DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

SPECIFIC ELEMENTS

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

A. Where the services are not identified with prefix #, the *specific elements* are those listed in the General Preamble GP11.

B. Where the services are identified with prefix #, the *specific elements* are those listed in the General Preamble GP11 except for specific element H. In place of H includes providing premises, equipment, supplies and personnel for any aspect(s) of the *specific elements* that is (are) performed in a place other than the place in which the included procedures are performed.

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

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

Non-Invasive Diagnostic Procedures (other than Laboratory Medicine)

Some non-invasive diagnostic procedures are divided into a *technical component* and a *professional component* that, for some services, may have two levels identified as P1 and P2. In addition to the *common elements*, the components of non-invasive diagnostic procedures include the following *specific elements*.

For Professional Component P1

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

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

For Professional Component P2

A. Interpreting the results of the diagnostic procedure.

B. Providing premises for any aspect(s) of the *specific elements*, that is(are) performed at a place other than the place in which the procedure is performed.

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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

For Technical Component

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

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

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

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

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

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional component*s except for the premises for any aspect(s) of A and D of the P1 *professional component* and A of the P2 *professional component* that is(are) not performed at the place in which the procedure is performed.

Where the listings refer to the "*professional component*" the reference is to P1 unless specifically identified as P2. Where the only *professional component* provided is P2, the *specific elements* A and C listed for the *professional component* (P1) are further *specific elements* of the *technical component*.

Where non-invasive diagnostic procedures are not divided into technical and *professional component*s, the *specific elements* of services are:

1. for services not identified with prefix **#**, the combination of the *specific elements* listed for the *professional component* (P1) and for the *technical component*.
2. for services identified with prefix **#**, the combination of the *specific elements* listed for the *professional component* (P1) and *specific elements* A through E of the *technical component*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

THERAPEUTIC AND INVASIVE DIAGNOSTIC PROCEDURES

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

A. Supervising the preparation of the patient and preparing the patient for the procedure(s).

B. Performing the procedure(s), by any method, including ongoing monitoring and detention during the immediate post-procedure period.

C. Where appropriate, interpreting the results of the procedure and providing written interpretative report to the referring physician.

D. Making arrangements for any related assessments, procedures or therapy, including obtaining any specimens from the patient and interpretation of any results where appropriate.

E. Where indicated, making or supervising the making of arrangements for follow-up care and post-procedure monitoring of the patient's condition, including intervening, until the next insured service is provided.

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

G. Providing premises, equipment, supplies and personnel for the *specific elements*

1. for services not identified with prefix #, for all elements.

2. for services identified with prefix #, for any aspect(s) of A, B, D, E and F that is (are) performed in a place other than the place in which the procedure is performed.

OTHER TERMS AND DEFINITIONS

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

1. a consultation or assessment is payable to the same physician for the same patient on the same *day*; and

2. that physician has a financial interest in the facility where the service is rendered.

Note:

1. G700 is *not eligible for payment* for a service provided in a hospital.

2. G700 is *not eligible for payment* when the service marked with (+) is *not eligible for payment*.

3. G700 is payable at 15% of the listed fee when the service is rendered to a patient who has signed the Ministry's Patient Enrolment and Consent to Release Personal Health Information form and who is enrolled to a physician or group of physicians who are signatories to a Ministry alternate funding plan agreement paying physicians primarily by capitation rather than fee for service, applicable regardless of which physician of the group renders the service to the enrolled patient.

		Fee
G700	Basic fee-per-visit premium for procedures marked(+).....	5.10

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ALLERGY

			Fee
		Note: If a patient presents for an allergy injection and has an acute infectious condition, albeit of the respiratory system, or some other unrelated condition which would have otherwise required a separate office visit, the physician is entitled to claim the appropriate assessment fee as well as the injection fee. If a patient requires a brief assessment of his allergic condition as well as the allergy injection, the physician should claim the injection and the basic fee, in which case the *specific elements* of the service include those of an assessment (see General Preamble GP11).	
#	G185	Drug(s) desensitisation - in a hospital where full cardioresuscitative equipment is readily available because a significant risk of life-threatening anaphylaxis exists. The service must be performed under direct and ongoing physician attendance	184.95
+	G200	Acute desensitisation, e.g. ATS, penicillin	8.65
+	G201	Direct nasal tests, to a maximum of 3 per year ... per test	1.60
		Hyposensitisation	
	G202	- each injection	4.45
	G212	- when sole reason for visit (including first injection)	9.75
		Payment rules: G202 is limited to a maximum of 2 when an assessment is eligible for payment for the same visit and a maximum of 1 in addition to the injection included in G212 when sole reason for visit.	
	G205	Insect venom desensitisation (immunotherapy) - per injection (maximum of 5 per day). In addition to G205, after the initial major assessment only, a minor or partial assessment may be claimed once per day if rendered	13.15
		Ophthalmic tests	
+	G203	- direct, to maximum of 3 per year ... per test	1.60
+	G204	- quantitative	12.40
		Patch test	
	G206	- maximum of 90 per patient, per year ... per test	2.39
	G198	- for industrial or occupational dermatoses, to a maximum of 125 per patient, per year ... per test	2.39
+	G207	Bronchial provocative testing - per session, to a maximum of 6 per year	14.15
		Provocation testing	
		For foods, food additives and medications, by blinded or open technique, maximum 5 testing sessions per *12 month period*.	
	G208	Provocation testing ... per unit	15.00
		Payment rules: **1.** G208 is a time base service. Unit means one hour or major part thereof. **2.** In the event the allergic response is respiratory, only one pulmonary function test is eligible for payment the same *day* as G208.	
		[Commentary: See General Preamble GP5 for definitions and time keeping requirements.]	

ALLERGY

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

[Commentary:
See G208 for similar services rendered in office.]

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

		Fee
	Venom allergy testing	
	Investigations including skin prick test(s), intracutaneous test(s) and any other procedures necessary to establish the role of venom allergy in contributing to a patient's illness(es).	
G199	Venom allergy testing, maximum of 2 per patient per physician per 12 month period	40.00
G195	Local anaesthetic hypersensitivity skin test, maximum of 2 per patient per physician per 12 month period	17.00
G196	Hypersensitivity skin test for validated drugs or agents excluding foods and inhalants, maximum of 3 per patient per physician per 12 month period	17.00
E582	- when testing with penicillin minor determinant mixture outside a hospital setting, to G196 ..... add	32.20

Physical urticaria challenges - to include at least 3 of the following:

a. assessment of dermographic challenge with 100, 250 or 500 gm needle, measuring immediate and delayed responses,

b. assessment of pressure challenge with 15 lbs. weight recording onset, peak, duration of response - immediate and delayed,

c. assessment of ice cube cold challenges,

d. assessment of cholinergic exercise challenge with use of treadmill or bicycle to target pulse rate greater or equal to 120 per minute and profuse sweating,

e. vibration effect of light and water,

f. histamine or methacholine

G213	Physical urticaria challenges	13.80

		Fee	Anae

SPECIFIC ELEMENTS

Examination under anaesthesia (EUA) (when sole procedure performed)

A. While this may be performed for diagnostic purposes, the *specific elements* are those for a therapeutic procedure.

B. EUA is payable only if sole procedure performed by examining physician. EUA claimed in conjunction with any other procedure is payable at nil.

C. Claims for EUA submitted without the applicable diagnostic code are payable at nil.

Despite paragraph b. listed under Basic Units on GP59, no anaesthesia service other than E023C is eligible for payment when rendered in support of Z432.

Refer to E023C on GP63 for anaesthesia services rendered in support of Z432.]

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

			Fee	Anae
		Vascular cannulation		
	Z459	Arterial puncture	10.20	
#	G268	Cannulation of artery for pressure measurements including cut down as necessary	31.25	
		G268 is *not eligible for payment* with G249, G259, G261, G176, G177, G178, G288, Z443 or Z440.		
#	G269	Cannulation of central vein for pressure measurements or for feeding line - not to be billed with right heart catheterization (Z439) or with Swan-Ganz catheter insertion	31.25	
#	G270	Intraosseous infusion	23.90	
#	G309	Umbilical artery catheterization (including obtaining of blood sample)	45.55	
		Venipuncture		
+	G480	- infant	9.90	
+	G482	- child	7.35	
+	G489	- adolescent or adult	3.54	
		G489 is not insured when rendered for the monitoring of adverse effects resulting from a calorie restricted weight loss program.		
+	G483	Therapeutic venisection	9.70	
	G282	Umbilical vein catheterization (including obtaining of blood sample)	19.90	
#	Z438	Insertion of Swan-Ganz catheter (not included in anaesthetic, respiratory or critical care benefits)	162.50	6
		Z438 includes dye dilution densitometry and/or thermal dilution studies, when rendered (except in the setting of a cardiac catheterization laboratory).		
		See G285 for dye dilution densitometry and G286 for thermal dilution studies performed using a Swan-Ganz catheter in a cardiac catheterization laboratory.]		
#	Z456	Insertion of implantable central venous catheter	168.00	6
#	Z457	Surgical removal or repair of implanted central venous catheter	48.90	6
#	Z446	Insertion of subcutaneous venous access reservoir	168.00	6
#	Z447	- revision same site	74.05	6
#	E684	- when performed in infant or child, to Z456 or Z446 ..... add	214.10	

FOR ANTICOAGULANT SUPERVISION - LONG-TERM, TELEPHONE ADVICE

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

A. Monitoring the condition of a patient with respect to anticoagulant therapy, including ordering blood tests, interpreting the results and inquiry into possible complications.

B. Adjusting the dosage of the anticoagulant therapy and, where appropriate, prescribing other therapy.

C. Discussion with, and providing advice and information to the patient or patient's representative, by telephone, on matters related to the service even when initiated by the patient or patient's representative.

D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G271	Anticoagulant supervision - long-term, telephone advice ..... per month	12.75	

			Fee	Anae
		BLOOD TRANSFUSIONS		
#	G275	Exchange transfusion	205.45	
		Assistant at exchange transfusion (see General Preamble GP54).		
#	G280	Intra-uterine fetal transfusion - initial or subsequent	186.90	
	G276	Donor cell pheresis (platelets or leukocytes)	15.35	
		Therapeutic plasma exchange		
#	G277	- initial and repeat, to a maximum of 5 per year ... each	82.00	
#	G278	- more than 5 per year ... each	41.80	
#	G272	Manual plasmapheresis (see General Preamble GP8)	I.C	
		LDL apheresis		
#	G287	- initial and repeat, to a maximum of 5 per year ... each	82.00	
#	G290	- more than 5 per year ... each	41.80	
		LDL apheresis is an insured service only for the treatment of homozygous familial hypercholesterolemia.		
		CARDIOVERSION		
#	Z437	Cardioversion (electrical and/or chemical) - maximum of three sessions per patient, per day	92.45	6
		CARDIAC CATHETERIZATION		

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

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

		HAEMODYNAMIC/FLOW/METABOLIC STUDIES		
		Right heart		
#	Z439	- pressures only	166.90	6
		Left heart		
#	Z440	- retrograde aortic	210.55	7
#	Z441	- transeptal	297.15	7
#	G296	Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab	110.95	
#	G285	Dye dilution densitometry when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438 ... add	32.90	
#	G286	Thermal dilution studies when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438 ... add	32.90	

Note:

1. G296 is *not eligible for payment* on the same patient, same *day* as Z438.

2. G296, G299 and/or G289 are *not eligible for payment* with anaesthesia services rendered for a surgical procedure.

3. G285 or G286 are *not eligible for payment* on the same patient, same *day* as G296.

4. G285 is limited to a maximum of three services per Swann-Ganz insertion.

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

CARDIOVASCULAR

			Fee	Anae
		ANGIOGRAPHY		
#	G297	Angiograms (only two angiograms may be billed - one per right heart catheterization and one per left heart catheterization) irrespective of the number of chambers injected	118.70	
		Bypass graft angiogram		
#	G509	- maximum one per bypass graft	80.40	
		Note: Includes internal mammary artery implant.		
		Selective coronary catheterization		
#	Z442	- both arteries	289.55	6
#	G263	- with other drug interventional studies ..... add	97.40	
		Note: Includes injection of intracoronary nitroglycerin.		
		Transluminal coronary angioplasty		
#	Z434	- one or more sites on a single major vessel	471.60	6
	G262	- each additional major vessel ..... add	212.45	
		Note: If anatomy unknown at time of procedure, claim G297 at 50%.		
#	G298	Coronary angioplasty stent, per stent	78.95	
		Note: J058 claimed same patient same *day* as G298 is payable at nil.		
		Percutaneous angioplasty		
#	Z448	- aortic valve, pulmonic valve, pulmonary branch stenosis	487.90	20
#	Z449	- for coarctation of aorta	415.15	20
#	Z460	- closure of patent ductus arteriosis with umbrella	377.55	20
#	Z461	- mitral valvuloplasty for rheumatic stenosis	566.20	
		Note: Z448 to Z461 includes angiography *with or without* pressure measurements.		

		Fee	Anae

ELECTROPHYSIOLOGY/ARRHYTHMIAS

#	G249	Electrophysiologic measurements (includes one or all of sinus node recovery times, HIS bundle measurements, conduction times and/or refractory periods), includes percutaneous access and insertion of electrodes	231.65	

Arrhythmia induction

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

#	G261	- atrial	331.05	
#	G259	- ventricular	383.30	

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

Electrophysiologic Pacing, Mapping and Ablation

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

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

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

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

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

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

CARDIOVASCULAR

			Fee	Anae
		Electrophysiologic pacing, mapping and ablation		
#	G178	- catheter ablation therapy	352.05	
#	G179	- repeat pacing, mapping and catheter ablation for additional distinct arrhythmia(s) without the use of an advanced mapping system	111.20	
		Note: G179 is *not eligible for payment* with Z423.		
#	Z424	- transseptal left heart catheterization, with or without pressure measurements, with or without dye injection	297.15	6
		Note: **1.** Z424 is *only eligible for payment* when rendered with G176, G177 and/or G178. **2.** Z424 is eligible for payment for each transseptal catheter placement to a maximum of 2.		
#	Z422	- retrograde aortic left heart catheterization with or without pressure measurement(s)	210.55	6
		Note: **1.** Z422 is *only eligible for payment* when rendered with G176, G177 and/or G178. **2.** Z422 is limited to a maximum of one per electrophysiological pacing, mapping and/or ablation sitting.		
	G115	External cardiac pacing (temporary transthoracic) once per 24-hour period	46.30	
		Note: G115 is *not eligible for payment* with G521, G522, G523, G395 and G391.		
#	G366	Testing of arrhythmia inducibility by acute administration of anti-arrhythmic or adrenergic drugs to a maximum of 2 per 24 hours	148.50	
		Note: G366 is *not eligible for payment* for the use of isoproterenol for arrhythmia induction when rendered with G261 and/or G259.		
#	Z443	Insertion of temporary endocardial electrode	154.10	6
#	Z431	Repositioning of temporary endocardial electrode	64.25	6
		Endomyocardial Biopsy		
#	G288	- transvascular, right or left	200.00	
		Tilt table testing of vasomotor syncope		
#	G314	- to include arterial cannulation, provocative and blocking drugs, physician must be continually present	112.00	

ELECTROCARDIOGRAPHY (ECG)

PREAMBLE

1. ECGs may be requested by a Registered Nurse in the Extended Class (RN(EC)) in non-urgent and non-acute circumstances. Physicians and hospitals should use Fee Codes G313 and G310 for requests by RN(EC)s.
2. An ECG ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department is insured when the ECG is rendered:
   a. in connection with a dental surgical procedure provided by an oral and maxillofacial surgeon in a hospital and it is medically necessary for the patient to receive the dental surgical procedure in a hospital; or
   b. on the order of an oral and maxillofacial surgeon who has reasonable grounds to believe that a dental surgical procedure, performed by an oral and maxillofacial surgeon, will be required in connection with the ECG and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.
3. The technical and professional fee components for electrocardiogram, G310 and G313, are *not eligible for payment* in the routine preoperative preparation or screening of a patient for non-cardiac surgery unless the patient has at least one risk factor for cardiac disease or has known or suspected cardiorespiratory disease including dysrhythmias, unless there is a clinical indication requiring an ECG other than solely for preoperative preparation of the patient.
   1. Risk factors *may include* but are not limited to:
      hypertension, diabetes, vascular disease, renal disease, hyperlipidemia, smoking history, older age.
   2. ECG testing is not indicated prior to low risk surgery under local anaesthetic *with or without* procedural sedation such as cataract surgery unless there is an independent clinical indication unrelated to the surgery.]

		Fee
G175	Insertion of oesophageal electrode in monitoring position	21.85

		T	P
	Electrocardiogram - twelve lead		
G310	- technical component	6.60	
G313	- professional component - must include written interpretation		4.45

G310 and G313 are *not eligible for payment* when rendered to a patient who does not have symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

ELECTROCARDIOGRAPHY (ECG)

		T	P

STRESS TESTING

Maximal stress ECG

Maximal stress ECG (exhaustion, symptoms or ECG changes) or submaximal stress ECG (to target heart rate for patient) by a standard technique - with treadmill or ergometer and oscilloscopic continuous monitoring including ECGs taken during the procedure and resting ECGs before and after the procedure - physician must be in attendance at all times. The *professional component* includes the necessary clinical assessment immediately prior to testing.

