CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

GENERAL LISTINGS

A005 Consultation 77.20

Special family and general practice consultation

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

A911 Special family and general practice consultation 144.75

Comprehensive family and general practice consultation

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

A912 Comprehensive family and general practice consultation 217.15

Payment rules:

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

[Commentary:

1. A911 and A912 must satisfy all the elements of a consultation (see page GP12).
2. The calculation of the 50 minute and 75 minute minimum for special and comprehensive consultations respectively excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

Special palliative care consultation

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

A945 Special palliative care consultation 144.75

Payment rules:

1. Start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
2. When the duration of a *palliative care* consultation (A945 or C945) exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 are met. The time periods for A945 or C945 and K023 are mutually exclusive (i.e. the start time for determination of minimum time requirements for K023 occurs 50 minutes after start time for A945 or C945).

A905 Limited consultation 65.90

A006 Repeat consultation 45.90

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*.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

House call assessment

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

A901 House call assessment 45.15

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

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

Complex house call assessment

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

A900 Complex house call assessment 45.15

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

[Commentary:
1. A frail elderly patient is defined as:

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

  and

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

2. A housebound patient is defined as:

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

Medical record requirements:
Complex house call assessment is not payable If the medical record does not:

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

House call assessment - Pronouncement of death in the home

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

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

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

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

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 *Specialist*s 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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

General/Family physician emergency department assessment

General/Family physician emergency department assessment is an assessment of a patient that satisfies as a minimum the requirements of an intermediate assessment and is rendered by the patient's general/family physician in an emergency department funded under an Emergency Department Alternative Funding Agreement (ED-AFA). For that visit, the service includes any re-assessment of the patient by the general/family physician in the emergency department and any appropriate collaboration with the emergency department physician.

The service is *only eligible for payment* when the general/family physician's attendance is required because of the complexity, obscurity or seriousness of the patient's condition.

A100	General/Family physician emergency department assessment	76.90

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Focused practice assessment (FPA)

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

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

Payment rules:

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

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

Mini assessment

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

A008	Mini assessment	13.05

[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, glauc*oma*, 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 year*s 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. glauc*oma*
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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Midwife-Requested Anaesthesia Assessment (MRAA)

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

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

A816 Midwife-Requested Anaesthesia Assessment (MRAA) 106.80

Midwife-Requested Assessment (MRA)

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

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

A813 Midwife-Requested Assessment (MRA) 101.70

Midwife-Requested Special Assessment (MRSA)

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

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

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

A815 Midwife-Requested Special Assessment (MRSA) 186.95

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Attendance at maternal delivery for care of high risk baby(ies)

Attendance at maternal delivery for high risk baby(ies) requires constant attendance at the delivery of a baby expected to be at risk by a physician who is not a paediatrician, and includes an assessment of the *newborn*.

H007	Attendance at maternal delivery for care of high risk baby(ies)	61.65

Payment rules:
This service is *not eligible for payment* if any other service is rendered by the same physician at the time of the delivery.

H001	Newborn care in hospital and/or home	52.20

Low birth weight baby care (uncomplicated)

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

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*.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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

Note:

1. H105 is payable in addition to the initial consultation or assessment rendered in the emergency department or Hospital Urgent Care Clinic provided that each service is rendered separately by the Emergency Department Physician.
2. H105 is an insured service payable at nil if the hospital admission assessment is payable to the Emergency Department Physician.

Monday to Friday - Daytime (08:00h to 17:00h)

H102	Comprehensive assessment and care	37.20
H103	Multiple systems assessment	35.65
H101	Minor assessment	15.00
H104	Re-assessment	15.00

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

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

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

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

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

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

3. With the exception of ultrasound guidance, (J149) or emergency department investigative ultrasound (H100), ultrasound services listed in this *Schedule* rendered by an Emergency Department Physician are *not eligible for payment*.
4. When any other service is rendered by the Emergency Department Physician in premium hours (and assessments may not be claimed), apply one of the following premiums per patient visit.

H112	- nights (00:00h to 08:00h)	34.20
H113	- daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays	19.80

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Emergency department investigative ultrasound

An Emergency Department investigative ultrasound is *only eligible for payment* when:

1. the procedure is personally rendered by an Emergency Department Physician who meets standards for training and experience to render the service;
2. a *specialist* in Diagnostic Radiology is not available to render an urgent interpretation; and
3. the procedure is rendered for a patient that is clinically suspected of having at least one of the following life-threatening conditions:
   - **a.** pericardial tamponade
   - **b.** cardiac standstill
   - **c.** intraperitoneal hemorrhage associated with trauma
   - **d.** ruptured abdominal aortic aneurysm
   - **e.** ruptured ectopic pregnancy

H100 Emergency department investigative ultrasound..... 19.65

Payment rules:

1. H100 is limited to two (2) services per patient per day where the second service is rendered as a follow-up to the first service for the same condition(s).
2. Services listed in the Diagnostic Ultrasound section of the *Schedule*, both technical and *professional component*s are *not eligible for payment* to any physician when ultrasound images described by H100 are eligible for payment.

Note:

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

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

Medical record requirements:

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

Claims submission instructions:

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

[Commentary:

1. See page 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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment

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

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

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing home or home for the aged

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

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

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Primary mental health care

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Chronic disease shared appointment

Definition /Required elements of service:

Chronic disease shared appointment is a pre-scheduled primary care service rendered for chronic disease management, to two or more patients with the same diagnosis of one of the diseases listed below, that consists of assessment and the provision of advice and information in respect of diagnosis, treatment, health maintenance and prevention.

Each patient must have an established diagnosis of one of the following chronic diseases:

- **a.** Diabetes
- **b.** Congestive Heart Failure
- **c.** Asthma
- **d.** Chronic obstructive pulmonary disease (COPD)
- **e.** Hypercholesterolemia
- **f.** Fibromyalgia

The physician must be in constant personal attendance for the duration of the appointment session, although another appropriately qualified health professional may lead parts of the educational component of the session (for example, a diabetic educator or nurse). In addition, a clinically appropriate assessment must be rendered to each patient by the same physician as a component of the chronic disease shared appointment.

This service has the same *specific elements* as an assessment.

[Commentary:
A clinically appropriate assessment *may include* a brief history or examination of the affected part or region or related mental or emotional disorder.

