr>
<tr>
<td>C193</td>
<td>Specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C194</td>
<td>Specific re-assessment</td>
<td>61.25</td>
</tr>
</tbody>
</table>

Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C192</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C197</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C199</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

Subsequent visits by the Most Responsible Physician (MRP)
See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

Subsequent visits by the MRP following transfer from an Intensive Care Area
See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
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<td>C121</td>
<td>Additional visits due to intercurrent illness</td>
<td>31.00</td>
</tr>
<tr>
<td>C198</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
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</tbody>
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</thead>
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<tr>
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<td>232.70</td>
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<td>Geriatric psychiatric consultation - subject to same conditions as A795</td>
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</tr>
<tr>
<td>W695</td>
<td>Neurodevelopmental consultation - subject to same conditions as A695</td>
<td>395.65</td>
</tr>
<tr>
<td>W395</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>W196</td>
<td>Repeat consultation</td>
<td>105.25</td>
</tr>
</tbody>
</table>
PSYCHIATRIC CLINICAL PRACTICE MODIFIERS/PREMIUMS

Acute post-discharge community psychiatric care

Acute post-discharge community psychiatric care is a premium for a service that occurs during the (4) week period immediately following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition. The premium is only applicable to K195, K196, K197 or K198.

K187 Acute post-discharge community psychiatric care, to K195, K196, K197 or K198.................................................................add 15%

High risk community psychiatric care

High risk community psychiatric care is a premium for a service that occurs during the six (6) month period following a suicide attempt. For the purposes of this premium, suicide attempts include self-harm attempts with intent to commit suicide or high lethality self-harm attempts, but do not include self harm attempts of low lethality with no intent to commit suicide. The premium is applicable to A190, A191, A192, A195, A197, A198, A695, A795, K195, K196, K197 and K198.

K188 High risk community psychiatric care, to A190, A191, A192, A195, A197, A198, A695, A795, K195, K196, K197 or K198 .............................................add 15%

Payment rules:
1. K187 or K188 are both payable with K195, K196, K197 or K198 when rendered during the first four (4) week period following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition and the requirements for both K187 and K188 are met.
2. K188 is not eligible for payment in addition to K189 on the same patient same day.

K189 Urgent community psychiatric follow-up, to A190, A195, A695 or A795 ...........add 200.00

Payment rules:
1. K189 is only eligible for payment when the psychiatrist providing the urgent community psychiatric follow-up:
   a. renders a service described by A190, A195, A695 or A795 to an out-patient on an urgent basis during the four (4) week period immediately following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition;
   b. did not provide services to the same patient during the same psychiatric hospital admission; and
   c. will continue appropriate care of the out-patient for a minimum of six (6) months as required.
2. K189 is limited to a maximum of one per physician per patient per 12 month period.
Assessments under the Mental Health Act
See General Preamble GP22 for definitions and conditions.

Consultation for involuntary psychiatric treatment
Consultation for involuntary psychiatric treatment in accordance with the Mental Health Act. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

K620 Consultation for involuntary psychiatric treatment ........................................ per unit 85.00

Form 1
Application for psychiatric assessment, in accordance with the Mental Health Act includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K623 Application for psychiatric assessment................................................................. 104.80

Form 3
Certification of involuntary admission in accordance with the Mental Health Act includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K624 Certification of involuntary admission ................................................................. 129.05
K629 All other re-certification(s) of involuntary admission including completion of appropriate forms................................................................. 38.25

Note:
1. A completed Form 1 Application by a Physician For Psychiatric Assessment retained on the patient's medical record is sufficient documentation to indicate that a consultation for involuntary psychiatric treatment has been requested by the referring physician.
2. Consultations or assessments claimed in addition to certification or re-certification same day are payable at nil.
3. Interviews with relatives on behalf of a patient, Children's Aid Society (CAS) staff or legal guardian, etc. - see listings in Family Practice & Practice In General.
4. Certification of incompetence (financial) including assessment to determine incompetence is not an insured benefit.
CONSULTATIONS AND VISITS