G315	- technical component		43.50	
G319	- professional component			62.65

Dobutamine stress test

G174	- technical component, when rendered outside of hospital	add	46.75	

Dipyramidole Thallium stress test

G111	- technical component		50.75	
G112	- professional component			75.00

1. The technical and professional fee components for maximal stress ECG are *not eligible for payment* in the routine preoperative preparation or screening of a patient for surgery where the patient will undergo a low risk procedure or has a low risk of per*iop*erative cardiac complications, unless there is a clinical indication requiring a exercise stress test study other than solely for preoperative preparation of the patient.
2. G315, G319, G174, G111 and G112 are *uninsured service*s for routine annual stress tests in asympt*oma*tic patients where the patient's 10 year risk of coronary heart disease is less than 10% calculated by generally accepted methodology.

An example of a generally accepted methodology for determining 10 year risk of coronary heart disease is the Framingham Risk Score.

1. Studies have indicated that for non cardiac surgery, there may be no clinical benefit and there may be harm in performing functional cardiac testing in patients with low operative risk and little or limited benefit in moderate risk patients. BMJ 2010, Jan 28; 340.
2. One example of a generally accepted guideline is the American College of Cardiology (ACC)/ American Heart Association (AHA) Guidelines that states:
   a. Non invasive testing could be considered in patients with 1 to 2 risk factors and poor functional capacity (less than 4 mets) who require intermediate risk surgery if it will change management (class IIb)
   b. Non invasive testing has not been show to be useful in patients with no clinical risk factors undergoing intermediate risk non cardiac surgery (class III).
   c. Non invasive testing has not been shown to useful in patients undergoing low risk non cardiac surgery (class III).]

ELECTROCARDIOGRAPHY (ECG)

		T	P

CONTINUOUS ECG MONITORING (E.G. HOLTER)

Level 1

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

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

Level 2

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

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

Note:

1. Maximum one *professional component*, one technical recording component and one technical scanning component per patient, per recording.
2. Where the duration of the service is more than 36 hours, claims for such services must be submitted using the appropriate listed code for that time duration and cannot be submitted using multiples of lesser time duration codes.

ELECTROCARDIOGRAPHY (ECG)

		T	P	P2
	Cardiac loop monitoring (per 14 day test)			
	Patient interactive technology continuously capable of capturing retrospective real-time ECG data and of transferring this data to a remote base station for analysis and interpretation.			
G692	- technical component	168.45		
G690	- professional component, interpretation		122.25	
	Event recorder			
G661	- technical component	4.00		
G660	- professional component		8.65	
	Interpretation of telephone transmitted ECG rhythm strip			
G311	- technical component	1.92		
G320	- professional component (P2)			4.30
	Single chamber reprogramming including electrocardiography			
G284	- technical component	8.80		
G283	- professional component		11.30	
	Dual chamber reprogramming including electrocardiography			
G181	- technical component	11.55		
G180	- professional component		16.95	
	Pacemaker pulse wave analysis including electrocardiography			
G308	- technical component	8.80		
G307	- professional component		9.55	
	Automatic implantable defibrillator			
	Non-programmable including electrocardiography, interrogation and analysis			
G317	- professional component		27.80	
	Programmable including electrocardiography, interrogation and reprogramming			
G321	- professional component		47.65	

NON-INVASIVE CARDIOGRAPHY

		Fee
	BLOOD FLOW STUDY (DOPPLER OR OTHER) - UNILATERAL OR BILATERAL	
G517	Ankle pressure determination, includes calculation of the ankle-arm index systolic pressure ratio	10.05

Note:

1. G517 is *not eligible for payment* when rendered during surgery or during the patient's post-operative stay in hospital.

2. G517 is *not eligible for payment* in conjunction with J200/J500.

		T	P
	Phlebography and/or carotid pulse tracing (with systolic time intervals)		
G519	- technical component	10.35	
G518	- professional component		11.20
	Impedance plethysmography		
G121	- technical component	12.55	
G120	- professional component		7.00
	Digital photoplethysmography		
G127	- technical component, per extremity	12.55	
G126	- professional component, per extremity		7.00

ECHOCARDIOGRAPHY

T	P1	P2

PREAMBLE

1. P1 is the professional fee for the performance of some or all of the procedure by a suitably trained physician or alternatively, the same physician being physically present in the echocardiography laboratory to supervise the procedure, interpret the results and provide a written report. P2 is the professional fee for interpretation of the results (the video tape or digital images must be reviewed in its entirety by the physician) and provision of a written report by a suitably trained physician.
2. Echocardiography services include cardiac monitoring and/or oximetry when rendered.
3. The technical and professional fee components for echocardiography are *not eligible for payment* in the routine preoperative preparation or screening of a patient for surgery, unless there is a clinical indication requiring an echocardiogram other than solely for preoperative preparation of the patient.

   Patients should only be considered for preoperative testing if the results of the test will change their management.]

Complete Study - 1 and 2 dimensions

Definition/Required elements of service:

A Complete Study – 1 and 2 dimensions is an echocardiogram that must include as a minimum all of the following components: acquisition, recording and storage of ultrasound images relevant to the assessment of all components of cardiac structure and function including chambers, valves, septae, pericardium and proximal great vessels.

Note:
Where one or more components of cardiac structure and function cannot be imaged due to circumstances beyond the physician's control the echocardiogram is payable as a complete echocardiogram.

[Commentary:
If a single component of cardiac structure and function is imaged see G574/G575.]

		T	P1	P2
G570	- technical component	74.55		
G571	- professional component (P1)		74.10	
G572	- professional component (P2)			55.40

Medical record requirements:
G570, G571 and G572 are *only eligible for payment* for an echocardiogram when:

1. The required components and findings of a complete study are documented;
2. There is a permanent recording on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements; and
3. If applicable, a description of the circumstance beyond the physician's control leading to one or more components of the echocardiogram not being rendered.

ECHOCARDIOGRAPHY

	T	P1	P2

Stress Study

Definition/Required elements of service:

A stress echocardiography study includes the following required elements:

1. Initial baseline study of all components of cardiac structure and function including chambers, valves and septae;
2. Stress images which *may include* various stages of stress and must include relevant peak or immediate post stress images relevant to the patient's clinical and diagnostic findings; and
3. A simultaneous comparison of all left ventricular wall segments and global function obtained from pre-stress and stress images.

[Commentary:
Stress images may be obtained when the stress is induced by exercise, pharmacologic agents or pacing.]

		T	P1	P2
G582	- technical component	90.60		
G583	- professional component (P1)		91.55	
G584	- professional component (P2)			72.85

Payment rules:
G570, G571, G572, G574 or G575 are *not eligible for payment* with G582, G583 or G584.

Medical record requirements:
G582, G583 or G584 are *only eligible for payment* for an echocardiogram when:

1. The required components of the study and any findings from the simultaneous comparison of pre-stress and stress images are documented in the echocardiogram report; and
2. There is a permanent recording acquired with a high frame rate and includes the time from cessation of exercise on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements.

Cardiac Doppler study, with or without colour doppler, in conjunction with complete 1 and 2 dimension echocardiography studies

Definition/Required elements of service:

Acquisition, recording and storage of spectral and colour Doppler images relevant to the assessment of cardiac function including quantification of intraventricular flow and obstruction, valvular stenosis and regurgitation, intracardiac shunts, and diastolic function.

		T	P1	P2
G577	- technical component	44.00		
G578	- professional component (P1)		36.90	

Note:
G577 is *not eligible for payment* in the absence of a claim for G578.

Medical record requirements:Medical record requirements:
G577 and G578 are *only eligible for payment* for an echocardiogram when:

1. The required components of the Cardiac Doppler study have been documented; and
2. There is a permanent recording on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements.

ECHOCARDIOGRAPHY

		T	P1	P2

Focused Study - not to be claimed in conjunction with pregnancy study

Definition/Required elements of service:

An examination limited to a single component of the cardiac assessment.

[Commentary:
Examples where a focused study may apply are:
1. Emergency assessment to guide immediate patient management.
2. Follow up within 2 *week*s of a complete study to re-evaluate a specific finding or question.]

G574	- technical component	16.05		
G575	- professional component (P1 or P2)		17.45	17.45

Medical record requirements:
G574 and G575 are *only eligible for payment* for a focused echocardiography study when:

1. The component of the cardiac assessment and findings are documented; and
2. There is a permanent recording on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements.

Echocardiography contrast

G585	- technical component, with use of contrast agent, to G570 or G582	add	126.75

Payment rules:
1. G585 is *only eligible for payment* with a complete study or stress study in difficult-to-image patients where:
- **a.** two or more contiguous segments are not seen on a recent non-contrast echocardiogram images;
- **b.** the contrast agent is bubble-based with a diameter 5 microns or less, with resonance frequencies in the diagnostic ultrasound range and the contrast agent is able to cross the pulmonary circulation; and
- **c.** *professional component* (P1) G571 or G583 is eligible for payment for the same echocardiography study.

2. G585 is *only eligible for payment* if the physician performing the service establishes they:
- **a.** Have Level III (advanced) echocardiography training, with experience in administering and interpretation of contrast echocardiography; or
- **b.** Have Level II (basic prerequisites for independent competence in echocardiography) training, plus additional training in contrast echocardiography to learn the appropriate techniques for administering contrast agents and interpreting contrast-enhanced echocardiograms.
- **c.** Started practice prior to January 1, 1990 and:
  - **i.** was trained to applicable echocardiography standards at the time of starting practice;
  - **ii.** has rendered and been paid for echocardiography services regularly since January 1, 1990;
  - **iii.** has rendered and been paid for at least 1800 echocardiograms in total in the 36 *month*s prior to September 1, 2011; and
  - **iv.** has additional training in contrast echocardiography to learn the appropriate techniques for administering contrast agents and interpreting contrast-enhanced echocardiograms.

Note:
Documentation of requirements 2a-c must be available to the ministry on request.

[Commentary:
1. Additional training in contrast echocardiography can be obtained through courses, tutorials and preceptorships as examples.]

2. The *MOHLTC* and the *OMA* will review utilization of this service in 2012.]

Medical record requirements:
G585 is *not eligible for payment* unless a permanent record of study images and loops is maintained on an appropriate dynamic medium, either videotape or digitally.

Transoesophageal echocardiography

G581	- professional component (P1)		25.00

ECHOCARDIOGRAPHY

			Fee
G579	Saline study (including venipuncture, to G571, G574, G581 or G584	add	11.35
G580	Insertion of oesophageal transducer		45.00

Note:
Peripheral Arterial and Venous Systems - see listings under Diagnostic Ultrasound.

[Commentary:
The Provision of Echocardiography in Canada guidelines of the Canadian Cardiovascular Society and the Canadian Society of Echocardiography can be found at the following internet link: http://www.ccs.ca/download/consensus_conference/consensus_conference_archives/2004_Echo.pdf]

		Fee

LIFE THREATENING CRITICAL CARE

The service rendered when a physician provides critical care to a critically ill or critically injured patient. For the purpose of this service, a critical illness or critical injury is one that acutely impairs one or more vital organ system(s) causing vital organ system failure as a result of which imminent life threatening deterioration in the patient's condition is highly probable.

[Commentary:
Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and or respiratory failure.]

Amount payable per physician per patient for the first three physicians:

G521	- first ¼ hour (or part thereof)	110.55
G523	- second ¼ hour (or part thereof)	55.20
G522	- after first ½ hour, per ¼ hour (or part thereof)	36.35
G391	Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof)	28.35

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same *day* as any code described as "life threatening critical care":

1. Assessment and ongoing monitoring of the patient's condition.
2. Intravenous lines.
3. Cutdowns.
4. Arterial and/or venous catheters.
5. Central venous pressure (CVP) lines.
6. Endotracheal intubation.
7. Tracheal toilet.
8. Blood gases.
9. Nasogastric intubation with/without anaesthesia with/without lavage.
10. Urinary catheters.
11. Pressure infusion sets and pharmacological agents.
12. Defibrillation.
13. Cardioversion.

Payment rules:

1. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions on the patient receiving the "life threatening critical care". The service is *only eligible for payment* for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located. Time unit total *may include* time which is consecutive or non-consecutive.
2. During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients.
3. "Life threatening critical care" is *not eligible for payment* for the services of a physician rendered to the same patient on the same *day* for which the physician is paid a per diem fee for Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.
4. Consultation or assessments rendered before or after provision of "life threatening critical care" may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.

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

[Commentary:
Time unit total *may include* time which is consecutive or non-consecutive.]

CRITICAL CARE

Fee

OTHER CRITICAL CARE

The service rendered when a physician provides resuscitation assessment and procedures in an emergency in circumstances other than those described as "life threatening critical care", where there is a potential threat to life or limb of such a type that without resuscitation efforts by the physician, there is a high probability the patient will suffer loss of limb or require "life threatening critical care".

Amount payable per physician per patient for the first three physicians:

G395	- first ¼ hour (or part thereof)	56.80
G391	- after first ¼ hour per ¼ hour (or part thereof).....	28.35

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same *day* as any code described as "other critical care":

1. Assessment and ongoing monitoring of the patient's condition.
2. Intravenous lines.
3. Cutdowns.
4. Arterial and/or venous catheters.
5. Central venous pressure (CVP) lines.
6. Endotracheal intubation.
7. Tracheal toilet.
8. Blood gases.
9. Nasogastric intubation with/without anaesthesia with/without lavage.
10. Urinary catheters.
11. Pressure infusion sets and pharmacological agents.

Payment rules:

1. G395 is *not eligible for payment* with G521, G522 or G523 for services rendered to the same patient by the same physician on the same *day*.
2. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions on the patient receiving "other critical care". The service is *only eligible for payment* for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located. Time units *may include* time which is consecutive or non-consecutive.
3. During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients.
4. "Other critical care" is *not eligible for payment* for the services of a physician rendered to the same patient on the same *day* for which the physician is paid a per diem fee for Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.
5. Consultation or assessments rendered before or after provision of "other critical care" may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.

Medical record requirements:

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

[Commentary:

Time unit total *may include* time which is consecutive or non-consecutive.]

CRITICAL CARE

Fee

[Commentary:
Life threatening critical care and other critical care
The duration of "life threatening critical care" and "other critical care" services that physicians should document is the time they actually spend evaluating, managing, and providing care to the critically ill or injured patient to the exclusion of all other work.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be included in the definition of critical care, even when it does not occur at the bedside, if this time represents their full attention to the management of the critically ill/injured patient.

Time spent involved in activities in any location other than the bedside, emergency department or hospital floor where the patient is located cannot be claimed as the physician is not immediately available to the patient.

Submit claims manually when the total time spent in providing "life threatening critical care" or "other critical care" is greater than two (2) hours.]

G303	Transthoracic pacemaker - insertion	51.25
G211	Endotracheal intubation for resuscitation (not to be claimed when followed by a surgical procedure at which time it is included in the anaesthetic procedure) ...	38.35

CRITICAL CARE PER DIEM LISTINGS

A. The fees under physician-in-charge (the physician(s) daily providing the critical care services) apply per patient treated, i.e. while the physician-in-charge may change during the course of treatment, the daily fee formula as set out should be claimed by the physicians involved as if there was only one physician-in-charge during the treatment program; in this sense, the daily fees are team fees.

B. When claiming Critical, Ventilatory, Neonatal Intensive Care or Comprehensive Care fees no other Critical Care codes may be paid to the same physician(s).

C. Other physicians other than those providing Critical Care or Comprehensive Care may claim the appropriate consultation, visit and procedure fees not listed in the fee *schedule* for Critical Care. These claims will be adjudicated by the *Medical Consultant* in an Independent Consideration basis.

D. If Ventilatory Support only is provided, for example, by the anaesthetist(s), claims should then be made under Ventilatory Support. Comprehensive Care and Neonatal Intensive Care fees do not apply.

E. Other physicians should then claim Critical Care fees or the appropriate consultation, visit or procedures.

F. If the patient has been discharged from the Unit more than 48 hours and is re-admitted to the Unit, the 1st *day* rate applies again on the *day* of re-admission.

G. The appropriate consultation, assessment and procedural benefits apply after stopping Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.

H. Unless otherwise stated, the Critical Care per diem fees should not be claimed for stabilized patients and those patients who are in an intensive care unit for the purposes of monitoring. The appropriate consultation, assessment and procedural benefits apply.

		Fee

CRITICAL CARE (INTENSIVE CARE AREA)

Critical Care is the service rendered by a physician for providing, in an Intensive Care Area, all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, emergency resuscitation, intravenous lines, cutdowns, intraosseous infusion, pressure infusion sets and pharmacological agents, insertion of arterial, C.V.P. or urinary catheters and nasogastric intubation *with or without* anaesthesia, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases, and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). Except when a patient is on a ventilator, these fees are not payable for services rendered to stabilized patients in I.C.U.s, or patients admitted for ECG monitoring or observation alone. If the patient has been transferred from comprehensive care to critical care, the *day* of the transfer shall be deemed for payment purposes to be the second *day* of critical care.

Physician-in-charge

#	G400	- 1st day		223.10
#	G401	- 2nd to 30th day, inclusive	per diem	146.45
#	G402	- 31st day onwards	per diem	58.60

VENTILATORY SUPPORT (INTENSIVE CARE AREA)

Ventilatory Support includes provision of ventilatory care including initial consultation and assessment of the patient, intravenous lines, endotracheal intubation with positive pressure ventilation including insertion of arterial C.V.P lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, transcutaneous blood gases and assessment. If the patient has been transferred from comprehensive care to ventilatory care, the *day* of the transfer shall be deemed for payment purposes to be the second *day* of ventilatory care.