Chronic disease shared appointment - per patient - maximum 8 units per patient per day

K140	- 2 patients	per unit	31.40
K141	- 3 patients	per unit	20.90
K142	- 4 patients	per unit	15.80
K143	- 5 patients	per unit	13.00
K144	- 6 to 12 patients	per unit	11.05

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

Payment rules:

1. Unit means ½ hour or major part thereof - see General Preamble GP6, GP45 to GP50 for definitions and time-keeping requirements.
2. The service is *only eligible for payment* when:
   - **a.** the appointment is pre-*schedule*d; 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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Psychotherapy

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

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

K007	Individual care	per unit	62.75
	Group - per member - first 12 units per day		
K019	- 2 people	per unit	31.40
K020	- 3 people	per unit	20.90
K012	- 4 people	per unit	15.80
K024	- 5 people	per unit	13.00
K025	- 6 to 12 people	per unit	11.05
K010	- additional units per member (maximum 6 units per patient per day)	per unit	10.00
	Family		
K004	- 2 or more family members in attendance at the same time	per unit	68.10

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	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. Certification of incompetence (financial) including assessment to determine incompetence is not an insured service (see Appendix A).

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Community treatment order (CTO)

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

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

- **a.** all consultations and visits with the patient, family or substitute decision-maker for the purpose of mandatory assessment of the patient in support of initiation, renewal, or termination of the CTO;
- **b.** interviews with the patient, family or substitute decision-maker to give notice of entitlement to legal and rights advice or to obtain informed consent under the *Health Care Consent Act*;
- **c.** all consultations, assessments and other visits including psychotherapy, psychiatric care, interviews, counselling or hypnotherapy with the patient family or substitute decision-maker pertaining to on-going clinical management of the patient under a CTO;
- **d.** preparation of a CTP, including any necessary chart review and clinical correspondence;
- **e.** participation in *schedule*d or un*schedule*d 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.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Interviews

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

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

Payment rules:

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

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Multidisciplinary cancer conference

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

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

Payment rules:

1. K708, K709 and K710 are *only eligible for payment* in circumstances where:

- **a.** the MCC meets the minimum standards, including attendance requirements, established by Cancer Care Ontario; and
- **b.** the MCC is pre-scheduled.

2. K708, K709 and K710 are eligible for payment for each patient discussed where the total time of discussion for all patients meets the minimum time requirements described in the table below, otherwise the number of patients for K708, K709 and K710 are payable will be adjusted to correspond to the overall time of discussion.

3. K708 and K710 are *only eligible for payment* if the physician is actively participating in the case conference, and their participation is documented in the record.

4. K708 and K710 are each limited to a maximum of 5 services per patient per day, any physician.

5. K708 and K710 are each limited to a maximum of 8 services, per physician, per day.

6. Only K708 or K709 or K710 is eligible for payment to the same physician, same day.

7. K709 is limited to a maximum of 8 services per physician, per day.

8. Any other insured service rendered during a MCC is *not eligible for payment*.

9. K708, K709 and K710 are *not eligible for payment* where a physician receives payment, other than by fee-for-service under this *Schedule*, for the preparation and/or participation in a MCC.

10. K708 and K709 are *not eligible for payment* to physicians from the following specialties: Radiation Oncology (34), Diagnostic Radiology (33) and Laboratory Medicine (28).

11. K710 is *only eligible for payment* to physicians from Diagnostic Radiology (33).

Medical record requirements:

1. identification of the patient and physician participants;

2. total time of discussion for all patients discussed; and

3. the outcome or decision of the case conference related to each of the patients discussed.

[Commentary:

1. The 2006 Multidisciplinary Cancer Conference standards can be found at the Cancer Care Ontario website at the following internet link: http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=14318.

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

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[Commentary:

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

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

CASE CONFERENCES

PREAMBLE

Definition/Required elements of service:

Where the conditions set out in this *Schedule* are met, a case conference is an insured service despite paragraph 6 of s. 24(1) of Regulation 552. A case conference is a pre-scheduled meeting, conducted for the purpose of discussing and directing the management of an individual patient. The required elements are applicable for all case conferences, except in circumstances where these requirements are modified for specific case conferences, as indicated. A case conference:

a. must be conducted by personal attendance, videoconference or by telephone (or any combination thereof);

b. must involve at least 2 other participants who meet the eligible participant requirements as indicated in the specific listed case conference services; and

c. at least one of the physician participants is the physician most responsible for the care of the patient.

[Commentary:
Case conferences for educational purposes such as rounds, journal club, group learning sessions, or continuing professional development, or any meeting where the conference is not for the purpose of discussing and directing the management of an individual patient is not a case conference.]

For case conferences where the time unit is defined in 10 minute increments, the following payment rules and medical record requirements are applicable, except in circumstances where these requirements are modified for specific listed case conference services, as indicated.

Note:
"Regulated social worker" refers to a social worker regulated under the *Social Work and Social Service Work Act* and who holds a current certificate of registration from the Ontario College of Social Workers and Social Service Workers.

Case conferences are time based services calculated in time units of 10 minute increments. In calculating time unit(s), the minimum time required is based upon consecutive time spent participating in the case conference as follows:

# Units	Minimum time
1 unit	10 minutes
2 units	16 minutes
3 units	26 minutes
4 units	36 minutes
5 units	46 minutes
6 units	56 minutes
7 units	66 minutes [1h 6m]
8 units	76 minutes [1h 16m]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. A case conference is *only eligible for payment* if the physician is actively participating in the case conference, and the physician's participation is evident in the record.
2. A case conference is *only eligible for payment* in circumstances where there is a minimum of 10 minutes of patient related discussion.
3. A case conference is *only eligible for payment* if the case conference is pre-scheduled.
4. Any other insured service rendered during a case conference is *not eligible for payment*.
5. A case conference is *not eligible for payment* in circumstances where the required participants necessary to meet the minimum requirements of the case conference service receive remuneration, in whole or in part, from the physician claiming the service.
6. The case conference is *not eligible for payment* to a physician who receives payment, other than by fee-for-service under this *Schedule*, for the preparation and/or participation in the case conference.
7. Where payment for a case conference is an included element of another service, services defined as case conferences are *not eligible for payment*.

[Commentary:

1. Chronic dialysis team fees are all-inclusive benefits for professional aspects of managing chronic dialysis and includes all related case conferences (see page 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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Hospital in-patient case conference

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

K121	Hospital in-patient case conference	per unit	31.35

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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Paediatric out-patient case conference

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

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

Payment rules:

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

[Commentary:

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

Mental health out-patient case conference

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

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

Payment rules:

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

[Commentary:

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

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 *month*s.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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

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

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

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 *Home*s.

[Commentary:

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

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Convalescent care program case conference

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

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.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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

1. patient's name and health number;
2. start and stop times of the discussion;
3. name of the referring 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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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).