PSYCHIATRY (19)

PSYCHOTHERAPY, FAMILY PSYCHOTHERAPY, HYPNOTHERAPY AND PSYCHIATRIC CARE

Note:
1. For conditions and definitions - see General Preamble GP37 to GP41.
2. For electroconvulsive therapy fees, see Diagnostic and Therapeutic Procedures.
3. When claiming group therapy only services rendered to one group are payable at the same time
4. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>K198 - Out-patient PSYCHOTHERAPY</td>
<td>80.30</td>
</tr>
<tr>
<td>K199 - In-patient PSYCHOTHERAPY</td>
<td>92.60</td>
</tr>
<tr>
<td>K196 - Out-patient FAMILY PSYCHOTHERAPY</td>
<td>91.10</td>
</tr>
<tr>
<td>K191 - In-patient FAMILY PSYCHOTHERAPY</td>
<td>105.10</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>K197 - Individual out-patient PSYCHOTHERAPY</td>
<td>80.30</td>
</tr>
<tr>
<td>K190 - Individual in-patient PSYCHOTHERAPY</td>
<td>84.15</td>
</tr>
<tr>
<td>K195 - Family psychotherapy - out-patients (two or more members)</td>
<td>91.10</td>
</tr>
<tr>
<td>K193 - Family psychotherapy - in-patients (two or more members)</td>
<td>95.45</td>
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<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate per Unit</th>
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</thead>
<tbody>
<tr>
<td>K208 - 2 people group psychotherapy, out-patients</td>
<td>40.15</td>
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<tr>
<td>K209 - 3 people group psychotherapy, out-patients</td>
<td>26.75</td>
</tr>
<tr>
<td>K203 - 4 people group psychotherapy, out-patients</td>
<td>20.10</td>
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<tr>
<td>K204 - 5 people group psychotherapy, out-patients</td>
<td>16.05</td>
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<tr>
<td>K205 - 6 to 12 people group psychotherapy, out-patients</td>
<td>14.45</td>
</tr>
<tr>
<td>K206 - additional units - per member (maximum 6 per patient per day)</td>
<td>12.85</td>
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</table>

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>K210 - 2 people group psychotherapy, in-patients</td>
<td>42.10</td>
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<tr>
<td>K211 - 3 people group psychotherapy, in-patients</td>
<td>28.05</td>
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<td>K200 - 4 people group psychotherapy, in-patients</td>
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<td>K201 - 5 people group psychotherapy, in-patients</td>
<td>16.80</td>
</tr>
<tr>
<td>K202 - 6 to 12 people group psychotherapy, in-patients</td>
<td>15.15</td>
</tr>
<tr>
<td>K207 - additional units - per member (maximum 6 per patient per day)</td>
<td>12.85</td>
</tr>
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<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>K192 - Individual HYPNOTHERAPY</td>
<td>80.30</td>
</tr>
<tr>
<td>K194 - Group - for induction and training for hypnosis</td>
<td>14.60</td>
</tr>
</tbody>
</table>

April 1, 2015
CONSULTATIONS AND VISITS

GENERAL LISTINGS

Consultation
A diagnostic radiology consultation is the service rendered when:

a. when radiographs or ultrasounds made at one institution or facility are referred to a radiologist at a different institution or facility for his/her written opinion. In this case, the specific elements are as for nuclear medicine professional component P2 (see page B1).

b. a radiologist is required to make a special visit at evening or night (17:00h to 07:00h) or on a Saturday, Sunday or holiday to consult on the advisability of performing a diagnostic radiological procedure which eventually is not done. In this case, the specific elements are the same as for consultations; or

c. when a radiologist is required to render an opinion prior to an interventional procedure and all of the following requirements are met. In this case, the specific elements are the same as for consultations:
   i. the consultation is performed in an area remote from the radiologist's normal procedural suite;
   ii. the requirements for a consultation are met;
   iii. the consultation is not solely for the purpose of clarifying or obtaining consent; and
   iv. the associated procedure is one of the following: J021, J025, J040, J041, J046, J048, J049, J050, J055, J056, J057, J058, J059, J063, J065, J066, N107, N118, N122, N125, S233, Z446, Z456, Z562, Z594.