Physician-in-charge

#	G405	- 1st day		193.45
#	G406	- 2nd to 30th day, inclusive	per diem	101.55
#	G407	- 31st day onwards	per diem	67.60

COMPREHENSIVE CARE (INTENSIVE CARE AREA)

Comprehensive Care is the service rendered by an Intensive Care physician who provides complete care (both Critical Care and Ventilatory Support as defined above) to Intensive Care Area patients. This service includes the initial consultation and assessment and subsequent examinations of the patient, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, cutdowns, intraosseous infusion, arterial and/or venous catheters pressure infusion sets and pharmacological agents, insertion of C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric intubation *with or without* anaesthesia, securing and interpretation of blood gases and laboratory tests, oximetry, transcutaneous blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). Except when a patient is on a ventilator, these fees are not payable for services rendered to stabilized patients in I.C.U.s or patients admitted for E.C.G. monitoring or observation alone. If the patient has been transferred from critical care to comprehensive care, the *day* of the transfer shall be deemed for payment purposes to be the second *day* of comprehensive care.

Physician-in-charge

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

		Fee

NEONATAL INTENSIVE CARE

Neonatal Intensive Care is the service rendered by a physician for being in constant or periodic attendance during a one-*day* period, to provide all aspects of care to Intensive Care Area patients. This consists of an initial consultation or assessment and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition and the following procedures as required: insertion of arterial, venous, C.V.P. or urinary catheters, intravenous lines, interpreting of blood gases, nasogastric intubation *with or without* anaesthesia, pressure infusion sets and pharmaceutical agents, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support. Separately billable interventions may be claimed in addition to these fees. There are three levels of neonatal intensive care depending on the procedures performed.

Level A

Full life support including monitoring (either invasive or non-invasive), ventilatory support and parenteral alimentation (all modalities)

#	G600	- 1st day		358.00
#	G601	- 2nd to 30th day, inclusive	per diem	178.95
#	G602	- 31st day onwards,	per diem	89.40
#	G603	Neonatal low volume intensive care - payable in lieu of G600 or G604 if sole newborn to maximum of 25 services per physician per fiscal year		536.95
#	G604	Neonatal low birth weight intensive care - payable in lieu of G600 or G603 for newborn less than 750 grams in weight or 26 weeks gestational age		536.95

Level B

Intensive care including monitoring (invasive or non-invasive), oxygen administration and intravenous therapy, but without ventilatory support

#	G610	- 1st day		245.65
#	G611	- 2nd day onwards,	per diem	122.80

Level C

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

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

Note:

1. Physician-in-charge is the physician(s) daily providing the Neonatal Intensive Care.

2. These are team fees which apply to neonatologists /paediatricians/anaesthetists providing complete care. If *infant* has been transferred from one level to another in either direction, up or down, second *day* benefits apply.

			Fee

HYPERBARIC OXYGEN THERAPY (HBOT)

Hyperbaric Oxygen Therapy is the service rendered when a physician administers and supervises HBOT. Time is calculated based on the period of physician supervision while each patient receives HBOT inside the chamber. The *specific elements* of HBOT are those of an assessment, including ongoing monitoring of the patient's condition and intervening as appropriate.

Physician in constant attendance

Physician in chamber with patient(s), per session per patient

#	G800	- first ¼ hour	83.80
#	G801	- after first ¼ hour (per ¼ hour or major part thereof)	41.90
#	G802	- after 2 hours in chamber (per ¼ hour or major part thereof)	83.80

Physician in hyperbaric unit but not in chamber(s) with patient(s), per session per patient

#	G804	- first ¼ hour	71.85
#	G805	- after first ¼ hour (per ¼ hour or major part thereof)	35.90

Payment rules:

1. A consultation or assessment is eligible for payment with HBOT when rendered.

2. If the physician is in the chamber, time calculated for HBOT *may include* time the physician devotes to separately billable interventions rendered to a patient provided that such interventions take place in the chamber during a period of continuous, uninterrupted HBOT.

[Commentary:

1. If the physician is outside the chamber, the time eligible for payment of HBOT does not include time spent rendering any separately billable intervention(s) during which the HBOT is interrupted or discontinued.

2. For multi-patient sessions, the time eligible for payment of HBOT is measured as the period of physician supervision (either inside or outside of the chamber) for each patient, subject to payment rule #2.]

Medical record requirements:

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

Note:

1. HBOT is insured only for the treatment of those internationally recognized indications approved by the ministry.

2. HBOT is *only eligible for payment* for idiopathic sudden sensorineural hearing loss (ISSHL) when the following conditions are met:

- **a.** The patient is treated concurrently with corticosteroid unless corticosteroids are contraindicated; and
- **b.** The treatment is initiated within 14 days of a diagnosis of ISSHL is made or confirmed by an Otolaryngologist.

			Fee

Physician not in constant attendance

The service rendered when a physician supervises HBOT but is not physically present in the hyperbaric unit with the patient, but present in the facility and available to intervene in a timely fashion.

#	G807	- not in the hyperbaric unit, supervision	35.75

Payment rules:

1. G807 is limited to a maximum of one per patient per *day*.

2. G807 is limited to a maximum of 3 per physician per *day*.

3. G807 is *not eligible for payment* for the same patient, same *day* as G800, G801, or G802.

4. G805 is limited to a maximum of three units when claimed with G807 same patient same *day*.

Medical record requirements:

The medical record must demonstrate that there has been contact and/or direction provided to the hyperbaric unit in circumstances where G807 is claimed, otherwise the service is *not eligible for payment*.

[Commentary:

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

- air or gas embolism
- carbon monoxide poisoning and/or cyanide poisoning
- clostridial myositis and myonecrosis (gas gangrene)
- crush injury, compartment syndrome, and other acute traumatic ischemias
- decompression sickness
- enhancement of healing in selected problem wounds
- exceptional blood loss
- intracranial abscess
- necrotizing soft tissue infections (subcutaneous tissue, muscle, fascia)
- osteomyelitis (refractory)
- delayed radiation injury (soft tissue and bony necrosis)
- skin grafts and flaps (compromised)
- thermal burns
- idiopathic sudden sensorineural hearing loss (ISSHL)]

Hypothermia induction

#	G210	Hypothermia (therapeutic) induction and management.....	190.75

ICU/NICU admission assessment fee

	G556	- ICU/NICU admission assessment is an initial visit rendered during night time (00:00-07:00), to G400, G405, G557, G600, G603, G604, G610 or G620 ..... add	136.40

Payment rules:

G556 is payable once per patient per hospital admission.

		Fee

ULTRAVIOLET LIGHT THERAPY

Ultraviolet light therapy (general or local application) and/or Psoralen plus Ultraviolet A (PUVA) is an insured service only for treatment of dermatological conditions (maximum 1 per patient per *day*). G470 is an insured service payable at nil if rendered in a hospital in-patient or out-patient department or physiotherapy clinic prescribed as a health facility under sub-section 35(10) under Regulation 552 of the *Health Insurance Act*.

+	G470	Ultraviolet light therapy	7.85

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

DIALYSIS

			Asst	Fee	Anae
		Note: Team benefits to include listed items. This does not include preliminary investigation of the case.			
		Haemodialysis			
#	R849	Initial and acute (includes both medical and surgical components)		621.35	6
#	R850	Surgical component alone - insertion of Scribner shunt		313.25	7
	G325	Medical component alone		317.25	
#	G323	Acute, repeat - for the first 3 services		158.60	
#	G083	Continuous venovenous haemodialysis - initial and acute (for the first 3 services)		380.75	
#	G091	Continuous arteriovenous haemodialysis - initial and acute (for the first 3 services)		253.85	
#	G085	Continuous venovenous haemofiltration - initial and acute (for the first 3 services)		369.65	
#	G295	Continuous arteriovenous haemofiltration - initial and acute (for the first 3 services)		246.45	
		Note: Haemodialysis to include haemofiltration, haemoperfusion.			
		Continuous haemodiafiltration			
#	G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services)		444.15	
#	G092	Continuous arteriovenous haemodiafiltration - initial and acute (for the first 3 services)		317.25	
#	G094	Chronic, continuous haemodiafiltration		67.00	
		Slow continuous ultrafiltration			
#	G090	Venovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		317.25	
#	G294	Arteriovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		184.75	
#	G096	Chronic, slow continuous ultrafiltration		67.00	
		Revision of Scribner shunt			
#	Z450	- single		102.55	7
#	Z451	- both		152.40	6
#	Z452	De-clotting of Scribner shunt		93.60	
#	R843	Removal of cannula or A.V. shunt		101.00	7
#	R827	Creation of A.V. fistula	6	440.00	7
		Note: R827 - see also listing under Cardiovascular System, Veins - Repair.			
		Bypass graft for haemodialysis			
#	R851	- synthetic		444.70	7
#	R840	- autogenous vein		424.10	7
		Subclavian or external jugular catheter for haemodialysis			
#	G324	- insertion		102.95	
#	G336	- revision		17.65	
#	R848	Dialysis cannula insertion under vision into central line (excluding percutaneous)		219.15	6
#	G099	Percutaneous insertion of permanent jugular/femoral dialysis catheter (including subcutaneous positioning)		168.40	
#	G327	Insertion of femoral catheter for dialysis		77.30	
#	G312	Thrombolytic instillation into temporary and permanent percutaneous catheters		15.40	

DIALYSIS

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

Note:

1. E860 is *not eligible for payment* with R852 or R885, except in circumstances described in paragraph 23 of Surgical Preamble.
2. Z552, Z553 and S312 are *not eligible for payment* in association with R852 or R885.

		Tenckhoff type peritoneal catheter			
#	R853	- insertion, chronic by trocar		154.40	7
#	R854	- removal		63.10	
		Revision or repair of arterio-venous (AV) fistula or graft for haemodialysis			
#	Z464	Declotting by cannula, any method	nil	150.00	nil
#	R941	Thrombectomy, by open technique	7	350.00	10
#	R942	Ligation, removal or obliteration of AV fistula or graft for haemodialysis	6	250.00	6
#	R943	Revision and/or repair of AV fistula or graft by plication, imbrication, and/or resection, with or without thrombectomy	6	400.00	6
#	R944	Revision and/or repair of AV fistula or graft by angioplasty, patch or graft, and/or segment replacement, with or without thrombectomy	6	650.00	6
#	R945	Resection or repair of an AV fistula aneurysm(s), includes any necessary repair, with or without thrombectomy	6	975.50	6
#	R946	Brachio-basilic vein AV fistula transposition for haemodialysis	10	975.50	17

Note:

1. Z464 includes placement of the cannula, administration of contrast and/or therapeutic agent(s), and any image guidance, when rendered. Obtaining and interpreting any images in conjunction with Z464 are *not eligible for payment* to any physician.
2. R943 and R944 include revision and/or repair of both the venous and arterial components of the AV fistula or graft, when rendered.
3. Only one of R941, R942, R943, R944, R945 or R946 is eligible for payment per patient per *day*, any physician.
4. R946 includes placement, venography and any image guidance. Obtaining and interpreting any images in conjunction with R946 are *not eligible for payment* to any physician.
5. R946 includes any revision and/or re-anastomosis, when rendered.
6. R942 is *not eligible for payment* for the same patient on the same *day* as R841 and R833.

Fee

CHRONIC DIALYSIS TEAM FEE

Chronic Dialysis Team Fee is the all-inclusive benefit per patient per *week* for professional aspects of managing chronic dialysis and end-stage renal failure in dialysis patients. It is a modality independent fee and is equal in monetary value whether the dialysis is delivered in hospital, community or *home* and whether it is haemodialysis or peritoneal dialysis. The team fee includes the services of all physicians routinely or periodically participating in the patient's dialysis treatment at:

a. the patient's principal treatment centre; or

b. at a place other than the patient's principal treatment centre (auxiliary treatment centre) where 3 or more dialysis treatments are rendered to the patient during the 7-*day* period referred to below.

The amount payable is in respect of a 7-*day* period of care, commencing at midnight Sun*day* and is payable to the *most responsible physician*.

Except as set out below, the amount payable to another physician in respect of these services rendered to a patient in respect of whom a claim is submitted and paid for this code is nil.

When a full 7-*day* period of team care is not rendered at the patient's principal treatment centre due to absence of the patient with treatment at an auxiliary treatment centre, the amount claimed for treatment at the principal treatment centre is reduced on a pro rata basis to equal 1/7 of the *week*ly fee for each *day* that the patient is the responsibility of the principal treatment centre.

In addition to the *common elements* of insured services and the *specific elements* of Diagnostic and Therapeutic Procedures, the team fee includes the following elements:

A. All consultations and visits for management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients.

B. All consultations and visits within the scope of practice of nephrology and general internal medicine for assessment and treatment of complications of chronic dialysis and management of end-stage renal disease and its complications in chronic dialysis patients.

C. All related counselling, interviews, psychotherapy of patients and family members.

D. All related case conferences.

The team fee does not include:

A. Assessments and special visit premiums for emergent calls to the emergency department.

B. Admission assessments and subsequent visits to acute care hospital in-patients for treatment of complications of dialysis, chronic renal disease or intercurrent illness.

C. Any other diagnostic and therapeutic procedures, including acute dialysis treatments.

D. Consultations and assessments by *specialist*s in other than internal medicine or internal medicine sub-specialists other than nephrologists.

E. Primary care by the patient's family physician.

F. Assessment by a renal transplantation specialist for entry into a transplantation program.

G. Intermittent chronic haemodialysis treatment at an auxiliary treatment centre if fewer than three dialysis treatments are rendered to the patient in the 7-*day* period referred to above.

Chronic dialysis week**ly team fee**

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

Note:

1. Claim the code representing the predominant location and modality.

2. Where 3 or more treatments are rendered per 7-*day* period at an auxiliary treatment centre, the service comprises the chronic dialysis *week*ly team fee paid at the full amount, regardless of the number of treatments rendered.

ENDOCRINOLOGY AND METABOLISM

			Fee
+	G493	ACTH test - single or multiple, per injection	6.25
+	G337	Antidiuretic hormone response test including the 8 hour water deprivation test	16.95
+	G338	Clonidine suppression test (for the investigation of pheochromocytoma) - with physician present - includes venipunctures	24.90
		Glucagon test	
+	G494	- (Type A) for carbohydrate response	10.20
+	G495	- (Type B) for hypertension, pheochromocytoma and insulinoma provocative test (including cold pressor test)	42.30
	G358	Growth hormone exercise stimulation test with physician present (includes venipunctures)	24.90
+	G340	Histamine test to include a control cold pressor test	45.45
+	G341	Hypertonic saline infusion test	16.95
+	G342	Implantation of hormone pellets	31.05
+	G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination	49.80

Diabetes monthly management

The provision to a patient, patient's relative(s), patient's representative or other caregiver(s) of medical advice, direction or information by telephone, fax or e-mail in which a change in the frequency or dose of insulin therapy is initiated regarding a patient treated with insulin injections (2 or more daily) or insulin by pump (a "contact").

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

A. Monitoring the condition of a patient with respect to insulin therapy, including ordering blood tests, reviewing patient's glucose self-monitoring, interpreting the results and inquiry into possible complications.

B. Adjusting the type, frequency and dose of insulin therapy, and where appropriate, prescribing alternate or additional therapy.

C. Discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), by telephone, fax or e-mail on matters related to the service, regardless of identity of person initiating discussion.

D. Making arrangements for any related assessments, procedures and/or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G500	- month in which insulin injections (2 or more daily) or insulin by pump is initiated; or month in which initial assessment by a specialist of a diabetic patient treated with insulin injections (2 or more daily) or insulin by pump occurs, 1 or more contacts	31.80
G514	- each additional month, 1 to 3 contacts	10.60
G520	- each additional month, 4 or more contacts	21.20

Payment rules:

1. G500 is limited to a maximum of two per patient per lifetime.
2. G500, G514 and G520 are *only eligible for payment* when rendered by the physician most responsible for the patient's diabetes care or by a physician substituting for that physician ("the substitute physician").
3. The clinical decision(s) pertaining to the medical advice, direction or information provided must be formulated personally by the physician or substitute physician.
4. A contact rendered on the same *day* as a consultation or assessment by the same physician to the same patient does not constitute a contact for the purpose of G500, G514 or G520.
5. G500, G514 and G520 are *not eligible for payment* for reviewing laboratory reports, patient created reports, or for communicating results to a patient when no change in the frequency or dose of insulin therapy is required.
6. Only one of G500, G514 and G520 is eligible for payment per patient per physician per *month*.

Medical record requirements:

G500/G514/G520 is *only eligible for payment* when a dated summary of each contact is recorded in the patient's permanent medical record.

Fee

[Commentary:

1. The clinical decision(s) formulated by the physician or substitute physician may be communicated to the patient, patient's relative, patient's representative or other caregiver by a staff member other than the physician.
2. *Month* refers to a calendar *month*.
3. If G514 and G520 are claimed in the same *month* by the same physician for the same patient, the total fee eligible for payment will be adjusted to the value of G520.]

+	G498	Intravenous glucose tolerance test	10.20
+	G499	Intravenous tolbutamide test	49.80
+	G513	Pentagastrin stimulation for calcitonin	42.30
+	G344	Phentolamine test	42.30
+	G501	TRH or LHRH test, per injection	6.25
+	G490	Saralasin test	42.30

Open circuit indirect calorimetry

Isothermal environment employing a ventilated hood system, to include height and weight of the subject, measurement of subjects body fat using four skin folds. Determination of resting energy expenditure in a patient 12-14 hours post prandial to include measurement of O2 consumption and CO2 saturation.