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Claims submission instructions:
K733 and K737 are *only eligible for payment* if the consultant physician includes the referring physician's billing number with the claim.

[Commentary:

1. "Payment, other than by fee-for-service" includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.
2. In certain circumstances, more than one consultant physician may be required to participate in the same CritiCall telephone consultation. Each consultant physician may submit a claim for the teleconference subject to the established limits.
3. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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 *specialist*s in Dermatology(02) or Ophthalmology(23).

7. K738 is eligible for payment to the primary care physician when this physician is required to collect additional data (for example dermatology or ophthalmology images not present in the primary care physician's records) to support a *specialist*'s initial, repeat, follow-up or minor e-assessment (see page 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.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Genetic assessment

A genetic assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means 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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Diabetic management assessment (DMA)

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

K030 Diabetic Management Assessment 39.20

Diabetes management incentive (DMI)

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

a. Lipids, cholesterol, HbA1C, blood pressure, weight and *body mass index (BMI)*, and medication dosage;

b. Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination;

c. Health promotion counselling and patient self-management support;

d. Albumin to creatinine ratio (ACR);

e. Discussion and offer of *referral* for dilated eye examination; and

f. Foot examination and neurologic examination.

Q040 Diabetes management incentive 60.00

Payment rules:
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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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

Pre-operative medical management of a bariatric surgery patient in a Bariatric RATC

Definition/Required elements of service:

Pre-operative medical management of a bariatric surgery patient is the supervision and pre-operative management of a bariatric surgery patient who is registered with, and, who is undergoing pre-operative medical evaluation and preparation related to bariatric surgery in a Bariatric RATC. The applicable service is payable only to the physician at the Bariatric RATC who is most responsible for the supervision and medical management of the patient in the pre-operative period.

In addition to the *Common Elements* in this *Schedule*, this service includes the provision of the following services to the same patient, during the pre-operative period:

a. All medication reviews.

b. All telephone calls involving the staff, patient, patient's relative(s) or *patient's representative* and the physician in connection with the patient.

K090 Pre-operative medical management of a bariatric surgery patient in a Bariatric RATC 100.00

Payment rules:

1. K090 is *only eligible for payment* if the pre-operative period is a minimum of four *week*s.

2. K090 is *not eligible for payment* if a patient is determined not to be a candidate for bariatric surgery at the time of the initial consultation/assessment in the 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.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

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

Definition/Required elements of service:

Post-operative *month*ly management of a bariatric surgery patient is the supervision and medical management of a post-operative bariatric surgery patient registered with, and who is receiving post-operative care, in a 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 *week*s following the date of surgery.

3. K091 is *only eligible for payment* if the physician personally has contact with the patient whether in person or by telephone during the *month* for which K091 is claimed.

4. K091 is *only eligible for payment* to a physician previously registered with the ministry as providing services in a 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.

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, A903, A905, K005, K007, K013, K017, K130, K131, K132, P003, P004, P005, P008, W001, W002, W003, W004, W008, W010, W102, W104, W107, W109 or W121.

2. E079 is limited to a maximum of one service per patient per *12 month period*.

Medical record requirements:

The medical record for this service must document that an initial smoking cessation discussion has taken place, by either completion of a flow sheet or other documentation consistent with the most current guidelines of the "Clinical Tobacco Intervention" (CTI) program, or the service is *not eligible for payment*.

[Commentary:

A copy of a flow sheet meeting the medical record requirements and guidelines of the CTI program is available at www.*oma*.org or www.*oma*cti.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 *month*s 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 *month*s following E079.

Medical record requirements:

The medical record for this service must document that a follow-up visit regarding smoking cessation has taken place, by either completion of a flow sheet or other documentation consistent with the most current guidelines of the "Clinical Tobacco Intervention" (CTI) program, or the service is *not eligible for payment*.

[Commentary:

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.*oma*cti.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.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Northern health travel grant application form

K036 Completion of northern health travel grant application form 10.25

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

Long-Term Care application

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

K038 Completion of Long-Term Care health report form 45.15

Immediate telephone reporting - specified reportable disease to the Medical Officer of Health

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

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

Payment rules:

1. K034 is limited to a maximum of one service per physician, per patient, per specified reportable disease, per *12 month period*.
2. K034 is *only eligible for payment* when the telephone report is personally rendered by the physician.
3. K034 is *only eligible for payment* for the following specified reportable diseases:
   anthrax, botulism, brucellosis, cholera, cryptosporidiosis, cyclosporiasis, diphtheria, primary viral encephalitis, food poisoning (all causes), sympt*oma*tic 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.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Addiction medicine – initial assessment – substance abuse

Initial assessment - substance abuse is an assessment where the physician spends a minimum of 50 minutes of personal contact assessing a patient related to substance abuse *with or without* the patient's relative(s) or *patient's representative*, exclusive of time spent rendering any other service to the patient. This service is *only eligible for payment* to the physician intending to subsequently render treatment of the patient's substance abuse.

The elements of the service must include:

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

A680 Initial assessment – substance abuse 144.75

Payment rules:

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

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

Medical record requirements:

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

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

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	add	6.00

Definitions:

- **a.** Required services are:
  - **i.** a consultation, assessment or visit from the Consultation and Visits section of this *Schedule*; or
  - **ii.** a K-prefix time-based service excluding group services and case conferences.
- **b.** OAMP - intensive, is the service for management of an OAMP patient receiving an opioid agonist where the physician renders at least two (2) required services in the *month*.
- **c.** OAMP - maintenance, is the service for management of an OAMP patient receiving an opioid agonist where the physician renders one required service in the *month*.

d. OAMP - team premium, is the service for management of an OAMP patient receiving an opioid agonist where:

- **i.** the physician most responsible for the OAMP management of the patient provides one of K682 or K683 in the *month* and supervises members of the OAMP management team;
- **ii.** the OAMP management team consists of the physician most responsible for the OAMP treatment and at least two other non-physician members who have successfully completed a training program in addiction medicine that includes opioid agonist management;
- **iii.** the OAMP management team members provides at least one in-person therapeutic encounter with the patient in the *month* for which the service is payable; and
- **iv.** the therapeutic encounter is not primarily for the purpose of urine testing or the provision of a prescription.

e. 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 *month*ly management fees may be claimed for a patient enrolled in a treatment program using methadone or buprenorphine.]