A335 Consultation ............................................................................................................. 50.00

Payment rules:
1. A diagnostic radiology consultation is not eligible for payment when radiographs made in a different institution or facility are used for comparison purposes with radiographs or ultrasounds made in the consultant's institution or facility.

2. A335 is not eligible for payment for CT and MRI services.

[Commentary:
For a second opinion by a radiologist of CT and MRI studies, see A330 and A332 respectively.]

Special interventional radiological consultation
A special interventional radiological consultation is the service described under part (c) of a regular consultation (A335) in circumstances in which because of the very complex, obscure or serious nature of the problem, the physician is required to spend a minimum of 50 minutes with the patient in consultation.

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

A365 Special interventional radiological consultation ....................................................... 223.20
CONSULTATIONS AND VISITS

DIAGNOSTIC RADIOLOGY (33)

Radiology second opinion of CT or MRI Study

A radiology second opinion of CT or MRI study is the service rendered when CT or MRI images made and interpreted by a radiologist at one institution or facility are referred to a radiologist ("consultant radiologist") at a different institution or facility for his/her written interpretation. For the purposes of these services, “study” means all images related to one anatomical region, as these regions are listed in the payment rules below.

A330 Radiology second opinion of CT study, per study .................................................... 89.50
A332 Radiology second opinion of MRI study, per study .................................................. 199.70

Payment rules:
1. A330 and A332 are not eligible for payment when CT or MRI images made in a different institution or facility are used for comparison purposes with CT or MRI images made in the consultant radiologist's institution or facility.
2. A330 and A332 are limited to a maximum of one each per study per patient per 30 day period.
3. For CT studies, the anatomical regions are head, neck, thorax, abdomen, pelvis, extremities (one or more) and spine (one or more segments).
4. For MRI studies, the anatomical regions are head, neck, thorax, abdomen, breast(s), pelvis, extremities (one or more) and spine (one or more segments).
5. E406, E407 or E408 after hours premiums for diagnostic CT/MRI services are not eligible for payment with A330 or A332.

Medical record requirements:
A330 and A332 are only eligible for payment if both the written request from the referring physician and the consultant radiologist's second opinion report are included in the patient's permanent medical record.

Minor assessment

A minor assessment (A331) is the service rendered when a radiologist evaluates a patient on a non-emergent basis resulting in the cancellation or deferral of a planned diagnostic radiology procedure due to procedural difficulties, including lack of patient cooperation, if no other diagnostic radiology procedure is rendered.

A331 Minor assessment ........................................................................................................... 17.75

Minor assessment

A minor assessment (A338) is the service rendered when a radiologist evaluates a patient on a non-emergent basis on the advisability of performing a diagnostic radiological procedure which eventually is not done.

A338 Minor assessment ........................................................................................................... 17.75

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

#### RADIATION ONCOLOGY (34)

**GENERAL LISTINGS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A345</td>
<td>Consultation</td>
<td>152.40</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>A745</td>
<td>Limited consultation</td>
<td>99.30</td>
</tr>
<tr>
<td>A346</td>
<td>Repeat consultation</td>
<td>99.30</td>
</tr>
<tr>
<td>A343</td>
<td>Medical specific assessment</td>
<td>77.55</td>
</tr>
<tr>
<td>A340</td>
<td>Medical specific re-assessment</td>
<td>59.55</td>
</tr>
<tr>
<td>A341</td>
<td>Complex medical specific re-assessment</td>
<td>68.90</td>
</tr>
<tr>
<td>A348</td>
<td>Partial assessment</td>
<td>37.05</td>
</tr>
<tr>
<td>E078</td>
<td>- chronic disease assessment premium (see General Preamble GP16)</td>
<td></td>
</tr>
</tbody>
</table>