	G515	Open circuit indirect calorimetry	46.30

		P1	P2
	Measurement of thermic effect of feeding		
	To follow 1 hour measurement of resting energy expenditure, subject is given a balanced test meal and then calorimetry measurements are taken for two hours, to include timed urine samples (2-3 hours) and urine nitrogen excretion measurements in a steady state condition, interpretation of results in context of patient's clinical status and written report.		
G516	Measurement of thermic effect of feeding	36.90	
	Oesophageal motility study(ies) with manometry		
G350	- standard, with physician in continuous attendance (P1)	89.45	
G343	- interpretation only (P2)		19.90
	Oesophageal acid perfusion test and/or provocative drug testing		
G353	- with physician in continuous attendance (P1)	33.80	
G252	- interpretation only (P2)		10.75
	Oesophageal pH study for reflux, with installation of acid		
G251	- standard, with physician in continuous attendance (P1)	33.80	
G351	- with 24 hour monitoring		39.80
G346	- tracing interpretation only (P2)		19.90
	Anal-rectal manometry		
G354	- with physician in continuous attendance (P1)	45.30	
G253	- interpretation only (P2)		10.65

GASTROENTEROLOGY

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

Note:

1. G254 is *not eligible for payment* in addition to a subsequent hospital visit or assessment.

2. G254 is *not eligible for payment* when rendered to an out-patient.

3. G254 is limited to a maximum of one service per patient per *day*.

4. G254 is *only eligible for payment* for a maximum of 2 *week*s post liver, lung or pancreas transplant surgery.

			Fee
	G349	Oesophageal tamponade (Blakemore bag) - insertion	45.30
		Gastric lavage	
+	G355	- diagnostic	9.60
	G356	- therapeutic - with or without ice water lavage	33.80
#	Z520	Change of gastrostomy tube	10.65
+	G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin) - procedure and supervision	19.55
	G352	Biliary tract provocative test with cholecystokinin	9.60
#	G322	Nasogastric intubation under general anaesthesia	9.60

			T	P
		Hydrogen breath test		
	G167	- technical component	6.60	
	G166	- professional component		10.45

			P
#	G332	Capsule endoscopy	122.25

Payment rules:

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

			Fee
	G367	Artificial insemination	34.50
	E542	- when performed outside hospital, to G367 add	11.15
	G363	Cervical mucous penetration test	22.00
+	G364	Postcoital test of cervical mucous	17.60
	G378	Insertion of intrauterine contraceptive device	25.50
	E542	- when performed outside hospital add	11.15
+	G362	Insertion of laminaria tent	6.25
	E870	- when laminaria tent supplied by the physician add	8.35
	G334	Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (not eligible for payment same day as visit), to a maximum of 10 per cycle per call	4.05
	G399	Transvaginal sonohysterography, introduction of catheter, with or without injection of contrast media	44.15

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

[Commentary:
See Diagnostic Ultrasound section page G6.]

Papanicolaou smear

+	G365	- periodic.	6.75
	E430	- when papanicolaou smear is performed outside of hospital, to G365 add	11.55

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

Payment rules:

1. G365 is limited to one per patient per 33 *month* period.
2. G365 is uninsured for patients less than 21 years of age.
3. G365 is uninsured for patients older than 70 years of age who have had three or more normal tests in the prior 10 years.
4. G365 is *not eligible for payment* when performed in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment or routine post-natal visit.

[Commentary:

1. Periodic Papanicolaou smears in excess of the limit are not insured.
2. Guidelines for cervical screening can be found at https://www.cancercare.on.ca/
3. Current guidelines recommend routine Pap smear screening once every 36 *months*. The schedule period of 33 *months* is in recognition that some patients may be seen just prior to the recommended time interval.]

+	G394	- additional for: - follow-up of abnormal pap smear; or - follow-up of inadequate pap smear; or - annually in a patient who is immunocompromised, e.g. HIV-positive or taking long-term immunosuppressants; or - a patient with a history of oncogenic HPV-typing; or - where the physician is of the opinion that the patient is a member of a vulnerable group that may have difficulty accessing the services within the specified time period	6.75

Physicians claiming G394 must have documentation of an abnormal or inadequate Pap result for which a follow-up is required or documentation of the cause of the immunocompromised status or documentation of difficulties in accessing the service within the specified time period otherwise G394 is *not eligible for payment*.

	E431	- when papanicolaou smear is performed outside of hospital, to G394 add	11.55

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

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

GYNAECOLOGY

		Fee
Z463	Removal of Norplant	65.30

Pessary

G398	Medical management of prolapse - initial pessary fitting or re-fitting as required. This service is eligible for payment in addition to any applicable consultation or assessment. Maximum one per patient per 12 month period	61.30

[Commentary:
G398 is *not eligible for payment* for routine follow-up insertion of a pessary as that service is included as an element of the assessment or consultation.]

		Fee

HAEMOGLOBINOPATHIES AND CONGENITAL HAEMOLYTIC ANAEMIAS

Transfusion support

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

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

G098	Transfusion support, per patient	per week	32.35

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

HOME/SELF-CARE HAEMOPHILIA

Services rendered by the specialist in charge of the patient.

Haemophilia infusion

Haemophilia infusion includes routine clinic visits (system/drug/infusions technique/blood work review and physical examination), counselling/psychotherapy/genetic counselling of patients and relatives and supervised haemophilia infusion when required. The *specific elements* of this service are all services performed by the specialist in charge of the patient during a one-*week* period in providing non-emergency care to the patient who is self administering haemophilia therapy, including providing any advice and supervision in regard to self administration, whether by telephone or otherwise and even when initiated by the patient, patient's relative(s), or their representative and including providing all premises, equipment, supplies and personnel used by the specialist in charge of the patient to perform these services.

G100 Haemophilia infusion, per patient ..... per week 32.35

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

HOME/SELF-CARE VENTILATION

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

a. services rendered by *most responsible physician*;

b. includes routine clinic visits, *home* visits, telephone advice, communication with family and other medical personnel, care of supervised tracheostomy, counselling/psychotherapy of patients and relatives and supervised ventilation when required.

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

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

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

		Fee
	BOTULINUM TOXIN SERVICES	
G870	Botulinum toxin injection(s) of extraocular muscle(s), (unilateral)	120.00
G871	Botulinum toxin injection(s) for blepharospasm, (unilateral or bilateral)	120.00
G872	Botulinum toxin injection(s) for hemifacial spasm, (unilateral or bilateral)	120.00
G873	Botulinum toxin injection(s) for spasmodic dysphonia	120.00
G874	Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral)	50.00
	Botulinum toxin injection for the following conditions: Oromandibular dystonia, limb dystonia, cervical dystonia or spasticity	
G875	First injection	40.00
G876	- each additional injection to a maximum of 11, to G875 add	10.00
	EMG and/or ultrasound guidance for Botulinum toxin injections	
G877	- with EMG guidance (when required to determine the injection site), for one injection, to G870, G873, G874, or G875 add	18.85
G878	- with EMG guidance (when required to determine the injection site), for two or more injections, to G870, G873, G874 or G876 add	28.10
E543	- use of disposable EMG hypodermic electrode outside hospital (maximum of one per patient per day), to G877 or G878 add	30.60
G879	- with ultrasound guidance (when required to determine the injection site), for one injection, to G870, G873, G874 or G875 add	18.85
G880	- with ultrasound guidance (when required to determine the injection site), for two or more injections, to G870, G873, G874 or G876 add	28.10

Payment rules:

1. When used to determine the injection site, EMG or ultrasound services other than G877, G878, G879 or G880 are *not eligible for payment* with Botulinum toxin services.

2. All Botulinum toxin services are limited to one treatment per condition, per patient every 10 *week*s. If, in the opinion of the treating physician, more frequent treatments are necessary, submit claim for manual review with supporting documentation. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

[Commentary:
Botulinum toxin injection(s) for indications other than those listed above are not insured services.]

INJECTIONS OR INFUSIONS

			Fee	Anae
+	G369	B.C.G. inoculation, following tuberculin tests	5.30	
+	G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	20.25	
	G371	- each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5	19.90	
	E542	- when performed outside hospital, to G370 ... add	11.15	
	G328	Aspiration of bursa or complex joint, with or without injection	39.80	
	G329	- each additional bursa or complex joint, to a maximum of 2	20.25	
	E542	- when performed outside hospital, to G328 ... add	11.15	
	E446	- peripheral joint injection using image guidance following a failed blind attempt, to G370 or G371 ... add	30.00	

Note:

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

a. a joint other than the knee; or

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

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

Payment rules:

1. G370, G371, G328 or G329 are *not eligible for payment* when rendered in conjunction with a surgical procedure involving the same site or area.

2. Only one of G370, G371, G328 and G329 is eligible for payment for the same bursa, joint or complex joint.

3. Aspiration and/or injection of the olecranon bursa is *only eligible for payment* as G370/G371.

4. G328/G329 are *not eligible for payment* solely for injection of complex joint.

5. G370, G371, G328, G329 are *uninsured service*s for injection of intra-articular viscosupplementation agents.

[Commentary:

1. Use of intra-articular viscosupplementation agent for treatment of osteoarthritis is not supported by evidence. An example of a viscosupplementation agent is hyaluronic acid. See http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/ohtas-reports-and-ohtac-recommendations/intra-articular-viscosupplementation-with-hylan-g-f-20-to-treat-osteoarthritis-of-the-knee

2. For percutaneous provocation vertebral discography, refer to J006 Discogram page E4.]

	G396	Injections of extensive keloids	24.90	
#	Z455	- under general anaesthesia	44.70	6

INJECTIONS OR INFUSIONS

			Fee	Anae
		INTRAMUSCULAR, SUBCUTANEOUS OR INTRADERMAL		
	G372	- with visit (each injection)	3.89	
	G373	- sole reason (first injection)	6.75	
	G372	- each additional injection	3.89	

Note:

1. G372, G373 includes interpretation.

2. G372, G373 are not insured for vitamin injections when rendered for the purpose of facilitating weight loss.

IMMUNIZATION

[Commentary:
The immunization service may not be insured under some conditions. See Appendix A for link to relevant regulation.]

Note:

1. Where the sole reason for the visit is to provide the immunization service add G700.

2. G700 service is only payable once per patient per *day*.

+	G840	Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP-IPV) - paediatric	4.50	
+	G841	Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric	4.50	
+	G842	Hepatitis B (HB)	4.50	
+	G843	Human Papillomavirus (HPV)	4.50	
+	G844	Meningococcal C Conjugate (Men-C)	4.50	
+	G845	Measles, Mumps, Rubella (MMR)	4.50	
+	G846	Pneumococcal Conjugate	4.50	
+	G847	Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult	4.50	
+	G848	Varicella (VAR)	4.50	
+	G538	Other immunizing agents not listed above	4.50	
+	G590	Influenza agent	4.50	
		INTRALESIONAL INFILTRATION		
+	G375	- one or two lesions	8.85	
+	G377	- 3 or more lesions	13.30	
	G383	- extensive (see General Preamble GP8)	I.C	

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

	G462	Administration of oral polio vaccine	1.65	
	G384	Infiltration of tissues for trigger point	8.85	
	G385	- for each additional site (to a maximum of 2) ..... add	4.55	

INJECTIONS OR INFUSIONS

			Fee
		INTRAVENOUS	
+	G376	Newborn or infant	10.20
+	G379	Child, adolescent or adult	6.15

Note:

1. G376 or G379 apply to cryoprecipitate infusion.
2. G376 or G379 may not be claimed with x-rays as they are included in the service.
3. Except for G381 or G281, injections into established I.V. apparatus may not be claimed.

	G389	Infusion of gamma globulin, initiated by physician, including preparation per patient, per day	13.90
+	G380	Cutdown including cannulation as necessary	27.05
	G387	Intravenous local anaesthetic infusion for central neuropathic pain	125.00

Payment rules:

1. G387 is only insured for patients with central neuropathic pain who have first undertaken but not responded to generally accepted medical therapy.
2. The physician submitting the claim for this service must remain in constant attendance during the infusion and no part of the procedure may be delegated or G387 is not payable.
3. G387 is limited to a maximum of 6 per patient per *12 month period*.

Medical record requirements:

The medical record for the service must document the prior medical therapy that the patient did not respond to or G387 is *not eligible for payment*.

[Commentary:

1. Central neuropathic pain is pain caused by a primary lesion or dysfunction that affects the central nervous system.
2. At the time of this amendment to the *Schedule* of Benefits, generally accepted medical therapy that would be required prior to G387 is treatment with both a tricyclic antidepressant and at least one anticonvulsant.
3. For Intravenous drug test for pain, see Z811 p. X1.]

SCLEROTHERAPY

Sclerotherapy is only insured for veins greater than 5 mm in diameter and associated with physical sympt*oma*tology and when *rendered personally by the physician*.

G536	Sclerotherapy including one post injection visit, unilateral	77.85
G537	Repeat sclerotherapy, unilateral	26.05

Note:

1. G536 and G537 include multiple injections and application of any necessary compression bandages.
2. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance are *not eligible for payment* in addition to G536 and G537.
3. Assistant units nil for G536, G537.

SPECIFIC ELEMENTS

For Management of parenteral alimentation

In addition to the *common elements*, this service includes the *specific elements* of assessments (see General Preamble GP11). Not to be claimed in addition to hospital visits.

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

Fee

CHEMOTHERAPY

Chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) - with administration supervised by a physician for intravenous infusion for treatment of malignant or autoimmune disease. The physician must be available to intervene in a timely fashion at the initiation and for the duration of the prescribed therapy to manage immediate and delayed toxicities.

Chemotherapy and patient assessment provided by a physician includes all patient assessments by any physician for a 24 hour period following treatment administration.

Note:

1. G381, G281, G345 and G359 are *only eligible for payment* with respect to the following classes of biologic agents:

a. monoclonal antibodies; and

b. cytokines.

2. G381, G281, G345, G359, G075 and G390 include venipuncture, establishment of any vascular access line and administration of agent(s).

[Commentary:
Examples that are not considered biologic agents for payment purposes are blood products, insulin, and immunizing agents.]

\+ G381 Standard chemotherapy - agents with minor toxicity that require physician monitoring 54.25

G281 - each additional standard chemotherapy agent, other than initial agent..... 7.70

[Commentary:
Examples of standard chemotherapy agents include cyclophosphamide, methotrexate, fluorouracil, leucovorin, and zoledronic acid.]

G345 Complex single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) that can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicities that may require immediate intervention by the physician 75.00

[Commentary:
Examples of complex single agents include rituxamib, bevacizumab, trastuzumab, anthracyclines, bortezomib, taxanes, cisplatin, and etoposide fludarabine.]

G359 Special single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician 105.15

[Commentary:
Examples of special agent therapy include high-dose methotrexate with folinic acid rescue, methotrexate given in a dose of greater than 1 g/m2, high dose cisplatin greater than 75 mg/m2 given concurrently with hydration and osmotic diuresis, high dose cystosine, arabinoside (greater than 2 g/m2), high dose cyclophosphamide (greater than 1 g/m2), ifosfamide with MESNA protection, combination of biologic agents with complex chemotherapy.]

G075 Test dose (bleomycin and l-asparatiginase) once per patient per drug 30.50

G390 Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy) 262.40

Monthly telephone supervision

G382 Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, monthly 13.30

Fee

Management of special oral chemotherapy

This is the service for the supervision of oral chemotherapy treatment for malignant disease where the agent(s) has a significant risk of toxicity in the period immediately following initiation. The physician must be available to intervene in a timely fashion for a 24 hour period following the initiation of the treatment.

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

a. evaluation of any relevant laboratory, diagnostic and/or imaging investigations; and

b. all discussion or advice, whether by telephone or otherwise, involving the patient, staff, patient's relative(s) or *patient's representative* related to the oral chemotharapy for a period of twenty-one (21) *day*s following initiation of the agent(s).

G388 Management of special oral chemotherapy, for malignant disease 20.50

Payment rules:

1. G388 is *not eligible for payment* for the same patient in the same *month* where G382 is payable.

2. G388 is *only eligible for payment* once every twenty-one (21) *day*s to a maximum of six (6) services per patient per *12 month period*.

[Commentary:
Examples of special oral chemotherapy include fludarabine, imatinib, dasatanib, nilotinib, erlotinib, capecitabine, sunitinib, sorafenib, thalidomide, temazolamide and lenalidomide.]

LABORATORY MEDICINE

SPECIFIC ELEMENTS

In addition to the *common elements*, all services listed under Laboratory Medicine include the following *specific elements*:

A. Interpretation of the results of the laboratory procedure.

B. Providing a written interpretative report of the procedure to the referring physician, if other than the interpreting physician.

C. Providing premises, equipment, supplies and personnel for any aspect(s) of the *constituent elements* that is (are) performed at a place other than the place in which the laboratory procedure is performed.

DEFINITIONS

L861 SURGICAL PATHOLOGY, LEVEL 1.

Gross examination without microscopic examination. This service includes any specimen for which, in the judgment of the examining physician, a diagnosis can be established by gross examination alone.

L862 SURGICAL PATHOLOGY, LEVEL 2.

Gross and microscopic examination for the purpose of confirming the identity of tissue and the absence of disease of the following specimens:

Appendix (incidental appendectomy); fallopian tube (sterilization); digit (traumatic amputation); hernia sac; hydrocele sac; nerve; skin (neonatal foreskin; plastic repair); sympathetic ganglion; testis (castration); vaginal mucosa (incidental); vas deferens (sterilization).

L863 SURGICAL PATHOLOGY, LEVEL 3.