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

[Commentary:

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

CONSULTATIONS AND VISITS

ANAESTHESIA (01)

GENERAL LISTINGS

Consultation

A015 Consultation 106.80

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

A016 Repeat consultation 52.15

Limited consultation for acute pain management

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

A215 Limited consultation for acute pain management in association with special visit to hospital in-patient 47.50

Note:
This service is *not eligible for payment*:

1. with P014C - introduction of catheter for epidural labour analgesia;

2. for management of routine post-operative pain; or

3. for *referral*s from another anaesthesiologist.

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

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

A013 Specific assessment 47.50
A014 Partial assessment 31.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

C015 Consultation - subject to the same conditions as A015 ..... 106.80
C016 Repeat consultation 52.15
C215 Limited consultation for acute pain management - subject to the same conditions as A215 ..... 47.50

C013 Specific assessment 47.50
C014 Specific re-assessment 28.00

CONSULTATIONS AND VISITS

ANAESTHESIA (01)

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

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.

CARDIOLOGY (60)

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

C605	Consultation	157.00
C765	Consultation, patient 16 years of age and under	165.50
C600	Comprehensive cardiology consultation - subject to the same conditions as A600	300.70
C675	Limited consultation	105.25
C606	Repeat consultation	105.25
C603	Medical specific assessment	79.85
C604	Medical specific re-assessment	61.25
C601	Complex medical specific re-assessment	70.90
	Subsequent visits	
C602	- first five weeks ....per visit	31.00
C607	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ....per visit	31.00
C609	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

CARDIAC SURGERY (09)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C092	- first five weeks ..... per visit	31.00
C097	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	31.00
C099	- after thirteenth week (maximum 6 per patient per month) ..... per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C098	Concurrent care .....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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W095	Consultation	90.30
W096	Repeat consultation	60.00

CLINICAL IMMUNOLOGY (62)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A625	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50
A525	Limited consultation	105.25
A626	Repeat consultation	105.25
A623	Medical specific assessment	79.85
A624	Medical specific re-assessment	61.25
A621	Complex medical specific re-assessment	70.90
A628	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16) ....add 50%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

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

COMMUNITY MEDICINE (05)

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	58.80

C121	Additional visits due to intercurrent illness (see General Preamble GP28)	per visit	31.00
C058	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP34)	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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment

W402	- Type 1	69.35
W404	- Type 2	20.60
W407	- Type 3	30.70

W409	Periodic health visit	65.05
W054	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing *home* or *home* for the aged

W053	- first 2 subsequent visits per patient per month	per visit	32.20
W058	- additional subsequent visits (maximum 3 per patient per month)	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20

W121	Additional visits due to intercurrent illness (see General Preamble GP33)	per visit	31.00

DERMATOLOGY (02)

GENERAL LISTINGS

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

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

A026	Repeat consultation	44.45
A023	Specific assessment	38.70
A024	Partial assessment	21.90
U025	Initial e-assessment	44.45
U023	Repeat e-assessment	29.00
U026	Follow-up e-assessment	21.90
U021	Minor e-assessment	11.00

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 lymph*oma*s (including lymph*oma*toid 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 multifome major; or
- **iii.** toxic epidermal necrolysis.

or

d. "Complex psoriasis" or "complex dermatitis" as defined by at least one of the following criteria:

- **i.** involvement of body surface area of greater than 30%;
- **ii.** treatment with systemic therapy (e.g. methotrexate, acitretin, cyclosporine, biologics); or
- **iii.** a visit that requires at least 15 minutes 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.

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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble 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 MEDICINE (12)

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.

ENDOCRINOLOGY & METABOLISM (15)

GENERAL LISTINGS

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

Comprehensive endocrinology consultation

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

A150	Comprehensive endocrinology consultation	300.70

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

[Commentary:
1. A150 must satisfy all the elements of a consultation (see page GP12).

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

A255	Limited consultation	105.25
A156	Repeat consultation	105.25
A153	Medical specific assessment	79.85
A154	Medical specific re-assessment	61.25
A151	Complex medical specific re-assessment	70.90
A158	Partial assessment	38.05

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

Complex endocrine neoplastic disease assessment

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

a. thyroid neoplasm;

b. parathyroid neoplasm;

c. pituitary neoplasm; or

d. adrenal neoplasm.

A760	Complex endocrine neoplastic disease assessment	89.85

Payment rules:
1. A760 must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.

2. A760 is limited to 6 per patient, per physician, per *12 month period* and up to 12 per patient per physician for 24 consecutive *month*s. Services in excess of this limit will be adjusted to a lesser assessment fee.

3. E078 is *not eligible for payment* with A760.

[Commentary:
A760 is not payable for the evaluation and/or management of uncomplicated endocrine disorders.]

ENDOCRINOLOGY & METABOLISM (15)

DIABETES MANAGEMENT BY A SPECIALIST

Definition/Required elements of service:

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

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

K045 Diabetes management by a specialist 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]

ENDOCRINOLOGY & METABOLISM (15)

DIABETES TEAM MANAGEMENT (DTM)

Definition/Required elements of service:

This is an annual fee payable to a *specialist* in internal medicine or endocrinology for the comprehensive team-based care of a patient with diabetes.

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

K046 Diabetes team management..... 115.00

Payment rules:

1. A maximum of one K046 is eligible for payment per patient per *12 month period*.

2. K046 is *only eligible for payment* if all of the following requirements are fulfilled:

- **a.** the physician has rendered a minimum of 4 of any combination of consultations/assessments or K013, K033, K029, K002, K003 to the same patient in the *12 month period* for which K046 is claimed;
- **b.** the CDE is an employee of the physician;
- **c.** when the physician has treated more than 100 patients with diabetes during the period for which K046 is claimed; and
- **d.** the physician is from one of the following specialities: Internal Medicine (13) or Endocrinology (15).

3. K046 is *not eligible for payment* unless the physician documents the services rendered by the CDE. The physician must provide such documentation to the ministry, if requested.

4. The CDE must have current certification by the Canadian Diabetes Educator Certification Board at the time the CDE renders services to the patient.

Medical record requirements:

1. K046 is *only eligible for payment* when the record includes a flow sheet and/or a diabetic registry record meeting the published Standards of Care as defined in the Canadian Diabetes Association Clinical Practice Guidelines. The minimum required elements of the diabetes flow sheet include:

- **a.** Laboratory parameters including:
  - **i.** Lipid profile (cholesterol, triglycerides);
  - **ii.** glycated haemoglobin (HgbA1C);
  - **iii.** olbumin 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*.

ENDOCRINOLOGY & METABOLISM (15)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

ENDOCRINOLOGY & METABOLISM (15)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine section.