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>C345</td>
<td>Consultation</td>
<td>152.40</td>
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<tr>
<td>C765</td>
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</tr>
<tr>
<td>C745</td>
<td>Limited consultation</td>
<td>99.30</td>
</tr>
<tr>
<td>C346</td>
<td>Repeat consultation</td>
<td>99.30</td>
</tr>
<tr>
<td>C343</td>
<td>Medical specific assessment</td>
<td>77.55</td>
</tr>
<tr>
<td>C344</td>
<td>Medical specific re-assessment</td>
<td>59.55</td>
</tr>
<tr>
<td>C341</td>
<td>Complex medical specific re-assessment</td>
<td>68.90</td>
</tr>
</tbody>
</table>

**Subsequent visits**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C342</td>
<td>- first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C347</td>
<td>- sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C349</td>
<td>- after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>- day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>- second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>- day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C142</td>
<td>- first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>- second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C348</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>
For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

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

Comprehensive respiratory disease consultation

This service is a consultation rendered by a specialist in respiratory disease who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A470 Comprehensive respiratory disease consultation .................................................... 300.70

Medical record requirements:
The start and stop times must be recorded in the patient’s permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:
1. A470 must satisfy all the elements of a consultation (see page GP12).
2. The calculation of the 75 minute minimum time for comprehensive respiratory diseases consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A575 Limited consultation ................................................................................................. 105.25
A476 Repeat consultation ................................................................................................. 105.25
A473 Medical specific assessment .................................................................................... 79.85
A474 Medical specific re-assessment .............................................................................. 61.25
A471 Complex medical specific re-assessment ............................................................... 70.90
A478 Partial assessment .................................................................................................. 38.05
E078 - chronic disease assessment premium (see General Preamble 
GP16) ...............................................................................................add 50%

Complex respiratory assessment

This service is an assessment for the ongoing management of the following conditions of the respiratory system where the complexity of the condition requires the continuing management by a respirology specialist (47):

a. chronic respiratory failure (i.e. a symptomatic patient with a PaO2 <60mmHg and/or a PaCO2 >50mmHg);
b. bronchiectasis with frequent infections;
c. cystic fibrosis;
d. active pulmonary or extrapulmonary disease due to mycobacterial tuberculosis complex (latent tuberculosis infection is excluded); or
e. active pulmonary or extrapulmonary non-tuberculous mycobacterial disease (airway or tissue colonization without disease is excluded).

A570 Complex respiratory assessment ............................................................................ 89.85

Payment rules:
1. A570 must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.
2. A570 is limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.
3. E078 is not eligible for payment same patient same day as A570.

[Commentary:
A570 is not intended for the evaluation and/or management of uncomplicated respiratory disorders. For example, the applicable assessment service from the general listings should be claimed for assessment of patients for routine follow-up of uncomplicated chronic obstructive pulmonary disease (e.g. emphysema, chronic bronchitis).]
### RESPIRATORY DISEASE (47)

#### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

#### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C475</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>C765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
<tr>
<td>C470</td>
<td>Comprehensive respiratory disease consultation - subject to the same conditions as A470</td>
<td>300.70</td>
</tr>
<tr>
<td>C575</td>
<td>Limited consultation</td>
<td>105.25</td>
</tr>
<tr>
<td>C476</td>
<td>Repeat consultation</td>
<td>105.25</td>
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<tr>
<td>C473</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>C474</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
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<tr>
<td>C471</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>C570</td>
<td>Complex respiratory assessment – subject to the same conditions as A570</td>
<td>89.85</td>
</tr>
</tbody>
</table>