Gross and microscopic examination of the following specimens:

Abscess; aneurysm; anal tag; appendix (other than incidental); artery or vein (ather*oma*tous plaque; varicosity); Bartholin gland cyst; bone (other than pathologic fracture); bursa or synovial cyst; carpal tunnel tissue; cartilage (shavings); cholesteat*oma*; colostomy st*oma*; conjunctiva (pterygium); cornea; diverticulum (digestive tract); Dupuytren contracture tissue; femoral head (other than fracture); fissure or fistula; gallbladder; ganglion cyst; haemat*oma*; haemorrhoid; hydatid of Morgagni; intervertebral disc; joint loose body; meniscus; mucocele (salivary); neur*oma* (traumatic; Morton); nasal or sinusoidal polyp (inflammatory); skin (acrochordon/tag; cyst; foreskin, other than neonate; debridement; pilonidal cyst or sinus); soft tissue (lip*oma*, debridement); spermatocele; tendon or tendon sheath; testicular appendage; thrombus or embolus; uterine contents (induced abortion); varicocele; vas deferens (other than sterilization).

L864 SURGICAL PATHOLOGY, LEVEL 4.

Gross and microscopic examination of the following specimens:

Artery (b*iop*sy); bone marrow (b*iop*sy); bone exostosis; brain or meninges (other than neoplasm resection); branchial cleft cyst; breast (b*iop*sy, not requiring microscopic evaluation of surgical margin; reduction mammoplasty); bronchus (b*iop*sy); cell block; cervix (b*iop*sy); digestive tract (b*iop*sy); endocervix (b*iop*sy or curettings); endometrium (b*iop*sy or curettings); extremity (traumatic amputation); fallopian tube (b*iop*sy; ectopic pregnancy); femoral head (fracture); digit (non-traumatic amputation); heart valve; joint (resection); kidney (b*iop*sy); larynx (b*iop*sy); lip (b*iop*sy; wedge resection); lung (transbronchial b*iop*sy); lymph node (b*iop*sy); muscle (b*iop*sy); nasal mucosa, nasopharynx or oropharynx (b*iop*sy); nerve (b*iop*sy); odontogenic or dental cyst; omentum (b*iop*sy); oral or gingival mucosa (b*iop*sy); ovary *with or without* fallopian tube (non-neoplastic); ovary (b*iop*sy, wedge resection); paranasal sinus (b*iop*sy); parathyroid gland; pericardium (b*iop*sy); peritoneum (b*iop*sy); pituitary gland (neoplasm); placenta (other than third trimester); pleura (b*iop*sy); polyp (cervical; endometrial; digestive tract); prostate (needle b*iop*sy; transurethral resection); salivary gland (b*iop*sy); skin (other than cyst / tag / debridement / plastic repair); synovium; spleen; testis (other than b*iop*sy, castration or neoplasm); thyroglossal duct cyst; tongue (b*iop*sy); tonsil or adenoid (b*iop*sy); trachea (b*iop*sy); ureter (b*iop*sy); urethra (b*iop*sy); urinary bladder (b*iop*sy); uterine contents (spontaneous or missed abortion); uterine leiomy*oma* (myomectomy); uterus *with or without* tubes and ovaries (for prolapse); vagina (b*iop*sy); vulva (b*iop*sy).

L865 SURGICAL PATHOLOGY, LEVEL 5.

Gross and microscopic examination of the following specimens:

Adrenal gland (resection); bone (b*iop*sy or curettings, pathologic fracture); brain (b*iop*sy); brain or meninges (neoplasm resection); breast (partial or simple mastectomy; excision requiring microscopic evaluation of surgical margin); cervix (conization); colon (segmental resection, other than neoplasm); extremity (non-traumatic amputation); eye (enucleation); kidney (partial or total nephrectomy); larynx (partial or total resection); liver (b*iop*sy or wedge or partial resection); lung (wedge b*iop*sy); lymph nodes (regional resection; sentinel); mediastinum (b*iop*sy); myocardium (b*iop*sy); odontogenic neoplasm; ovary *with or without* fallopian tube (neoplasm); pancreas (b*iop*sy); placenta (third trimester); prostate (other than transurethral resection or radical resection); salivary gland; small intestine (resection, other than neoplasm); soft tissue mass (other than lip*oma*; b*iop*sy or simple excision); st*oma*ch (partial or total resection, other than neoplasm); testis (b*iop*sy); thymus (neoplasm); thyroid (partial or total thyroidectomy); ureter (resection); urinary bladder (transurethral resection); uterus *with or without* fallopian tubes and ovaries.

Note:

1. For uterine leiomy*oma* or prolapse, see L864.

2. For uterine neoplasm, see L866.

L866 SURGICAL PATHOLOGY, LEVEL 6.

Gross and microscopic examination of the following specimens:

Bone (resection); breast (mastectomy with regional lymph nodes); colon (segmental resection for neoplasm); colon (total resection); extremity (disarticulation); fetus (with dissection); larynx (partial or total resection with regional lymph nodes); lung (partial or total resection); oesophagus (partial or total resection); pancreas (partial or total resection); prostate (radical resection); small intestine (resection for neoplasm); soft tissue neoplasm (extensive resection); st*oma*ch (partial or total resection for neoplasm); testis (neoplasm); tongue (resection for neoplasm); tonsil (resection for neoplasm); urinary bladder (partial or total resection); uterus *with or without* fallopian tubes and ovaries (neoplasm other than leiomy*oma*); vulva (partial or total resection).

L867 SURGICAL PATHOLOGY

Gross and microscopic examination of specimens not listed in Levels 2 through 6.

Payment rules:

1. The unit of a service in Surgical Pathology and Cytopathology is a specimen. A specimen is tissue that is identified and submitted for individual and separate examination and diagnosis.

[Commentary:
Surgical Pathology codes L861 through L866 denote increasing levels of physician work associated with examination of the specimens listed in the respective service code definitions.]

2. When the examination of a specimen requires any of the services listed under Special Procedures and Interpretation - Histology or Cytology, such services are eligible for payment in addition to any of the following services (when rendered):

- **a.** services listed under Anatomic Pathology - Surgical Pathology,
- **b.** services listed under Anatomic Pathology – Cytopathology; or
- **c.** a Diagnostic Laboratory Medicine Consultation (A585/C585) as listed in the "Consultation and Visits" section of the *Schedule*.

3. Cytology smears fees are payable in each case for which the physician is responsible whether or not all slides are personally examined by the physician.

[Commentary:

1. For the *technical component*s of Laboratory Medicine (L001 to L799 and L900 codes), please refer to the separate *Schedule* of Benefits for Laboratory Services.

2. See section 37.1 of regulation 552 under the *Health Insurance Act* for additional information regarding payment and insurability of Laboratory services.]

Claims submission instructions:

If multiple specimens are submitted from a single patient on the same occasion, assign each specimen the appropriate fee *schedule* code(s).

		Fee
	INTERPRETATION OF ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY	
	Anatomic Pathology - Surgical Pathology	
L861	Surgical Pathology, Level 1	5.20
L862	Surgical Pathology, Level 2	8.45
L863	Surgical Pathology, Level 3	14.30
L864	Surgical Pathology, Level 4	48.65
L865	Surgical Pathology, Level 5	103.20
L866	Surgical Pathology, Level 6	181.65
L867	Surgical Pathology, Unlisted specimens	46.65
L822	Operative consultation, with or without frozen section	77.20
L823	- each subsequent frozen section or direct smear and/or selection of tissue for biochemical assay e.g. estrogen receptors ..... add	38.25
L801	Metabolic bone studies	95.30
L833	Nerve teasing	140.75
	Anatomic Pathology - Cytopathology	
L812	Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation	4.60
L805	Aspiration biopsy e.g. lung, breast, thyroid, prostate	79.00
L806	Bronchial, oesophageal, gastric, endometrial or other brushings and washings	35.45
L808	Imprint, touch preparation and/or direct smear	36.35
L815	Sputum per specimen for general and/or specific assessment e.g. cellular abnormalities, asbestos bodies, lipids, haemosiderin.	36.35
L804	Smear, specific assessment e.g. eosinophils, asbestos bodies, amniotic fluid cells for estimation of fetal maturation	14.30
L810	Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	22.05
L824	Synovial fluid analysis, including description, viscosity, mucin clot, cell count, and compensated polarized light microscopy for crystals	24.70
L825	Compensated polarized light microscopy for synovial fluid crystals	12.80
L819	Seminal fluid analysis for infertility, including count, motility and morphology	13.60
L848	Seminal fluid analysis - quantitative kinetic studies, including velocity linearity and lateral head amplitude	29.65
L820	Smear for spermatozoa	6.05

		Fee
	Cytogenetics	
L807	Smear for sex chromatin (Barr Body) or Neutrophil drumsticks	4.95
L811	Y chromosome	6.05
L803	Karyotype	73.95
	Special Procedures and Interpretation - Histology or Cytology	
L834	Histochemistry of muscle - 1 to 3 enzymes	11.85
L835	- each additional enzyme ..... add	11.85
L841	Enzyme histochemistry and interpretation - per enzyme	11.85
L837	Immunohistochemistry and interpretation - per marker	15.60
L868	Special histochemistry for identification of microorganisms	35.05
L869	Special histochemistry for identification of elements other than microorganisms	15.55
L817	Anti-tissue antibodies and interpretation - per case	6.05
L842	- anti-tissue antibodies, screening dilution, titration and interpretation ..... add	8.45
L849	Interpretation and handling of decalcified tissue	12.80
L843	Special microscopy of tissues including polarization, interference phase contrast, dark field, autofluorescence or other microscopy and interpretation	19.80
L844	Special microscopy of fluids (polarization, interference, phase contrast, dark field, autofluorescence or other microscopy and interpretation)	12.80
L845	Specimen radiography or microradiography and interpretation	10.40
L832	X-ray diffraction analysis and interpretation	23.70
L816	Electron microscopy by TEM, STEM or SEM technique	97.95
L831	- analytical electron microscopy, elemental detection or mapping, electron diffraction, per case ..... add	49.35
L836	Morphometry per parameter	24.70
L846	Flow cell cytometry and interpretation - per marker	11.85
L847	Caffeine - halothane contracture test and other confirmatory tests for malignant hyperthermia	65.15
	Biochemistry and Immunology	
L827	Interpretation of carcinoembryonic antigen (CEA)	5.30
L828	Interpretation of hormone receptors for carcinoma to include estrogen and/or progesterone assays	7.95
	Haematopathology	
L800	Blood film interpretation (Romanowsky stain)	20.85
L826	Blood film interpretation (special stain)	11.85
L802	Bone marrow interpretation (Romanowsky stain)	44.45
Z403	Bone marrow aspiration	33.90
L830	Terminal transferase by immunofluorescence	11.85
L838	Leukocyte phenotyping by monoclonal antibody technique	19.80
L829	Haemoglobinopathy interpretation (payable for abnormal results only)	12.90

Fee

LABORATORY MEDICINE IN PHYSICIAN'S OFFICE

Definition:

A laboratory service ("test") set out in this section is an insured service eligible for payment only when rendered by a physician ("the original physician"), or by a physician substituting for the original physician, who performs the test in the original physician's own office for the physician's own patient.

Note:
Tests listed under "Miscellaneous Tests" may be claimed by any physician. Tests listed under "Reproductive medicine" and "Point of care drug testing" are only payable to those physicians where point of care testing is necessary for their practice.

[Commentary:
Fee codes listed in the separate *Schedule* of Benefits for Laboratory Services apply only to services provided by private laboratories licensed under the *Laboratory and Specimen Collection Centre Licensing Act*.]

Medical record requirements:
Laboratory services are *only eligible for payment* if the result of the test(s), the physician's interpretation of the results of the test(s) and the treatment decision based on the test results are documented in the patient's permanent medical record.

A. Reproductive medicine

G015	FSH (pituitary gonadotrophins)	11.37
G016	TSH (thyroid stimulating hormone)	9.82
G017	Prolactin	14.48
G018	Estradiol	28.44
G019	LH (luteinizing hormone)	9.31
G020	Progesterone	14.48
G021	HCG (human chorionic gonadotrophins) quantitative	15.51

Note:
G021 is *not eligible for payment* for pregnancy tests. See G005.

G022	Testosterone	14.48
G023	Testosterone, free	25.85
G024	Androstenedione	38.78
G025	Dehydroepiandrosterone sulphate (DHEAS)	20.68
G026	17-OH progesterone	31.02
G027	Seminal fluid examination (complete)	11.37
G028	Cervicovaginal mucous specimen for cellular analysis for postcoital testing	10.34

Note:
G028 is *not eligible for payment* for obtaining, preparing or interpreting a papanicolaou smear.

G029	Antithrombin III assay	28.44
G030	Circulating anticoagulant (e.g., lupus anticoagulant)	5.17
G032	Anti-DNA	23.27
G033	Anti-RNA	23.27
G034	Serial tube 4 or more antigens	15.51
G035	Titre - serial tube single antigen	7.76
G036	Sperm antibodies – screen	10.34
G037	Sperm antibodies – titre	20.68

			Fee

B. Point of care drug testing

G041	Target drug testing, urine, qualitative or quantitative	per test	7.25
G042	Target drug testing, urine, qualitative or quantitative	per test	2.50

[Commentary:
G041 and G042 are tests for a specific drug of abuse.]

G040	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse	per test	29.00
G043	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse	per test	15.00

[Commentary:
Drugs of abuse *may include* any of the following: alcohol, methadone, methadone metabolite, morphine, a synthetic or semi-synthetic opiate, cocaine, benzodiazepines, amphetamines, methamphetamines, cannabinoids, barbiturates or any other drug of abuse.]

G039	Creatinine		2.59

Payment rules:

1. For the purposes of opioid agonist maintenance treatment, G040, G042, G041 and G043 are *only eligible for payment* to a physician who has an active general exemption for methadone maintenance treatment or chronic pain treatment with methadone pursuant to Section 56 of the *Controlled Drugs and Substances Act* 1996.
2. G040 and G041 are limited to a maximum of five (5) services per patient (any combination) per *month* to any physician when K682 or K683 is payable.
3. G042 and G043 are limited to a maximum of four (4) services per patient (any combination) per *month* to any physician when K682 or K683 is payable.
4. Any combination of G040, G041, G042 and G043 is limited to a maximum of three (3) services per patient per *month* for management of a patient with chronic pain, an addiction, or receiving opioid agonist treatment program where K682 or K683 is not payable in the *month* for the same patient to any physician.
5. G040, G041, G042 and G043 are *not eligible for payment* unless K623 or K624 or a consultation, assessment or time–based service involving a direct physical encounter with the patient is payable in the same *month* to the same physician rendering the G040, G041, G042 or G043 service.
6. G039 is limited to a maximum of two (2) tests per patient per *week*, any physician.
7. G039 is *only eligible for payment* when rendered to rule out urine tampering.
8. Only one of G040, G041, G042 or G043 is eligible for payment per urine sample.

[Commentary:
G040, G041, G042, and G043 will be subject to a joint review by the *MOHLTC* and the Ontario Medical Association on or before December 31, 2012.]

C. Miscellaneous Tests

G031	Prothrombin time	6.20
G001	Cholesterol, total	5.50
G002	Glucose, quantitative or semi-quantitative	2.18
G481	Haemoglobin screen and/or haematocrit (any method or instrument)	1.32
G004	Occult blood	1.53
G005	Pregnancy test	3.88
G009	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)	4.30
G010	One or more parts of above without microscopy	2.07
G011	Fungus culture including KOH preparation and smear	12.60
G012	Wet preparation (for fungus, trichomonas, parasites)	1.86
G014	Rapid streptococcal test	5.50

Payment rules:
G009 and G010 are not insured when rendered for the monitoring of adverse effects resulting from a calorie restricted weight loss program.

		Fee

SPECIFIC ELEMENTS

Nephrological management of donor procurement

In addition to the *common elements*, this service includes the following *specific elements*.

A. Monitoring the life support systems of a neurologically dead donor to ensure adequate perfusion and oxygenation of the kidneys.

B. Assessment of renal functions pre-nephrectomy, including the obtaining of specimens and interpretation of results and assessment as to potential recipients to be called in.

C. Prescribing and providing appropriate pre-nephrectomy immunotherapy.

D. Making arrangements for any related assessments, procedures or therapy, related to the harvesting of the organ(s).

E. Discussion with and providing advice and information to the patient's family or representative, whether by telephone or otherwise, on matters related to the service including advice unless separately billable, as to the results of such procedure(s) and/or related assessments as may have been performed.

F. Providing premises, equipment, supplies and personnel for the *specific elements*.

While no occasion may arise for performing elements C, D and E, when performed in connection with the other *specific elements*, they are included in the service.

	G411	Nephrological management of donor procurement	192.10
#	G347	Renal perfusion with hypothermia for organ transplantation	96.35
#	G348	Renal preservation with continuous machine perfusion	96.35

Nephrological component of renal transplantation

This applies to the service of being in constant or periodic attendance following transplantation, to provide all aspects of care to the renal transplant patient. This consists of an initial consultation or assessment and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition and intervening as appropriate.

#	G412	1st day following transplantation		242.90
#	G408	2nd to 10th day, inclusive	per diem	121.45
#	G409	11th to 21st day, inclusive	per diem	60.70

Note:
G412, G408, G409 includes complete patient care.

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

PREAMBLE

1. Nerve blocks listed in this section are eligible for payment only when rendered for acute pain management, including peri-operative or post-operative pain management as described below and where the nerve block has a duration of action of more than 4 hours. Acute pain is defined as pain that occurs with sudden onset and that is expected to resolve within 6 *week*s.