GENERAL LISTINGS

A415	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50
A545	Limited consultation	105.25
A416	Repeat consultation	105.25
A413	Medical specific assessment	79.85
A414	Medical specific re-assessment	61.25
A411	Complex medical specific re-assessment	70.90
A418	Partial assessment	38.05
A120	Colonoscopy assessment, same day as colonoscopy	18.85

Note:

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

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

GASTROENTEROLOGY (41)

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

CONSULTATIONS AND VISITS

GENERAL SURGERY (03)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

GENERAL SURGERY (03)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

W035	Consultation	90.30
W036	Repeat consultation	60.00

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing *home* or *home* for the aged

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

GENERAL THORACIC SURGERY (64)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C642	- first five weeks ....per visit	31.00
C647	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ....per visit	31.00
C649	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C648	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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W645	Consultation	90.30
W646	Repeat consultation	60.00

GENETICS (22)

These listings may also be used by specialists with FCCMG designation (Fellow of the Canadian College of Medical Geneticists).

GENERAL LISTINGS

A225 Consultation* 165.00

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.

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.

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.

GENETICS (22)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

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 *schedule*d 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.

GERIATRICS (07)

A375	Limited consultation	105.25
A076	Repeat consultation	105.25
A073	Medical specific assessment	79.85
A074	Medical specific re-assessment	61.25
A071	Complex medical specific re-assessment	70.90
A078	Partial assessment	38.05

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

Geriatric telephone support

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

K077	Geriatric telephone support	per unit	35.45

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.

GERIATRICS (07)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

GERIATRICS (07)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

*Month*ly 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

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

INFECTIOUS DISEASE (46)

GENERAL LISTINGS

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

Comprehensive infectious disease consultation

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

A460	Comprehensive infectious disease consultation	300.70

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

[Commentary:
1. A460 must satisfy all the elements of a consultation (see page GP12).

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

A275	Limited consultation	105.25
A466	Repeat consultation	105.25
A463	Medical specific assessment	79.85
A464	Medical specific re-assessment	61.25
A461	Complex medical specific re-assessment	70.90
A468	Partial assessment	38.05

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

INFECTIOUS DISEASE (46)

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C468	Concurrent care .....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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble 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 *month*s 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

INTERNAL AND OCCUPATIONAL MEDICINE (13)

GENERAL LISTINGS

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

Comprehensive internal medicine consultation

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

A130	Comprehensive internal medicine consultation	300.70

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

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

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

A435	Limited consultation	105.25
A136	Repeat consultation	105.25
A133	Medical specific assessment	79.85
A134	Medical specific re-assessment	61.25
A131	Complex medical specific re-assessment	70.90
A138	Partial assessment	38.05
A120	Colonoscopy assessment, same day as colonoscopy	18.85

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

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

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

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

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

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

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

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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble 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 *month*s 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

LABORATORY MEDICINE (28)

The following fees are applicable to specialists in Haematopathology, Neuropathology, Medical Biochemistry, Medical Microbiology, Anatomic and General Pathology.

GENERAL LISTINGS

A285	Consultation	102.00
A286	Limited consultation	71.20
A586	Repeat consultation	71.20
A283	Medical specific assessment	55.55
A284	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP16) ....add 50%	

Diagnostic consultation

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

A585	Diagnostic consultation	64.70

Payment rules:

1. A diagnostic laboratory medicine consultation is *not eligible for payment* when tissues, slides, specimens and/or laboratory results from a different licensed laboratory are used for comparison purposes with tissues, slides, specimens and/or laboratory results done in the consultant's licensed laboratory.
2. With the exception of those services set out in the section, "Special Procedures and Interpretation – Histology or Cytology", any other services rendered by the physician in association with a diagnostic laboratory medicine consultation are *not eligible for payment*.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

MEDICAL ONCOLOGY (44)

GENERAL LISTINGS

A445	Consultation	157.00
A765	Consultation, patient 16 years of age and under	165.50
A845	Limited consultation	105.25
A446	Repeat consultation	105.25
A443	Medical specific assessment	79.85
A444	Medical specific re-assessment	61.25
A441	Complex medical specific re-assessment	70.90
A448	Partial assessment	38.05

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

MEDICAL ONCOLOGY (44)

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C448	Concurrent 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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

Admission assessment

W842	- Type 1.....	69.35
W844	- Type 2.....	20.60
W847	- Type 3.....	30.70
W849	Periodic health visit	65.05
W444	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing *home* or *home* for the aged

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

NEPHROLOGY (16)

GENERAL LISTINGS

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

Comprehensive nephrology consultation

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

A160	Comprehensive nephrology consultation	300.70

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

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

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

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble 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 *month*s 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

NEUROLOGY (18)

GENERAL LISTINGS

A185 Consultation 176.35

Special neurology consultation

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

A180 Special neurology consultation 300.70

Medical record requirements:

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

A385 Limited consultation 84.95
A186 Repeat consultation 84.95
A183 Medical specific assessment 78.80
A184 Medical specific re-assessment 62.10
A181 Complex medical specific re-assessment 71.90
A188 Partial assessment 37.65

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 neurologist:

a. generalized peripheral neuropathies;

b. myopathies;

c. diseases of the neuromuscular junction; or

d. diseases of the motor neurone.

A113 Complex neuromuscular assessment 89.85

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.]

NEUROLOGY (18)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

NEUROLOGY (18)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

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

Note:
*May only be claimed 6 *month*s 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

NEUROSURGERY (04)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C042	- first five weeks ....per visit	31.00
C047	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....per visit	31.00
C049	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

W045	Consultation	107.00
W046	Repeat consultation	51.45

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

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

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C202	- first five weeks ....per visit	31.00
C207	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ....per visit	31.00
C209	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C208	Concurrent care ....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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W305	Consultation*	101.70
W306	Repeat consultation*	54.10

Note:
*Includes (where indicated) b*iop*sy of cervix, papanicolaou smear, examination of trichomonas suspension.

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

A115 Major eye examination (see page A7) 51.10

Orthoptic assessment

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

A230 Orthoptic assessment 25.00

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

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

Retinopathy of prematurity (ROP) assessment

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

a. 9 *month*s of age or younger; or

b. aged 10 *month*s to 16 years with minimum stage 3 ROP disease.

A250 Retinopathy of prematurity assessment 120.00

Payment rules:
No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A250.

OPHTHALMOLOGY (23)

Vision Rehabilitation – Initial assessment and follow-up assessment

Definitions

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

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

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

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

Initial vision rehabilitation assessment

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

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

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

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

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

A252 Initial vision rehabilitation assessment..... 240.00

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.]