#### Subsequent visits

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

#### Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

- first subsequent visit by the MRP following transfer from an Intensive Care Area 58.80
- second subsequent visit by the MRP following transfer from an Intensive Care Area 58.80

- Additional visits due to intercurrent illness (see General Preamble GP28) per visit 31.00
- Concurrent care............................................................................................. 31.00
- Palliative care (see General Preamble GP34).............................................. 31.00
CONSULTATIONS AND VISITS

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>A485</td>
<td>Consultation</td>
<td>157.00</td>
</tr>
<tr>
<td>A765</td>
<td>Consultation, patient 16 years of age and under</td>
<td>165.50</td>
</tr>
</tbody>
</table>

**Comprehensive rheumatology consultation**

This service is a consultation rendered by a *specialist* in rheumatology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A590</td>
<td>Comprehensive rheumatology consultation</td>
<td>300.70</td>
</tr>
</tbody>
</table>

**Medical record requirements:**

For A590, the start and stop times must be recorded in the patient’s permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:
1. A590 must satisfy all the elements of a consultation (see page GP12).
2. The calculation of the 75 minute minimum time for comprehensive rheumatology consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A595</td>
<td>Limited consultation</td>
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<tr>
<td>A486</td>
<td>Repeat consultation</td>
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<tr>
<td>A483</td>
<td>Medical specific assessment</td>
<td>79.85</td>
</tr>
<tr>
<td>A484</td>
<td>Medical specific re-assessment</td>
<td>61.25</td>
</tr>
<tr>
<td>A481</td>
<td>Complex medical specific re-assessment</td>
<td>70.90</td>
</tr>
<tr>
<td>A488</td>
<td>Partial assessment</td>
<td>38.05</td>
</tr>
</tbody>
</table>

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

**Complex rheumatology assessment**

A complex rheumatology assessment is an assessment for the ongoing management of the following diseases of the musculoskeletal system where the complexity of the condition requires the continuing management by a rheumatologist:

- Systemic vasculitides;
- Inflammatory myopathies; or
- Polymyalgia rheumatica.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A480</td>
<td>Complex rheumatology assessment</td>
<td>89.85</td>
</tr>
</tbody>
</table>

**Payment rules:**

1. A complex rheumatology assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee.
2. This service is *not eligible for payment* to a physician for the initial evaluation of the patient by that physician.
3. Complex rheumatology assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.
4. E078 is *not eligible for payment* with A480.

[Commentary:
1. A complex rheumatology assessment is for the ongoing management of complex disorders of the musculoskeletal system, where the complexity of the condition requires the continuing management by a rheumatologist. It is not intended for the evaluation and/or management of uncomplicated rheumatologic disorders (e.g. osteoarthritis, bursitis/tendonitis, neck and back pain).
2. Examples of systemic vasculitides include Churg-Strauss angiitis, polyarteritis nodosa, Wegener’s granulomatosis, Takayasu’s vasculitis, microscopic polyangiitis, and temporal arteritis.
3. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex rheumatology assessment is for the ongoing management of a patient with a complex rheumatology disorder.]
Rheumatoid arthritis management by a specialist

Definition/Required elements of service
This is the service rendered by a specialist in Rheumatology who is most responsible for providing ongoing management of a patient with rheumatoid arthritis. This service includes all services related to the coordination, provision and documentation of ongoing management, including documentation of all medical record requirements, using a planned care approach.