2. Nerve blocks rendered for acute pain with a duration of action of less than 4 hours, topical anaesthesia or local infiltration used as an anaesthetic for any procedure, are *not eligible for payment*.

3. Except as described in paragraph 4, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.

4. A major or minor peripheral nerve block, major plexus block, neuraxial injection (*with or without* catheter) or intrapleural block (*with or without* catheter) for post-operative pain control (with a duration of action more than 4 hours) is eligible for payment as G224 when rendered in conjunction with a procedure which the physician performs on the same patient.

5. When a physician renders an anaesthesia service in support of a procedure performed by another physician, a peripheral nerve block, plexus block, neuraxial injection or intrapleural injection using short-acting medication (with a duration of action less than 4 hours) is *not eligible for payment* in addition to the C-suffix anaesthesia service.

6. When a physician renders an anaesthesia service in support of a procedure performed by another physician, a peripheral nerve block, plexus block, neuraxial injection or intrapleural injection, listed in this section and performed for post-operative analgesia (with a duration of action more than 4 hours) is eligible for payment in addition to the C-suffix anaesthesia service.

[Commentary:

1. For the purposes of paragraph 6, only peripheral nerve blocks, plexus blocks, neuraxial injections or intrapleural injections listed in this section are eligible for payment. Nerve blocks listed elsewhere in the *Schedule* are not payable for acute pain management.

2. For obstetrical continuous conduction anaesthesia, see P014C, E111A and P016C, listed in the Obstetrics section.]

7. With the exception of a bilateral pudendal block (where only one service is eligible for payment) a nerve block is payable once per region per side where bilateral procedures are performed.

8. Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of 8 per patient per *day* for any combination of nerve blocks. The ninth and subsequent nerve blocks per patient per *day* are *not eligible for payment*. Nerve blocks which are defined as a bilateral procedure are counted as two services for the purpose of the overall daily maximum.

9. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance (e.g. nerve stimulation, ultrasound, fluoroscopy) are *not eligible for payment* in addition to the injection services listed in this section.

10. For anaesthesia services in support of a nerve block or interventional pain injection procedure performed by another physician, see General Preamble.

11. Injection services listed elsewhere in the *Schedule* are *not eligible for payment* in addition to injections listed in this section for the same injection procedure.

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

			Fee
		Neuraxial	
#	G248	Caudal, single injection	55.00
#	G125	Caudal/lumbar epidural with catheter	100.00
#	G118	Thoracic epidural with catheter	130.00
#	G062	Cervical epidural with catheter	160.00
#	G222	Spinal or epidural injection of narcotic (duration of action more than 4 hours)	55.00

Payment rules:
G222 is *not eligible for payment* with G248, G125, G118 or G062.

[Commentary:
Spinal or epidural injection of short-acting narcotics such as fentanyl or sufentanil does not constitute G222 and is *not eligible for payment*.]

	G260	Major plexus block	80.00

Payment rules:

1. The G260 service is a block of one of the following: brachial plexus, lumbar plexus, sacral plexus, deep cervical plexus, or a combined 3-in-1 block which must include the femoral, obturator and lateral femoral cutaneous nerves.

2. When a major plexus block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

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

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

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

	G060	Peripheral nerve block, major	55.00

Payment rules:

1. The G060 service must consist of one of the following:

- **a.** a block of one of: radial, median, ulnar, musculocutaneous, femoral, sciatic, common peroneal and/or tibial, obturator, suprascapular, pudendal (uni or bilateral), trigeminal or facial nerve;
- **b.** a paravertebral block – first injection only;
- **c.** an ankle block (must include 2 or more of the following: deep peroneal, superficial peroneal, posterior tibial, saphenous or sural nerve); or
- **d.** a fascia iliaca block.

2. G060 is limited to a maximum of 4 services per patient per physician per *day*.

3. When a major peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

			Fee
	G061	Peripheral nerve block, minor	30.00

Payment rules:

1. The G061 service must consist of one of the following:

- **a.** a block of one of: ilioinguinal and/or iliohypogastric, genitofemoral, lateral femoral cutaneous, saphenous, occipital, supraorbital, infraorbital or glossopharyngeal nerve;
- **b.** an intercostal block;
- **c.** a superficial cervical plexus block;
- **d.** a transversus abdominis plane (TAP) block; or
- **e.** a paravertebral block – additional injection.

2. G061 is limited to a maximum of 4 services per patient per physician per *day*.

3. When a minor peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

Percutaneous nerve block catheter insertion for continuous infusion analgesia

#	G279	Percutaneous nerve block catheter insertion	80.00

Payment rules:

1. G279 is eligible for payment in addition to the applicable peripheral nerve or plexus block.

2. G260 is *not eligible for payment* in addition to G279 when rendered for a continuous combined 3-in-1 block; G060 is eligible for payment in addition to G279 in this circumstance.

3. No guidance (e.g. nerve stimulation, ultrasound) used for percutaneous nerve block catheter insertion is eligible for payment.

	G066	Intrapleural block	55.00
	G067	Intrapleural block with continuous catheter	80.00
#	G068	Epidural blood patch	125.00
#	G065	Epidural blood patch injected through existing epidural catheter	62.50
	G224	Nerve block by same physician performing the procedure	15.55

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

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

Payment rules:

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

1. continuous catheter infusion for analgesia for a hospital in-patient; or

2. lumbar sub-arachnoid drainage catheter placed in association with a surgical procedure where there is increased risk of spinal cord ischemia.

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

Fee

Initiation of outpatient continuous nerve block infusion

The initiation of outpatient continuous nerve block infusion is the service rendered to prepare outpatients for discharge from hospital after the patient has had an insertion of a percutaneous nerve block catheter for continuous infusion analgesia or for outpatient palliative epidural infusion. The service includes an assessment of the patient and all procedures required to prepare the infusion, the infusion of medications and education or counselling of the patient, patient's relative(s), *patient representative* or other caregiver(s).

G063 Initiation of outpatient continuous nerve block infusion 29.20

Note:
When rendered to a hospital in-patient, the service described by G063 is included in G247.

Management and supervision of outpatient continuous nerve block infusion or outpatient palliative epidural infusion

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

A. Monitoring the condition of a patient with respect to the continuous nerve block infusion.

B. Adjusting the dosage of the infusion therapy and, where appropriate, prescribing other therapy.

C. Discussion with, and providing advice and information to the patient, patient's relative(s), *patient representative* or other caregiver(s), by telephone, fax or e-mail on matters related to the service, regardless of the identity of the person initiating the discussion.

D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the *specific elements*.

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

Payment rules:

1. G064 is *only eligible for payment* when:

a. rendered by the physician most responsible for the patient's care or by a physician substituting for that physician (the "substitute physician"); and

b. the clinical decision(s) pertaining to the medical advice, direction or information provided is formulated personally by the physician or substitute physician.

2. G064 is *only eligible for payment* for a *day* when one or more components of element C are rendered in that *day*.

3. G064 rendered on the same *day* as a consultation or visit by the same physician is *not eligible for payment*.

4. G064 is limited to a maximum of 7 services per patient per G279 service.

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

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

PREAMBLE

1. Injections listed in this section rendered for the diagnosis of pain-related conditions are *only eligible for payment* when rendered solely for the purpose of diagnosing the source of pain or developing a therapeutic treatment plan.

[Commentary:
A repeat diagnostic pain-related injection on the same region is ideally rendered after 1 *week* of a previous diagnostic pain-related injection unless factors such as distance the patient has travelled for an assessment makes the ideal period impractical.]

2. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance are *not eligible for payment* in addition to the injection services listed in this section.

3. For anaesthesia services in support of interventional pain injection procedures, see General Preamble Anaesthesiologist Services.

4. Injections listed in this section include the injection of contrast, medication and/or other solution, unless separately listed.

5. Injection services listed elsewhere in the *Schedule* are *not eligible for payment* in addition to injections listed in this section for the same injection procedure.

[Commentary:
For example, joint injection fee codes G370 and G371 are *not eligible for payment* in addition to facet joint or sacroiliac joint injections listed in this section for the same injection procedure.]

6. If more than one procedure listed in this section is performed for the same patient on the same *day*, each procedure is *only eligible for payment* if rendered to diagnose or treat a separate condition.

7. For the purposes of this section, the term “site” refers to the anatomic area described by the fee code descriptor.

Medical record requirements:
Injections listed in this section are *only eligible for payment* if documentation clearly describes:

1. the procedure performed, or where image guidance is used, images of final needle placement that clearly identify the site of injection and/or spread of contrast, when indicated; and

2. the purpose of any diagnostic pain-related injection and the subsequent response to the procedure, indicating a positive or negative result.

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

			Fee	
	Vertebral facet injections			
	Percutaneous diagnostic injections with fluoroscopic guidance - facet medial branch block, facet joint injection or sacral lateral branch block.			
G910	Cervical, first site		80.00	
G911	Thoracic, first site		80.00	
G912	Lumbar/Sacral, first site		80.00	
G913	- each additional site, to G910, G911 or G912	add	20.00	
	Percutaneous diagnostic lumbar facet medial branch block with ultrasound guidance			
G914	First site		56.00	
G915	- each additional site, to G914	add	14.00	

[Commentary:
Ultrasound images must be of sufficient quality to clearly identify the injection site and needle placement at the junction of the transverse process and superior articular process.]

Payment rules:

1. G914 is *only eligible for payment* when a fluoroscopically guided facet injection has been rendered for the same site(s) within the previous *12 month period* by the same physician.
2. G913 and G915 are each limited to a maximum of 7 services per patient per *day*.
3. G910, G911, G912 or G914 are each limited to 6 services per patient per *12 month period*. If, in the opinion of the treating physician, more frequent services are necessary, the physician may obtain written prior authorization from the *MOHLTC*. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

	Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy				
# N556	First site		142.80		6
# E396	- each additional site to N556	add	71.40		
	Sacroiliac joint injections				
G916	Percutaneous diagnostic and/or corticosteroid sacroiliac joint injection with fluoroscopic guidance, unilateral		75.00		
	Nerve root injections				
G917	Percutaneous diagnostic selective nerve root block with fluoroscopic guidance, with or without contrast – any number of sites		160.00		

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

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

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

				Fee
		Epidural and spinal injections		
		Percutaneous epidural injections		
#	G246	Lumbar		150.00
#	G117	Thoracic		170.00
#	G119	Cervical		190.00
#	G918	Caudal		74.20
	E440	- with injection of contrast using fluoroscopy, to G246, G117, G119 or G918	add	30.00
	E441	- when performed at same level of previous spinal surgery, to G246, G117, G119 or G918	add	16.60
	E442	- when performed using a transforaminal technique, to G246, G117, G119 or G918	add	20.00
	E443	- with catheter for continuous infusion, to G246, G117, G119 or G918	add	80.00
#	E833	- with insertion of subcutaneous port, G117, G119, G246 or G918	add	116.10

Payment rules:

1. Percutaneous epidural injections are limited to 12 services per patient per *12 month period* for any combination of G119, G117, G246 and G918. If, in the opinion of the treating physician, more frequent treatments are necessary, the physician may obtain written prior authorization from the *MOHLTC*. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

2. G246, G117, G119 or G918 are *only eligible for payment* same patient same *day* with G236, G234 and G920 if rendered to diagnose or treat a separate condition.

[Commentary:
The sympathetic block that may result from an epidural injection is not payable as G920, G234 or G236.]

3. G246, G117, G119 or G918 are *not eligible for payment* with any concurrent surgical procedure or any anesthetic fee, except for E030C or E031C when indicated as described in the General Preamble Anaesthesiologist Services.

[Commentary:
1. For initiation and management services for outpatient palliative epidural infusion, refer to G063 and G064 page J57.

2. For epidural blood patch, refer to G068 and G065 page J56.]

	G245	Lumbar epidural or intrathecal injection of sclerosing solution	180.00
	G239	Differential intrathecal spinal block	127.60
#	G919	Percutaneous epidural adhesiolysis by infusion with fluoroscopic guidance	400.00

Note:
G919 is *only eligible for payment* if the following conditions are met:

1. it is used for the treatment of epidural fibrosis with symptoms of persistent back or radicular/neuropathic leg pain following spinal surgery;

2. the patient has had inadequate symptom control following fluoroscopically-guided epidural steroid injections to the suspected site of pain generation and there is no alternate primary diagnosis, such as facet-mediated or sacroiliac joint-mediated pain; and

3. it is rendered with fluoroscopic guidance using:

a. a directional epidural catheter, with its final position confirmed using contrast;

b. hypertonic saline and hyaluronidase, which are infused for at least one hour; and

c. epidural corticosteroid, which is injected prior to catheter removal.

[Commentary:
If any of these conditions are not met, epidural adhesiolysis is *only eligible for payment* using another appropriate epidural injection service listed above. For example, if performing an interlaminar lumbar adhesiolysis at a previous surgical site using a bolus-through-needle technique rather than an infusion, and hypertonic saline, hyaluronidase, local anesthetic and corticosteroid are injected following contrast injection to confirm needle placement, G246, E440 and E441 are eligible for payment.]

4. G919 is limited to a maximum of 4 services per patient per *12 month period*.

5. G246, G117, G119, G918, G245, E440, E441, E442, E443 or E833 are *not eligible for payment* with G919 for the same procedure for which G919 is payable.

			Fee
	Sympathetic nerve injections		
	Percutaneous cervical sympathetic nerve block or Stellate ganglion block		
G920	- with ultrasound or fluoroscopic guidance, unilateral		80.00
G234	- without ultrasound or fluoroscopic guidance, unilateral		55.10
	Percutaneous lumbar, thoracic or sacral sympathetic nerve block with fluoroscopic guidance		
G236	- unilateral or bilateral		150.00

Payment rules:

1. G920 and G234 are each limited to a maximum of one unilateral or one bilateral procedure per patient per *day* to a limit of 24 services for any combination of unilateral and bilateral procedures per patient per *12 month period*. G236 is limited to a maximum of one per patient per *day* to a limit of 12 per patient per *12 month period*. If, in the opinion of the treating physician, more frequent treatments are necessary, the physician may obtain written prior authorization from the *MOHLTC*. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.
2. G920, G234 and G236 are *only eligible for payment* same patient same *day* with other nerve block and/or injection services if rendered to diagnose or treat a separate condition.
3. G234 is *not eligible for payment* with G920 same patient same *day*.
4. The sympathetic block that may result from epidural, spinal, plexus and peripheral nerve blocks is not payable as G920, G234 or G236.

	Miscellaneous		
# G374	I.V. regional guanethidine		54.30
	Ganglion/Plexus injections		
G233	Percutaneous celiac, splanchnic or hypogastric ganglion/plexus block with fluoroscopic guidance		200.00
E444	- with radiofrequency ablation, to G233	add 50%	
G217	Percutaneous trigeminal ganglion block with fluoroscopic guidance		200.00
G232	Percutaneous spheno-palatine ganglion block with fluoroscopic guidance		150.00
E445	- when alcohol or other sclerosing solutions are used, to G920, G234, G236, G233, G217 or G232	add 50%	
G921	Spheno-palatine ganglion block, transnasal topical, uni or bilateral		12.50

Payment rules:

G921 is not eligble for payment same patient same *day* with G232.

[Commentary:

For percutaneous provocation vertebral discography, refer to J006 Discogram page E3.]

NERVE BLOCKS - PERIPHERAL/OTHER INJECTIONS

PREAMBLE

1. With the exception of G224 as described in the Nerve Blocks for Acute Pain Management section, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.
2. Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of 8 per patient per *day* for any combination of nerve blocks. The ninth and subsequent nerve blocks per patient per *day* are *not eligible for payment*. Nerve blocks which are defined as a bilateral procedure are counted as two services for the purpose of the overall daily maximum.
3. For anaesthesia services in support of a nerve block performed by another physician, see General Preamble.
4. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance (e.g. nerve stimulation, ultrasound, fluoroscopy) are *not eligible for payment* in addition to the injection services listed in this section.
5. Injection services listed elsewhere in the *Schedule* are *not eligible for payment* in addition to injections listed in this section for the same injection procedure.
6. Local infiltration used as an anesthetic for any procedure is *not eligible for payment*.

		Fee
G214	Brachial plexus	54.65
	Femoral nerve	
G243	- unilateral	54.65
G244	- bilateral	81.95
	Occipital nerve	
G264	- first block per day (maximum 1 per day to a maximum of 16 first blocks per calendar year)	34.10
G265	- each additional unilateral block following G264 per spinal level per day when G264 is payable in full (maximum 3 per day to a maximum of 48 additional blocks per calendar year)	17.10
G291	- first block per day in excess of 16 per calendar year may be payable on an independent consideration (IC) basis upon submission to the ministry of a written recommendation of an independent expert as described below. (maximum 1 per day to a maximum of 16 blocks for a single IC request). A new written recommendation is required on an IC basis each time the number of first blocks exceeds 16	19.85
G292	- each additional unilateral block following G291 per spinal level per day when G291 is payable in full (maximum 3 per day)	10.00

Note:

1. G265 and G292 are insured services payable at nil unless an amount is payable for G264 or G291 rendered to the same patient the same *day*.

2. When an amount is payable for G264, the amount payable for G291 rendered to the same patient on the same *day* is nil.

3. When an amount is payable for G265, the amount payable for G292 rendered to the same patient on the same *day* is nil.

4. For the purpose of G291, independent expert in respect of a patient is a physician who:

- **a.** has special knowledge and expertise in multidisciplinary management of chronic non-malignant pain;
- **b.** did not refer the patient for treatment;
- **c.** is not actively involved in management of the patient; and
- **d.** receives no direct or indirect financial benefit for the nerve block services being rendered to the patient.