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 chromos*oma*l abnormalities, autism, cerebral palsy etc. or evaluation of children/*infant*s with low vision associated with or resulting in developmental delay.]

OPHTHALMOLOGY (23)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C232	- first five weeks ....per visit	31.00
C237	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....per visit	31.00
C239	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C238	Concurrent care ....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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

ORTHOPAEDIC SURGERY (06)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C062	- first five weeks ....per visit	31.00
C067	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....per visit	31.00
C069	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

ORTHOPAEDIC SURGERY (06)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

W065	Consultation	83.10
W066	Repeat consultation	51.70

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing *home* or *home* for the aged

W063	- first 2 subsequent visits per patient per month	per visit	32.20
W068	- subsequent visits per month (maximum of 3 per patient per month)	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20

W121	Additional visits due to intercurrent illness (see General Preamble GP33)	per visit	31.00

OTOLARYNGOLOGY (24)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C242	- first five weeks	per visit	31.00
C247	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C249	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C248	Concurrent care 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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W345	Consultation	77.90
W346	Repeat consultation	48.85

PAEDIATRICS (26)

GENERAL LISTINGS

Services rendered by a physician with a specialty designation in Paediatrics (26) (i.e. “paediatrician”) are eligible for payment for an *adult* patient where:

1. the paediatrician has rendered at least one consultation, assessment or visit from the general listings for Paediatrics in the Consultation and Visits section of this *Schedule* for the same patient in the *12 month period* prior to the patient's eighteenth birthday; and ongoing management of the patient with a chronic condition by the paediatrician is necessary; and the patient is less than 22 years of age; or
2. the paediatrician has obtained written prior approval from the *MOHLTC* by demonstrating that the continuation of treatment is generally accepted and necessary for the patient under the circumstances.

A265 Consultation 167.00

Special paediatric consultation

Special paediatric consultation is a consultation in which the physician provides all the elements of a consultation (A265) and spends a minimum of 75 minutes of direct contact with the patient.

A260 Special paediatric consultaton 300.70

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

Extended special paediatric consultation

Extended special paediatric consultation is a consultation in which the physician provides all the elements of a consultation (A265) and spends a minimum of 90 minutes of direct contact with the patient.

A662 Extended special paediatric consultation 395.65

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

Neurodevelopmental consultation

Neurodevelopmental consultation is a consultation in which the physician provides all the elements of a consultation (A265) for an *infant*, *child* or *adolescent* with complex neurodevelopmental conditions (e.g. autism, global development disorders etc.) and spends a minimum of 90 minutes of direct contact with the patient and caregiver.

A667 Neurodevelopmental consultation..... 395.65

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

Medical record requirements:
The start and stop time must be recorded in the patient’s permanent medical record or the payment for this service will be reduced to a lesser fee.

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

PAEDIATRICS (26)

Prenatal consultation

A prenatal consultation is the service rendered by a paediatrician upon request of a physician who considers a fetus of greater than 20 *week*s gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or fetal distress.

[Commentary:
A prenatal consultation by a paediatrician does not preclude the paediatrician from claiming a post-natal consultation on the *infant*.]

A665	Prenatal consultation	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*.

PAEDIATRICS (26)

Developmental and/or behavioural care

Developmental and/or behavioural care are services encompassing any combination or form of assessment and treatment by a paediatrician for mental illness, behavioural maladaptations, developmental disorders, and/or other problems that are assumed to be of a developmental or emotional nature where there is consideration of the patient's biological and psychosocial functioning. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 to GP41 for definitions and time-keeping requirements.

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

Payment rules:
These services are only payable to paediatricians who satisfy one of the following criteria:

- **a.** 35% or more of the dollar value of the annual fee-for-service claims in any *12 month period* consist of K122 and/or K123;
- **b.** 35% or more of the dollar value of the annual fee-for-service claims in any *12 month period* consist of any combination of K005, K007, K019, K020, K012, K024, K025, K010, K004, K006, or K008; or
- **c.** additional residency or fellowship training in paediatrics or psychiatry. Residency or fellowship training includes either completion of training in paediatric or *adolescent* developmental and/or behavioural medicine within a recognized paediatric residency training programme of at least one-year duration following completion of the first three years of residency, or a post residency fellowship or other equivalent programme in paediatrics, *adolescent* medicine or psychiatry. Documentation of additional residency or fellowship training must be provided if requested by the ministry.

[Commentary:
Paediatricians who do not meet the criteria listed above but believe they have appropriate training and/or experience to permit them to provide paediatric or *adolescent* developmental and/or behavioural care may contact the ministry to determine whether their training and/or experience constitute an equivalent residency, training or programme.

Services rendered by physicians who do not meet these requirements are still insured but eligible for payment under another fee *schedule* code e.g. primary mental health care (K005), counselling (K013/K033) or group counselling (K040/K041).]

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

PAEDIATRICS (26)

Attendance at maternal delivery

Attendance at maternal delivery requires constant attendance at the delivery of a baby expected to be at risk by a paediatrician, and includes an assessment of the *newborn*.

H267	Attendance at maternal delivery	63.45

Payment rules:
This service is *not eligible for payment* if any other service is rendered by the same physician at the time of the delivery unless the *newborn* is sick in which case a medical specific assessment (C263) is payable in addition to attendance at maternal delivery if rendered.

H261	Newborn care in hospital or home	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

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

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

Admission assessment

W562	- Type 1	69.35
W564	- Type 2	20.60
W567	- Type 3	30.70

W269	Periodic health visit	30.70

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Note:
In surgical cases requiring medical direction, standard in-hospital medical fees are to be claimed in addition to the surgical fee. This includes all operations on babies under one year of age, and all other older *child*ren who require medical supervision.

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%

PHYSICAL MEDICINE & REHABILITATION (31)

Complex neuromuscular assessment

A complex neuromuscular assessment is an assessment for the ongoing management of the following diseases of the neuromuscular system where the complexity of the condition requires the continuing management by a physical medicine and rehabilitation *specialist*:

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

A510 Complex neuromuscular assessment..... 89.85

Payment rules:

1. A complex neuromuscular assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee**.**

2. This service is *not eligible for payment* to a physician for the initial evaluation of the patient by that physician.

3. Complex neuromuscular assessments are limited to 6 per patient, per physician, per *12 month period*. Services in excess of this limit will be adjusted to a lesser assessment fee.