K481 Rheumatoid arthritis management by a specialist ................................................... 75.00

Payment rules:
1. K481 is limited to a maximum of one service per patient per 12 month period.
2. K481 is only eligible for payment if the physician has rendered a minimum of three consultations/assessments to the patient in the 12 month period for which K481 is claimed.
3. K481 is only eligible for payment when the physician has treated greater than 100 patients with rheumatoid arthritis for the 12 month period for which K481 is claimed.
4. K481 is only eligible for payment to a physician in the following specialties: Rheumatology (48)

Medical record requirements:
K481 is only eligible for payment when the following information is recorded in the patient's permanent medical record for the previous 12 month period:
1. Measurement of tender joint count;
2. Measurement of swollen joint count;
3. Physician and patient global assessment of disease activity;
4. Patient pain score;
5. Patient assessment of function (e.g. HAQ [Health Assessment Questionnaire] or SF36 [Short Form 36]);
6. Measurement of acute phase reactant (ESR or CRP); and
7. Calculation and recording of a pooled measure of RA disease activity (DAS-28 [Disease Activity Score 28], SDAI [Simplified Disease Activity Index], or CDAI [Clinical Disease Activity Index]).

Claims submission instructions:
Claims for K481 should only be submitted when the required elements of the service have been completed for the 12 month period for which K481 is claimed.
Physician to allied professional telephone consultation

This is the service where the rheumatologist participates in a telephone consultation with one or more of the following allied professionals who is funded by and affiliated with the Arthritis Society, Ontario Division:

a. a physiotherapist who is a member of the College of Physiotherapists of Ontario;

b. an occupational therapist who is a member of the College of Occupational Therapists of Ontario; or

c. a social worker who is a member of the Ontario College of Social Workers and Social Service Workers.

Payment rules:

1. A maximum of one K480 service is eligible for payment per patient per day.

2. A maximum of two K480 services are eligible for payment per patient per 12 month period.

3. K480 is only eligible for payment for a physician to allied professional telephone consultation that:
   a. includes a minimum of 10 minutes of patient-related discussion; and
   b. where there is an established physician-patient relationship.

4. K480 is not eligible for payment to the physician in the following circumstances:
   a. when the purpose of the telephone discussion is to arrange for an evaluation of the patient by the physician; or
   b. in circumstances where a physician receives compensation, other than by fee-for-service under this Schedule, for participation in the telephone consultation, this service is not eligible for payment to that physician.

[Commentary:

1. In calculating the minimum time requirement, time does not need to be continuous. In circumstances where a physician to allied health professional telephone consultation service with the consultant physician on the same day is not continuous, the total time represents the cumulative time of all telephone consultations with the same allied health professional on that day pertaining to the same patient.

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

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

Medical record requirements:

K480 is only eligible for payment where the following elements are included in the medical record for a physician who submits a claim for the service:

1. patient’s name and health number;

2. start and stop times of the discussion;

3. name(s) of the allied professional participating in the telephone consultation;

4. reason for the consultation; and

5. the opinion and recommendations of the physician.

Note:

1. The definition/required elements of service and payment rules for consultations in the General Preamble are not applicable to physician to allied professional telephone consultations.

2. This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same physician.
CONSULTATIONS AND VISITS

RHEUMATOLOGY (48)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)
Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

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

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

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

Subsequent visits by the Most Responsible Physician (MRP)
See General Preamble GP29 to GP30 for terms and conditions.
C122 - day following the hospital admission assessment ..................................... 58.80
C123 - second day following the hospital assessment ........................................... 58.80
C124 - day of discharge .......................................................................................... 58.80

Subsequent visits by the MRP following transfer from an Intensive Care Area
See General Preamble GP31 for terms and conditions.
C142 - first subsequent visit by the MRP following transfer from an Intensive Care Area 58.80
C143 - second subsequent visit by the MRP following transfer from an Intensive Care Area ................................................................. 58.80
C121 Additional visits due to intercurrent illness (see General Preamble GP28).per visit 31.00
C488 Concurrent care ..................................................................................per visit 31.00
C982 Palliative care (see General Preamble GP34)..............................................per visit 31.00
CONSULTATIONS AND VISITS

UROLOGY (35)

GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A355</td>
<td>Consultation*</td>
<td>80.00</td>
</tr>
<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A356</td>
<td>Repeat consultation*</td>
<td>55.75</td>
</tr>
<tr>
<td>A353</td>
<td>Specific assessment*</td>
<td>45.00</td>
</tr>
<tr>
<td>A354</td>
<td>Partial assessment</td>
<td>26.00</td>
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EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

<table>
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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>C355</td>
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</tr>
<tr>
<td>C935</td>
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<td>160.00</td>
</tr>
<tr>
<td>C356</td>
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</tr>
<tr>
<td>C353</td>
<td>Specific assessment*</td>
<td>45.00</td>
</tr>
<tr>
<td>C354</td>
<td>Specific re-assessment</td>
<td>26.00</td>
</tr>
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Subsequent visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>C352</td>
<td>first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C357</td>
<td>sixth to thirteenth week inclusive</td>
<td>31.00</td>
</tr>
<tr>
<td>C359</td>
<td>after thirteenth week</td>
<td>31.00</td>
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Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122</td>
<td>day following the hospital admission assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C123</td>
<td>second day following the hospital assessment</td>
<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
</tr>
</tbody>
</table>

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

See General Preamble GP31 for terms and conditions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
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<tbody>
<tr>
<td>C142</td>
<td>first subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C143</td>
<td>second subsequent visit by the MRP following transfer from an Intensive Care Area</td>
<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C358</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>W355</td>
<td>Consultation*</td>
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</tr>
<tr>
<td>W356</td>
<td>Repeat consultation*</td>
<td>55.75</td>
</tr>
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</table>

Note:

*May include* physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration, catheterization and prostatic fluid examination, but not to include endoscopic examination.
## GENERAL LISTINGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>A175</td>
<td>Consultation</td>
<td>90.30</td>
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<tr>
<td>A935</td>
<td>Special surgical consultation (see General Preamble GP13)</td>
<td>160.00</td>
</tr>
<tr>
<td>A176</td>
<td>Repeat consultation</td>
<td>60.00</td>
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<tr>
<td>A173</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>A174</td>
<td>Partial assessment</td>
<td>24.10</td>
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### EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

### NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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<td>60.00</td>
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<tr>
<td>C173</td>
<td>Specific assessment</td>
<td>44.40</td>
</tr>
<tr>
<td>C174</td>
<td>Specific re-assessment</td>
<td>25.95</td>
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**Subsequent visits**

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>C172</td>
<td>first five weeks</td>
<td>31.00</td>
</tr>
<tr>
<td>C177</td>
<td>sixth to thirteenth week inclusive (maximum 3 per patient per week)</td>
<td>31.00</td>
</tr>
<tr>
<td>C179</td>
<td>after thirteenth week (maximum 6 per patient per month)</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Subsequent visits by the Most Responsible Physician (MRP)**

See General Preamble GP29 to GP30 for terms and conditions.

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<td>58.80</td>
</tr>
<tr>
<td>C124</td>
<td>day of discharge</td>
<td>58.80</td>
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</table>

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

See General Preamble GP31 for terms and conditions.

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<td>C143</td>
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<td>58.80</td>
</tr>
<tr>
<td>C121</td>
<td>Additional visits due to intercurrent illness (see General Preamble GP28)</td>
<td>31.00</td>
</tr>
<tr>
<td>C178</td>
<td>Concurrent care</td>
<td>31.00</td>
</tr>
<tr>
<td>C982</td>
<td>Palliative care (see General Preamble GP34)</td>
<td>31.00</td>
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</table>
## CONSULTATIONS AND VISITS

### VASCULAR SURGERY (17)

**Non-Emergency Long-Term Care In-Patient Services**

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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</thead>
<tbody>
<tr>
<td>W175</td>
<td>Consultation</td>
<td>90.30</td>
</tr>
<tr>
<td>W176</td>
<td>Repeat consultation</td>
<td>60.00</td>
</tr>
</tbody>
</table>

**Subsequent visits (see General Preamble GP33)**

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

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