[Commentary:
See Appendix B regarding conflict of interest.]

NERVE BLOCK S - PERIPHERAL/OTHER INJECTIONS

		Fee
	Percutaneous nerve block catheter insertion for continuous infusion analgesia	
G279	Percutaneous nerve block catheter insertion	80.00

Payment rules:

1. G279 is eligible for payment in addition to the applicable peripheral nerve or plexus block.

2. No guidance (e.g. nerve stimulation, ultrasound) used for percutaneous nerve block catheter insertion is eligible for payment.

[Commentary:
Maintenance of the catheter may constitute a subsequent visit subject to the limits as outlined on General Preamble GP28.]

G218	Ilioinguinal and iliohypogastric nerves	54.65
G219	Infraorbital	34.20
G220	Intercostal nerve	34.20
G221	- for each additional one ... add	16.95
G258	Intrapleural block (single injection)	44.25
G257	Intrapleural block (with the introduction of a catheter for the purpose of continuous analgesia)	77.25
G225	Mental branch of mandibular nerve	34.20
G250	Maxillary or mandibular division of trigeminal nerve	75.10
	Obturator nerve	
G241	- unilateral	54.65
G242	- bilateral	82.45
G227	Other cranial nerve block	54.65
G228	Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves	34.10
G123	- for each additional one (to a maximum of 4) ... add	17.10
	Pudendal	
G229	- unilateral	54.65
G240	- bilateral	82.45

Note:
For obstetrical continuous conduction anaesthesia, see P014 and P016, listed in the Obstetrics section of the *Schedule*.

G422	Retrobulbar injection (not to be claimed when used as a local anaesthesia)	34.20
	Sciatic nerve	
G230	- unilateral	54.65
G226	- bilateral	82.45
	Somatic or peripheral nerves not specifically listed	
G231	- one nerve or site	34.10
G223	- additional nerve(s) or site(s) ... add	17.10
G256	Superior laryngeal nerve	34.10
G235	Supraorbital	34.10
G238	Transverse scapular nerve	34.10
E958	- when alcohol or other sclerosing solutions are used, the appropriate nerve block fees as listed above ... add 50%	

NEUROLOGY

			Fee
	Z804	Lumbar puncture	67.60
#	Z805	- with instillation of medication or other therapeutic agent	75.10

Note:
Z804 and Z805 are *not eligible for payment* with C-suffix anaesthesia services rendered for surgical procedures, obstetrical anaesthesia procedures or with epidural services described in the nerve block sections of the *Schedule*.

	E871	- lumbar puncture using image guidance following a failed blind attempt, to Z804 or Z805 ..... add 25%.	

Note:
E871 is *only eligible for payment* when a lumbar puncture must be repeated using any method of image guidance following a failed blind attempt(s) by the same or different physician. Professional and/or technical fees for obtaining and interpreting images for the purpose of guidance of the lumbar puncture are *not eligible for payment* to any physician.

#	G410	Amytal test (Wada)-bilateral - supervision and co-ordination of tests	68.40
#	G413	Electrocorticogram - supervision and interpretation	170.85

Note:
G413 payable at nil when claimed with G267 same patient, same *day*.

	G419	Tensilon test	20.60
#	G551	Katzman test (subarachnoid infusion test) including lumbar puncture	170.85
#	G267	Intra-operative evaluation of movement disorder patient during functional neurosurgery	270.05

Note:
G267 is not payable with assistant units.

#	G547	Clinical Programming of Deep Brain Stimulator (DBS) - includes one or more visits for DBS checking, minor and major DBS adjustments, and intensive programming. First implantation site (maximum 1 per patient)	185.70
#	G549	- additional implantation site(s) (maximum 1 per patient)	157.85

Electrophysiological assessment

#	G266	- of movement disorders - includes multi-channel recording of EEG and EMG, rectification, averaging, back averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment	278.85
#	G548	- of Deep Brain Stimulators - includes measuring electrode impedance, recording EEG and EMG, rectification, averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment	278.85
	G417	- inserting subtemporal needle electrodes ..... add	15.90

		T	P

ELECTROENCEPHALOGRAPHY

Routine EEG

A routine EEG consists of at least a twenty minute recording with referential and bipolar montages and at least eight channels (except in neonates). Hyperventilation and photic stimulation should be done in all cases where clinically possible.

G414	Routine EEG - technical component	24.40	
G415	Routine EEG - professional component		23.15
G418	Routine EEG - professional component (16 - 21 channel EEG)		50.00

Sleep-deprived/induced EEG

A sleep-deprived/induced EEG is an EEG recording (*with or without* video monitoring) performed after:

a. an overnight period of sleep deprivation of greater than 4 hours; or

b. the administration of a sedative/hypnotic agent prior to the EEG recording for the purposes of sleep induction.

G541	- technical component	39.00	
G543	- professional component		60.00

Note:

1. G543 is *only eligible for payment* if the EEG recording includes all of the following:

a. at least 60 minutes of EEG recording time;

b. a minimum of 16 channels of EEG; and

c. recordings of at least two physiological parameters.

2. The amount payable for a sleep-deprived/induced EEG that does not meet the above requirements will be reduced to that for a routine EEG fees (i.e. G414 and G415/G418).

[Commentary:
Examples of physiological parameters include ECG, respirations, EMG, extra-ocular movements, oxygen saturation, and temperature.]

3. G414 is *not eligible for payment* with G541.

4. G415 and G418 are *not eligible for payment* with G543.

5. EEG services (i.e. G414, G415, G418, G541, G543, G540, G545, G542, G546, G554, G555, or G544) are *not eligible for payment* with any overnight or *day*time sleep study (i.e. J898, J899, J990, J896, J696, J897, J697, J895, J695, J890, J690, J889, J689, J893 or J894).

Prolonged EEG monitoring

Videotape recording of clinical signs in association with spontaneous EEG. Unit means ¼ hour or major part thereof. See General Preamble GP5 for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG.

G540	- technical component	per unit	9.05	
G545	- professional component	per unit		14.70

Note:
G540 and G545 are each limited to a maximum of 12 units.

Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add to routine fees.

G542	- technical component	23.10	
G546	- professional component		30.45

Ambulatory EEG monitoring

This is to include 12 to 24 hours of EEG monitoring. The fee includes EEG electrodes and other physiological parameters felt necessary to arrive at an appropriate electrographic diagnosis.

G554	- technical component	46.30	
G555	- professional component		47.75

Polygraphic recording of parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.)

G544	- technical component, per item	add	8.30

Note:
G544 limited to a maximum of 3.

NEUROLOGY

		T	P1	P2
	EVOKED POTENTIALS			
	Upper or lower limbs			
G140	- technical component	40.15		
G138	- professional component (P1)		89.55	
G139	- interpretation only (P2)			38.80

Note:
When only one limb is tested, claim the applicable fee - G140, G138, G139 - at 50%.

ACQUIRED ACUTE BRAIN INJURY MANAGEMENT

Definition/Required elements of service:

This is the service rendered by the neurosurgery specialist most responsible for management of a critically ill hospital in-patient with an acquired acute brain injury, where the neurosurgeon provides management:

a. post-operatively for a patient who has received an endovascular intracranial surgical procedure during the same hospital admission but only if that procedure was not performed by any neurosurgeon; or

b. for a patient who has not received an intracranial surgical procedure during the same hospital admission with the exception of Z819, Z820, Z812, N115, N139, N174, Z824, Z802, Z825, Z803.

[Commentary:

1. Examples of acquired acute brain injury include acutely raised intracranial pressure, subarachnoid, intracerebral or intraventricular haemorrhage, cerebritis, cerebral abscess, malignant cerebral edema, acute hydrocephalus, ventriculitis and trauma.

2. If a neurosurgeon renders an intracranial surgical procedure not on the exception list above, Acquired Acute Brain Injury Management is not payable for a post-operative patient to any physician.]

This service has the same *specific elements* as consultations and assessments.
In addition the service *may include* the following elements:

a. An initial consultation or assessment and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition and intervening as appropriate;

b. management of coma and monitoring the life support systems to ensure optimum neurological perfusion and oxygenation;

c. management of intracranial pressure (excluding insertion of I.C.P. or brain oxygen/pH measuring device) including monitoring, interpretation and drainage of cerebrospinal fluid when indicated;

d. monitoring and management of cerebral vasospasm;

e. prophylaxis and management of seizures;

f. making arrangements for any related assessments, procedures or therapy, related to the patient’s acute neurological deterioration, including decompressive craniectomy, cerebral angioplasty or evacuation of intracranial space occupying lesions;

g. clinical and radiological assessment of the cervical spine and spinal cord for the determination of spinal stability;

h. performance and/or arranging tests for the establishment of a diagnosis of brain death

i. making *referral*s, when appropriate, to organ procurement professionals

j. all related discussion, counselling and interviews with the patient’s relative(s), patient's representative or other caregiver(s);

k. All related case conferences.

NEUROSURGERY

			Fee
	Acquired acute brain injury management		
G790	1st day	per diem	223.10
G791	2nd day to 30th day, inclusive	per diem	146.45
G792	31st day onwards	per diem	58.60

Payment rules:

1. Critical Care ICU per diem fees are not payable with G790, G791or G792 for the same patient, same *day*, same physician.
2. Consultations, assessments or any time based service such as counselling or interviews or case conferences are *not eligible for payment* same patient, same *day* with G790, G791 or G792.
3. G790 is only payable once per patient, per same hospital admission.
4. G791 and G792 are each only payable once per patient, per *day*.
5. G790, G791 or G792 are *not eligible for payment* for stabilized patients, whether or not the patient is in an ICU.

			Fee	Anae
	Contact lens fitting			
G424	- includes follow-up for 3 months except for patients under 4 years of age at the time of the initial fitting		201.00	
G431	- under general anaesthesia	add	41.60	6

[Commentary:
Follow up services are payable in addition to contact lens fitting (G424) for *child*ren under 4 years of age.]

G423	One eye only, when the other eye has been previously fitted by the same physician, with follow-up for 3 months	90.30	

Note:
G424, G423 - Contact lens fitting is not a benefit except under certain specific conditions. Please check with the Ministry of Health and Long-Term Care *Medical Consultant*.

G463	Hydrophilic Bandage lens fitting	90.30	
G453	Electro-oculogram - interpretation fee	41.60	
G426	Glaucoma provocative tests, including water drinking tests	9.70	
G427	Ophthalmodynamometry	9.60	
	Radioactive phosphorus examination		
G429	- anterior approach	42.45	
G430	- posterior approach	86.05	
G421	Subconjunctival or sub-Tenons capsule injection	27.70	

Note:
G429, G430, G421 - for bilateral procedures, add 50% of the listed benefit.

+	G435	Tonometry	5.10	

Note:
G435 may not be claimed in conjunction with an ophthalmological consultation or specific assessment as this is included in these services.

		T	P

Colour vision detailed assessment

Colour vision detailed assessment (not to be claimed for screening tests such as Ishihara, HRR and University, etc.) only where underlying pathology is present or suspected. Requires that the following services are rendered: one of the screening tests and at least two (2) of the following detailed tests: 100 Hue, D-15, Lathony New Colour Test or anomaloscope test. To be performed where underlying pathology is present or suspect. Not to be performed as a routine screening test.

G850	- technical component	20.40	
G438	- professional component		22.15

Dark adaptation curve (Goldmann adaptometer or equivalent)

G851	- technical component	30.55	
G437	- professional component		22.90

Electro-retinography with report

G852	Full field or multi-focal electro-retinography - technical component	33.15	
G439	Full field electro-retinography - professional component		75.00
G524	Multi-focal electro-retinography - professional component		75.00

Payment rules:

1. G852 is limited to 4 services per patient per *12 month period*.
2. G439 is limited to 2 services per patient per *12 month period*.
3. G524 is limited to 2 services per patient per *12 month period*.
4. G524 is *only eligible for payment* for the evaluation of disorders of the retina involving high resolution vision function (i.e. cone function).
5. Electro-retinography includes any pupil dilation and refraction necessary to complete the study.

Fluorescein angiography

G853	- technical component	21.95	
G425	- professional component		44.40

Fluorescein angioscopy

G854	- technical component	6.40	
G444	- professional component		7.00

Note:

G425, G853, G444, G854 - for bilateral procedures, add 50% of the listed benefit.

Hess screen examination

G855	- technical component	6.30	
G428	- professional component		6.85

Tonography (to include tonometry) with or without water

G856	- technical component	9.05	
G433	- professional component		9.90

Visual fields - kinetic (with permanent record)

G857	- technical component	4.40	
G436	- professional component		14.50

Visual fields - static

Visual fields static perimetry, is *only eligible for payment* where underlying pathology is present or suspected and the following services are rendered: permanent record with measurement of a minimum of 50 points per eye, quantification of deficient points and monitoring of fixation/reliability.

G858	- technical component	13.30	
G432	- professional component		26.95

		Fee

Corneal pachymetry

Corneal pachymetry – measurement of corneal thickness by any method for the purpose of identifying patients at risk for glaucoma on the basis of suspicious optic nerve and/or visual field testing and/or elevated intraocular pressure, and/or family history.

G813 Corneal pachymetry, professional component..... 5.10

Payment rules:
This service is limited to one per patient per lifetime. Services in excess of this limit, or rendered for any purpose other than identifying patients at risk for glaucoma, are not insured services.

Keratometry

Keratometry - measurement of the central 4mm of the cornea for the purpose of assessing patients:

a. with irregular astigmatism resulting from scarring due to trauma, herpes simplex keratitis, dystrophies (such as Salzman's and map - dot-fingerprint dystrophy) or other inflammatory disorders; or

b. with keratoconus, pellucid marginal degeneration, keratoglobus, following penetrating keratoplasties or following pterygium excision.

G811 Keratometry, professional component 4.80

Corneal topography

Corneal topography - topographical mapping of the cornea for the purpose of assessing patients with same indications as those set out above for keratometry.

G810 Corneal topography, professional component 4.80

Payment rules:
G811 (keratometry) or G810 (corneal topography) rendered for other indications are not insured services.

Specular photomicroscopy

Specular photomicroscopy – Examination of the cornea prior to intraocular surgery when affected by Fuch's corneal dystrophy, pseudophacic keratopathy, or other conditions that may compromise the corneal endothelium.

G812 Specular photomicroscopy, professional component..... 4.80

Payment rules:
Specular photomicroscopy rendered for other indications is not an insured service.

		Fee
	Optical coherence tomography (OCT) - retinal disease	
G818	OCT unilateral or bilateral - retinal disease, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	35.00
	Optical coherence tomography (OCT) - glaucoma	
G820	OCT unilateral or bilateral - glaucoma, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	35.00
G821	OCT unilateral or bilateral - active management of retinal disease with laser or intravitreal injections when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	35.00
G822	OCT unilateral or bilateral - active management with laser or intravitreal injections for neovascularization associated with: **i.** retinal disease, e.g. wet acute macular degeneration; **ii.** diabetic macular edema; or **iii.** retinal vein occlusion when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	25.00

1. G822 is limited to a maximum of 8 services per patient per 12 *month* period and a maximum of 16 services per patient for 24 consecutive *months*.

2. G822 is only eligible for payment when the limit of any combination of G818, G820 or G821 is reached.

G823	OCT unilateral or bilateral - evaluation of an infant/child/adolescent with retinal disease and/or glaucoma (including genetic retinal anomalies and cancer), or low vision associated with or resulting in developmental delay when the physician interprets the results and either performs the procedure or supervises the performance of the procedure on a patient younger than 18 years of age	35.00

1. G823 is limited to a maximum of 12 services per 12 *month* period.

2. G818, G820, G821 and G822 are *not eligible for payment* when rendered on a patient younger than 18 years of age.

Payment rules:

1. Except as described in payment rule #2, OCT is an insured service only:
- **a.** for the diagnosis and management of retinal disease and/or glaucoma; and
- **b.** when the ophthalmologist performing the service is the physician most responsible for the care of the patient's retinal disease and/or glaucoma.

2. Any OCT service rendered in whole or in part for preparation related to cataract surgery is *not eligible for payment*.

3. G818 is eligible for payment only for one or more of the following:
- **a.** hemorrhage or exudate in the macula on clinical examination;
- **b.** retinal folds/wrinkling on clinical examination;
- **c.** macular hole/pseudohole on clinical examination;
- **d.** vision loss not explained by dilated clinical examination findings; or
- **e.** presence or reasonable suspicion of choroidal neovascular membrane, subretinal fluid or cystoid macular edema on clinical examination.

4. G820 is eligible for payment only for one or more of the following:
- **a.** suspicion of glaucoma based on optic nerve appearance on dilated clinical examination;
- **b.** suspicion of glaucoma based on visual field testing;
- **c.** elevated intraocular pressure; or
- **d.** history of glaucoma in an immediate family member.

5. G818, G820, G821, G822 or G823 is *only eligible for payment* when a consultation or assessment has been rendered by the same physician for the same patient in relation to the same condition for which OCT is being performed.

[Commentary:
For every claim for G818, G820, G822 or G823 there must be a separate consultation or assessment claimed by the same physician, but the services do not necessarily have to be rendered on the same *day*.]