4. E078 is *not eligible for payment* with A510.

[Commentary:

1. A complex neuromuscular assessment is for the ongoing management of complex neuromuscular disorders, where the complexity of the condition requires the continuing management by a physical medicine and rehabilitation *specialist*. It is not intended for the evaluation and/or management of uncomplicated neuromuscular disorders (e.g. carpal tunnel syndrome, Bell's palsy, asymptomatic diabetic neuropathy).

2. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex neuromuscular assessment is for the ongoing management of a patient with a complex neuromuscular disorder.]

Complex physiatry assessment

This service is an assessment in relation to the following diseases where the complexity of the condition requires the ongoing management by a physical medicine and rehabilitation *specialist*:

a. traumatic brain injury;

b. stroke (hemorrhagic and ischemic); or

c. spinal cord injury.

A511 Complex physiatry assessment..... 89.85

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.]

PHYSICAL MEDICINE & REHABILITATION (31)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

PHYSICAL MEDICINE & REHABILITATION (31)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

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

Admission assessment

W512	- Type 1	69.35
W514	- Type 2	20.60
W517	- Type 3	30.70
W419	Periodic health visit	65.05
W314	General re-assessment of patient in nursing home*	20.60

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

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing *home* or *home* for the aged

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

PHYSICAL MEDICINE & REHABILITATION (31)

Team management in a Rehabilitation Unit

Team management in a Rehabilitation Unit active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to fee codes H312, H317 and H319 means when this service is rendered by one physiatrist even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit, the *week*ly and *month*ly limitations under the following fee codes apply to the total rehabilitation care rendered. In other words, it is not possible to claim the maximum fees allowed under C312, C317 and C319 and then start claiming de novo under H312, H317 and H319 under the above circumstances.

H312	- first twelve weeks	per visit	39.00
H317	- from thirteenth to twenty-sixth week (maximum 3 per patient per week)	per visit	39.00
H319	- twenty-seventh week onwards (maximum 6 per patient per month)	per visit	39.00

Rehabilitation counselling

Rehabilitation counselling one or more persons. Unit means ½ hour or major part thereof - see General Preamble GP5, GP37 for definitions and time-keeping requirements.

H313	Rehabilitation counselling	per unit	76.95

Physiatric management

Physiatric management is the service rendered by physiatrists for regulation, management and supervision of the active, regular, and ongoing treatment of a patient in a rehabilitation department by physical or other (e.g. occupational, speech) therapists. The service also includes making arrangements for any related assessments, procedures or therapy and making arrangements for follow-up care as required.

K313	Physiatric management		8.10

Payment rules:

1. Physiatric management is *not eligible for payment* if any other service is rendered by the same physician on the same day to the same patient.
2. This service is *only eligible for payment* on days when rehabilitation services are provided to patients seen previously by the physiatrist for consultation or assessment.

[Commentary:

1. The fee is not meant as an administrative fee for supervising a department of rehabilitation.
2. This fee applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services or physical therapy, occupational therapy, speech therapy and discharge planning.]

PLASTIC SURGERY (08)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C082	- first five weeks ....per visit	31.00
C087	- sixth to thirteenth week inclusive (maximum 3 per patient per week)....per visit	31.00
C089	- after thirteenth week (maximum 6 per patient per month) ....per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C088	Concurrent care ....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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W085	Consultation	81.10
W086	Repeat consultation	47.95

PSYCHIATRY (19)

GENERAL LISTINGS

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

Claims submission instructions:
Submit claim using A895 and the appropriate special visit premium beginning with "C" prefix for a hospital in-patient, “W” prefix for a long-term care in-patient or “K” prefix for an emergency department patient.

Special psychiatric consultation

Special psychiatric consultation is a consultation in which the physician provides all the elements of a consultation (A195) and spends a minimum of 75 minutes of direct contact with the patient.

A190	Special psychiatric consultation	300.70

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 *schedule*d 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 *child*ren or *adolescent*s 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.]

PSYCHIATRY (19)

Psychiatric consultation extension

This service is eligible for payment for an extension to the consultations listed in the table below when the physician is required to spend an additional period of consecutive or non-consecutive time on the same day with the patient and/or patient's relative(s), *patient's representative* or other caregivers.

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

K630 Psychiatric consultation extension ..... per unit 105.10

Payment rules:

1. K630 is a time based service. Time is calculated based on units - Unit means ½ hour or major part thereof - see General Preamble GP5 for definitions and time-keeping requirements.
2. K630 is limited to a maximum of six units per patient per physician per day.
3. K630 is payable in accordance with the following rules:

Consultation	Minimum time with the patient before the start time for the first unit of K630	Minimum time required for consultation service + 1 unit of K630 to be payable	[Commentary: Minimum time required for consultation service + 2 units of K630 to be payable
A190, C190, W190	90 minutes	106 minutes	136 minutes
A195	60 min	76 min	106 min
A197 – sole service	60 min	76 min	106 min
A198 – sole service	60 min	76 min	106 min
A197 + A198 same patient same day	120 min	136 min	166 min
A695, C695, W695	120 min	136 min	166 min
A795, C795, W795	90 min	106 min	136 min
A895, C895, W895	60 min	76 min	106 min
A191	60 min	76 min	106 min
A192	60 min	76 min	106 min
A191+ A192 same patient same day	120 min	136 min	166 min]

PSYCHIATRY (19)

EMERGENCY OR OUT-PATIENT DEPARTMENT (ODP)

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

NON-EMERGENCY HOSPITAL SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) per visit	31.00
C198	Concurrent care ... 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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

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

PSYCHIATRY (19)

PSYCHIATRIC CLINICAL PRACTICE MODIFIERS/PREMIUMS

Acute post-discharge community psychiatric care

Acute post-discharge community psychiatric care is a premium for a service that occurs during the (4) *week* period immediately following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition. The premium is only applicable to K195, K196, K197 or K198.

K187 Acute post-discharge community psychiatric care, to K195, K196, K197 or K198.....add 15%

High risk community psychiatric care

High risk community psychiatric care is a premium for a service that occurs during the six (6) *month* period following a suicide attempt. For the purposes of this premium, suicide attempts include self-harm attempts with intent to commit suicide or high lethality self-harm attempts, but do not include self harm attempts of low lethality with no intent to commit suicide. The premium is applicable to A190, A191, A192, A195, A197, A198, A695, A795, K195, K196, K197 and K198.

K188 High risk community psychiatric care, to A190, A191, A192, A195, A197, A198, A695, A795, K195, K196, K197 or K198 .....add 15%

Payment rules:

1. K187 or K188 are both payable with K195, K196, K197 or K198 when rendered during the first four (4) *week* period following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition and the requirements for both K187 and K188 are met.

2. K188 is *not eligible for payment* in addition to K189 on the same patient same day.

K189 Urgent community psychiatric follow-up, to A190, A195, 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) *month*s as required.

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

PSYCHIATRY (19)

Assessments under the Mental Health Act

See General Preamble 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, *Child*ren's Aid Society (CAS) staff or legal guardian, etc. - see listings in Family Practice & Practice In General.
4. Certification of incompetence (financial) including assessment to determine incompetence is not an insured benefit.

PSYCHIATRY (19)

PSYCHOTHERAPY, FAMILY PSYCHOTHERAPY, HYPNOTHERAPY AND PSYCHIATRIC CARE

Note:

1. For conditions and definitions - see General Preamble 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.

Psychiatric care

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

Family psychiatric care

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

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

Psychotherapy

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

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

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

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

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

Hypnotherapy

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

DIAGNOSTIC RADIOLOGY (33)

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

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

RADIATION ONCOLOGY (34)

GENERAL LISTINGS

A345	Consultation	152.40
A765	Consultation, patient 16 years of age and under	165.50
A745	Limited consultation	99.30
A346	Repeat consultation	99.30
A343	Medical specific assessment	77.55
A340	Medical specific re-assessment	59.55
A341	Complex medical specific re-assessment	68.90
A348	Partial assessment	37.05
E078	- chronic disease assessment premium (see General Preamble GP16) ....add 50%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

RESPIRATORY DISEASE (47)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

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

Comprehensive respiratory disease consultation

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

A470	Comprehensive respiratory disease consultation	300.70

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 sympt*oma*tic patient with a PaO2 <60mmHg and/or or a PaCO2 >50mmHg);

b. bronchiectasis with frequent infections;

c. cystic fibrosis;

d. active pulmonary or extrapulmonary disease due to mycobacterial tuberculosis complex (latent tuberculosis infection is excluded); or

e. active pulmonary or extrapulmonary non-tuberculous mycobacterial disease (airway or tissue colonization without disease is excluded).

A570	Complex respiratory assessment	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.

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

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

Comprehensive rheumatology consultation

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

A590	Comprehensive rheumatology consultation	300.70

Medical record requirements:
For A590, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:
1. A590 must satisfy all the elements of a consultation (see page GP12).

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

A595	Limited consultation	105.25
A486	Repeat consultation	105.25
A483	Medical specific assessment	79.85
A484	Medical specific re-assessment	61.25
A481	Complex medical specific re-assessment	70.90
A488	Partial assessment	38.05
E078	- chronic disease assessment premium (see General Preamble GP16)	add 50%

Complex rheumatology assessment

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

a. Systemic vasculitides;

b. Inflammatory myopathies; or

c. Polymyalgia rheumatica.

A480	Complex rheumatology assessment	89.85

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 granul*oma*tosis, Takayasu's vasculitis, microscopic polyangiitis, and temporal arteritis.

3. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex rheumatology assessment is for the ongoing management of a patient with a complex rheumatology disorder.]

RHEUMATOLOGY (48)

Rheumatoid arthritis management by a specialist

Definition/Required elements of service

This is the service rendered by a *specialist* in Rheumatology who is most responsible for providing ongoing management of a patient with rheumatoid arthritis. This service includes all services related to the coordination, provision and documentation of ongoing management, including documentation of all medical record requirements, using a planned care approach.

K481	Rheumatoid arthritis management by a specialist	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.

RHEUMATOLOGY (48)

Physician to allied professional telephone consultation

This is the service where the rheumatologist participates in a telephone consultation with one or more of the following allied professionals who is funded by and affiliated with the Arthritis Society, Ontario Division:

a. a physiotherapist who is a member of the College of Physiotherapists of Ontario;

b. an occupational therapist who is a member of the College of Occupational Therapists of Ontario; or

c. a social worker who is a member of the Ontario College of Social Workers and Social Service Workers.

K480 Physician to allied professional telephone consultation..... 31.35

Payment rules:

1. A maximum of one K480 service is eligible for payment per patient per day.

2. A maximum of two K480 services are eligible for payment per patient per *12 month period*.

3. K480 is *only eligible for payment* for a physician to allied professional telephone consultation that:

a. includes a minimum of 10 minutes of patient-related discussion; and

b. where there is an established physician-patient relationship.

4. K480 is *not eligible for payment* to the physician in the following circumstances:

a. when the purpose of the telephone discussion is to arrange for an evaluation of the patient by the physician; or

b. in circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for participation in the telephone consultation, this service is *not eligible for payment* to that physician.

[Commentary:

1. In calculating the minimum time requirement, time does not need to be continuous. In circumstances where a physician to allied health professional telephone consultation service with the consultant physician on the same day is not continuous, the total time represents the cumulative time of all telephone consultations with the same allied health professional on that day pertaining to the same patient.

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

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

Medical record requirements:

K480 is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

1. patient's name and health number;

2. start and stop times of the discussion;

3. name(s) of the allied professional participating in the telephone consultation;

4. reason for the consultation; and

5. the opinion and recommendations of the physician.

Note:

1. The definition/required elements of service and payment rules for consultations in the General Preamble are not applicable to physician to allied professional telephone consultations.

2. This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same physician.

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

UROLOGY (35)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

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

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	58.80
C121	Additional visits due to intercurrent illness (see General Preamble GP28) .per visit	31.00
C358	Concurrent care ....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 *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP52.

W355	Consultation*	80.00
W356	Repeat consultation*	55.75

Note:

**May include* physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration, catheterization and prostatic fluid examination, but not to include endoscopic examination.

VASCULAR SURGERY (17)

GENERAL LISTINGS

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

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

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

Subsequent visits

C172	- first five weeks ... per visit	31.00
C177	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ...per visit	31.00
C179	- after thirteenth week (maximum 6 per patient per month) ... per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP29 to GP30 for terms and conditions.

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

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

See General Preamble GP31 for terms and conditions.

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

VASCULAR SURGERY (17)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

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

W175	Consultation	90.30
W176	Repeat consultation	60.00

Subsequent visits (see General Preamble GP33)

Chronic care or convalescent hospital

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

Nursing *home* or *home* for the aged

W173	- first 2 subsequent visits per patient per month	per visit	32.20
W178	- subsequent visits per month (maximum of 3 per patient per month)	per visit	21.20
W972	- palliative care (see General Preamble GP34)	per visit	32.20

W121	Additional visits due to intercurrent illness (see General Preamble GP33)	per visit	31.00