6. G820 is limited to a maximum of two services per patient per *12 month period*.

7. Any combination of G818, G820 or G821 is limited to a maximum of four services per patient per *12 month period*.

Fee

8. Only one of G818, G820, G821, G822 or G823 is eligible for payment per patient same *day*.

Orthoptic examination

Orthoptic examination must include quantitative measurement of all cardinal positions of gaze (straight ahead, left, right, up, down, tilt right and tilt left), sensory testing for binocular vision suppression, cyclodeviation, retinal correspondence and interpretation. Orthoptic examination is eligible for payment in addition to an ophthalmology consultation or visit. The examination must be rendered by an orthoptist who is certified by the Canadian Orthoptic Council and employed by the ophthalmologist or a public hospital. The interpretation component of the examination must be personally rendered by the ophthalmologist.

G814 Orthoptic examination 25.00

Note:
G814 is *only eligible for payment* when all tests described under orthoptic examination are rendered and the results and measurements are documented in the patient's permanent medical record.

[Commentary:
If the interpreting ophthalmologist is also rendering the examination, the service should be claimed as A230.]

OPHTHALMOLOGY

		T	P1	P2
	Visual evoked response - simple			
G149	- technical component	17.60		
G147	- professional component (P1)		15.35	
G148	- interpretation only (P2)			6.05
	Visual evoked response - threshold			
G152	- technical component	30.10		
G150	- professional component (P1)		24.00	
G151	- interpretation only (P2)			10.90

Note:
P1 may only be claimed when physician performs the studies and interprets the results.

Fee

OCULAR PHOTODYNAMIC THERAPY (PDT)

Ocular photodynamic therapy (PDT) is, subject to the limitations set out below, an insured service when rendered by an ophthalmologist. PDT must include completion and submission of patient registration and drug requisition forms, establishment of intravenous access, supervision of drug infusion and personal application of non-thermal diode laser for activation of verteporfin.

PDT is insured only if the patient's clinical condition meets all of the following:

a. the patient has predominantly classic subfoveal choroidal neovascularization (CNV) secondary to either age-related macular degeneration (AMD), Presumed Ocular Histoplasmosis Syndrome or pathologic myopia. Predominantly means that the area of classic subfoveal CNV is equal to or greater than 50% of the total CNV lesion, as determined by fluorescein angiography and documented by retinal photographs retained on the patient's permanent medical record;

b. treatment is commenced within 30 *month*s after initial diagnosis of predominantly classic subfoveal CNV secondary to AMD, Presumed Ocular Histoplasmosis Syndrome or pathologic myopia;

c. the patient's visual acuity is equal to or worse than 20/40; and

d. for each repeat therapy, recurrent or persistent CNV leakage is detected by fluorescein angiography and documented by retinal photographs retained on the patient's permanent medical record.

If the patient's clinical condition meets all the above criteria but retinal photographs are not made prior to the procedure and retained on the patient's permanent medical record or the procedure is not performed by an ophthalmologist, then PDT is *not eligible for payment*. Maximum one PDT (unilateral or bilateral) per patient per *day*.

G460	Unilateral PDT per patient	per day	330.00
G461	Bilateral PDT per patient.....	per day	500.00

Note:

1. G379 rendered to same patient in conjunction with G460 or G461 is an insured service payable at nil.

2. G460 rendered to same patient same *day* as G461 is an insured service payable at nil.

3. Assessments and angiography are payable in addition to PDT. Retinal photography is insured as a specific element of the assessment and is not payable separately.

[Commentary:

1. PDT will normally not be administered to each affected eye more frequently than once every 3 *month*s.

2. PDT performed for treatment of clinical conditions other than described above is uninsured.]

OTOLARYNGOLOGY

			Fee
#	G103	Debridement of maxillectomy cavity	6.05
+	G420	Ear syringing and/or extensive curetting or debridement unilateral or bilateral	11.25

Note:
G420 is *not eligible for payment* when rendered in addition to Z906, Z907, Z908 or Z913.

+	G403	Particle repositioning maneuvre for benign paroxysmal positional vertigo	21.15

OTOLARYNGOLOGY

PREAMBLE

DIAGNOSTIC HEARING TEST

A. Diagnostic hearing tests (DHTs) are identified for payment purposes as either basic or advanced DHTs.

B. Basic DHTs are insured services payable at nil unless:

1. the *professional component* is rendered personally by a physician qualified by appropriate education or training and experience to perform basic DHTs (qualified physician); and

2. the *technical component* is either rendered by a qualified physician or delegated by a qualified physician to a person who is either an appropriately qualified employee of the physician or is an audiologist who is a member of the College of Audiologists and Speech-Language Pathologists of Ontario and employed by a public hospital.

C. Advanced DHTs are insured services payable at nil unless:

1. the *professional component* is personally rendered by an otolaryngologist or, for evoked audiometry, a neurologist or by a non-certified physician with equivalent post-graduate academic training (appropriate specialist or equivalent); and

2. the *technical component* is personally rendered by an appropriate specialist or equivalent, or delegated by an appropriate specialist or equivalent to an audiologist who is a member of the College of Audiologists and Speech-Language Pathologists of Ontario and is employed by the appropriate specialist or equivalent or a public hospital.

D. Physicians submitting claims for DHTs shall maintain written records of appropriate qualifications as indicated above for themselves and those employees to whom they may delegate the *technical component*. Such records must be made available to the ministry on request. In the absence of such records, the DHT is an insured service payable at nil.

[Commentary:

1. Delegated DHT services - To qualify for payment, delegated DHT services must comply with the requirements for delegation of insured services described in the General Preamble GP42.

2. Interpretation of DHT services - To qualify for payment, the physician who claims the *professional component* must personally interpret the DHT and cannot delegate the interpretation to another person.

3. Controlled Acts - Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis, or prescribing a hearing aid for a hearing impaired person are controlled acts. If a physician interprets a diagnostic hearing test without communicating the diagnosis to the patient or his or her personal representative, a controlled act has not occurred.

4. Fixed level screening audiometry is not an insured service.

5. DHTs at the request of or arranged by third party, e.g. school boards, employers or WSIB etc. are not insured services. See Appendix A regarding third party service.]

		T	P
	BASIC DIAGNOSTIC HEARING TESTS		
	Pure tone threshold audiometry with or without bone conduction		
G440	- technical component	10.30	
G525	- professional component		5.85
	Pure tone threshold audiometry (with or without **bone conduction) and speech reception threshold and/or speech discrimination scores.**		
G441	- technical component	17.90	
G526	- professional component		15.70
	ADVANCED DIAGNOSTIC HEARING TESTS		
	Impedance audiometry by manual or automated methods		
G442	- technical component	3.25	
G529	- professional component		1.86

Note:
G442, G529 *may include* stapedial reflex and/or compliance testing.

	Sound field audiometry (infants and children)		
G448	- technical component	21.70	
G450	- professional component		5.70

Note:
The amount payable is reduced to nil if any claim is submitted for G525, G441 or G526 rendered to the patient on the same *day*.

	Miscellaneous advanced testing e.g. recruitment, tests of malingering, central auditory and stapedial reflex decay tests - per test		
G443	- technical component, to a maximum of 1 per test	7.80	
G530	- professional component, to a maximum of 1 per test		5.95

		T	P1	P2
	Cortical evoked audiometry			
G143	- technical component	36.00		
G141	- professional component (P1)		23.95	
G142	- interpretation only (P2)			10.85

Note:
For cortical evoked audiometry, multiple frequency, as required by WSIB - see Appendix F.

	Brain stem evoked audiometry			
G146	- technical component	36.00		
G144	- professional component (P1)		23.95	
G145	- interpretation only (P2)			15.85

Note:
P1 may only be claimed when physician performs the studies and interprets the results.

OTOLARYNGOLOGY

		T	P
	Electrocochleography (per ear): to include myringotomy if performed		
G815	- technical component	36.00	
G816	- professional component		104.45
	DIAGNOSTIC BALANCE TESTS		
	Positional testing with electronystagmography (ENG)		
G104	- technical component	18.55	
G105	- professional component		20.90
	Caloric testing with ENG		
G451	- technical component	18.55	
G533	- professional component		18.30

		Fee
G454	Stroboscopy	16.80
G191	Optokinetic tests	12.40
G108	Computerized rotation tests	20.20

Fee

TELEPHONE MANAGEMENT OF PALLIATIVE CARE

The provision by telephone of medical advice, direction or information at the request of the patient, patient's relative(s), *patient's representative* or other caregiver(s), regarding a patient receiving *palliative care* at *home*. The service must be rendered personally by the physician and is eligible for payment only when a dated summary of the telephone call is recorded in the patient's medical record.

G511	Telephone management regarding a patient receiving palliative care at home	per call	17.75

Payment rules:

1. This service is limited to a maximum of two services per *week*.
2. This service is *not eligible for payment* if rendered the same *day* as a consultation, assessment, time-based service or other visit by the same physician.
3. This service is *not eligible for payment* if a claim is submitted for K071 or K072 for the same telephone call.
4. This service is *only eligible for payment* when rendered by the physician most responsible for the patient's care or by a physician substituting for this physician.

[Commentary:
This service is *only eligible for payment* when the patient is receiving *palliative care* in either the patient's *home* or the *home* of a family member or other individual with whom the patient is residing. See definitions of "*home*" and "*palliative care*" in the Definitions section of the General Preamble.]

Fee

PALLIATIVE CARE CASE MANAGEMENT FEE

The service rendered for providing supervision of *palliative care* to a patient for a period of one *week*, commencing at midnight Sunday, and includes the following *specific elements*.

A. Monitoring the condition of a patient including ordering tests and interpreting test results.

B. Discussion with and providing telephone advice to the patient, patient's family or *patient's representative* even if initiated by the patient, patient's family or *patient's representative*.

C. Arranging for assessments, procedures or therapy and coordinating community and hospital care including but not limited to urgent rescue palliative radiation therapy or chemotherapy, blood transfusions, paracentesis/thoracentesis, intravenous or subcutaneous therapy.

D. Providing premises, equipment, supplies and personnel for all elements of the service

G512 Palliative care case management fee..... 62.75

Payment rules:

1. The service is *only eligible for payment* when rendered by the physician most responsible for the patient's care, or by a physician substituting for this physician.

2. G511, K071 or K072 are *not eligible for payment* to any physician when rendered during a *week* that G512 is rendered.

3. G512 is limited to a maximum of one per *week* (Monday to Sunday inclusive) per patient and, in the instance a patient is transferred from one *most responsible physician* to another, is *only eligible for payment* to the physician who rendered the service the majority of the *week*.

4. In the event of the death of the patient or where care commences on any *day* of the *week*, G512 is eligible for payment even if the service was not provided for the entire *week*.

[Commentary:

1. Services not excluded in payment rule #2 such as assessments, subsequent visit fees, W010, K023, special visit premiums etc. remain eligible for payment when rendered with G512.

2. See the Definitions section of the General Preamble for the definition of *palliative care*

3. This service is eligible for payment for services rendered to patients receiving *palliative care* in any location including their *home*, hospital, nursing *home* etc.]

NEEDLE ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

PREAMBLE

1. When patients are referred directly to an electromyography (EMG) and/or nerve conduction studies (NCS) facility for diagnostic testing, then consultation or assessment by the diagnostic physician is *not eligible for payment* except where a medically necessary consultation or assessment is requested by the referring physician in addition to the EMG.
2. If a physician owns the EMG/NCS equipment and either employs and provides clinical supervision for a technician to perform the procedure or performs the procedure personally, then both the technical and the *professional component* are payable to the physician.
3. *Schedule* A, *Schedule* B, *Schedule* C and Single Fibre Electromyography refer to procedures performed using intramuscular placement of a recording needle electrode. Claims for surface EMG or other EMG techniques are *not eligible for payment*.
4. A nerve conduction study is a procedure using direct electrical stimulation of relevant peripheral nerve(s) with corresponding measurement(s) of evoked latency, conduction velocity, and amplitude using surface or percutaneous recording electrodes. Additional recordings, such as late responses or reflexes, are included in the service, if rendered. A permanent record of the procedure must be maintained in the patient chart.

Schedule A

Complete procedure i.e. conduction studies on two or more nerves presumed to be involved in the disease process together with EMG studies of appropriate muscles, as necessary and/or detailed studies of neuromuscular transmission. It also includes as necessary study of normal nerve and/or opposite side for comparison.

G455	- technical component	27.40		
G456	- professional component - when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results (P1)		117.50	
G459	- interpretation only (P2)			22.30

Schedule B

Limited procedure i.e. conduction studies on a single nerve (motor and/or sensory conduction) and/or limited EMG studies of the involved muscle(s) and or limited neuromuscular transmission study.

G466	- technical component	18.40		
G457	- professional component - when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results (P1)		72.90	
G469	- interpretation only (P2)			22.60

Schedule C

A complete procedure for complex neuromuscular disorders requiring a minimum of 60 minutes to perform the procedure that includes either:

a. at least two motor and sensory NCS in each of three limbs; and

b. needle EMG studies of at least two muscles in two separate segments.

or

a. at least two motor and sensory NCS in two limbs;

b. needle EMG studies of at least two muscles in each of two separate segments; and

c. repetitive nerve stimulation studies of at least one nerve/muscle pair.

Note:
For the purposes of G471/G473, the cranial, cervical, thoracic and lumbosacral regions represent separate segments.

G471	- technical component	27.40	
G473	- professional component		191.00

1. G473 is *not eligible for payment* with G456, G459, G457, or G469 same patient same *day*.

2. G471 is *not eligible for payment* with G455 or G466 same patient same *day*.

3. G458 is eligible for payment in addition to G473 only when the time necessary to perform the G458 service is not included in the minimum time requirement for G473.

The start and stop time must be recorded in the patient's medical record or the service is *not eligible for payment*. See General Preamble GP6 and GP45 for definitions and time-keeping requirements.

Complex neuromuscular disorders where *Schedule* C nerve conduction studies/electromyography may be appropriate include demyelinating neuropathies, mononeuritis multiplex, motor neuron disease, brachial/lumbosacral plexopathies and neuromuscular transmission disorders.]

		Fee
	Single fibre electromyography	
G458	Single fibre electromyography	191.70
	CHEMODENERVATION INJECTION	

Chemodenervation injection of individual peripheral motor nerve using phenol, ethyl alcohol or similar non-anaesthetic chemical agents for reduction of focal spasticity, and *may include* electromyography (EMG) guidance of injection(s).

G485	- first major nerve and/or branches		45.45
G486	- each additional major nerve and/or its branches same day	add	28.50
	Repeat or additional procedure within 30 day**s of previous chemodenervation injection**		
G487	- first major nerve and/or its branches		28.50
G488	- each additional major nerve and/or its branches same day	add	18.80

1. Use nerve block listings under Nerve Blocks sub-section if anaesthetic agents are used instead of phenol or alcohol or similar non-anaesthetic chemical agents.

2. Chemodenervation injection into same muscle same *day* as botulinum toxin is an insured service payable at nil.

			Fee	Anae
		PSYCHIATRY		
		Electroconvulsive therapy (ECT) cerebral - single or multiple		
#	G478	- in-patient	80.30	6
#	G479	- out-patient	92.60	6

Electrosleep therapy or Sedac therapy are not insured benefits.

RESPIRATORY DISEASE

G404	Chronic ventilatory care outside an Intensive Care Unit	61.00	

Maximum 2 per *week*. Any other amount payable for consultations or assessments same patient, same physician, same *day* will be reduced to nil.

SLEEP STUDIES

For the purpose of sleep studies (including overnight sleep studies in non-specialized facilities, overnight sleep studies rendered in specialized facilities and *day*time sleep studies),

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

"off-site premises" means off-site premises operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

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

A "physician practicing sleep medicine" refers to a physician who meets the Medical Staff requirements as defined in Chapter 2 of the "Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine, September 2010 from the *CPSO*.]

SPECIFIC ELEMENTS

Sleep Studies are divided into a *professional component* listed in the columns headed with a "P1" or "P2", and a *technical component* listed in the column headed with an "H" (the *technical component*).

The *specific elements* for the *technical component* H include the *specific elements* for the *technical component* of non-invasive diagnostic procedures listed in the Preamble to Diagnostic and Therapeutic Procedures.

If the physician is physically present during the study, the physician's physical presence is a specific element of the technical and *professional component*s.

OTHER TERMS AND CONDITIONS

For services rendered outside a hospital or off-site premises, the only fees payable under the *Health Insurance Act* are for the *professional component* listed under the P1 or P2 columns (use suffix C). Fees for the *technical component* of these services are only payable under the *Independent Health Facilities Act* and are listed in the *Schedule* of Facility Fees.

The physician who submits a claim for the P1 fee is responsible for both the clinical supervision of the study and for the interpretation of the procedure.

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

[Commentary:
For definitions of maximum and limits see GP5.]

Claims submission instructions:
Submit claims for *professional and technical component*s separately. Submit claims for the *technical component* H using listed fee code with suffix B. Submit claims for *professional component* P1 using first listed fee code with suffix C (e.g. J890C), and claims for *professional component* P2 using second listed fee code with suffix C (e.g. J690C).

SLEEP STUDIES

Technical Component

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

1. It satisfies the conditions set out under “Diagnostic Services Rendered at a Hospital".
2. It is rendered at a hospital or off-site premises.
3. A technician is in constant attendance with the patient(s) during the period of the sleep study.
4. The qualifications of technical staff participating in the sleep study comply with the criteria set out in the *CPSO* Standards.
5. All equipment and test components comply with the criteria set out in the *CPSO* Standards.

Professional Component

Payment rules:
1. The *professional component* of any sleep study service is eligible for payment only if it meets all of the following requirements:

- **a.** The qualifications of the physician interpreting the sleep study comply with the criteria for physicians practicing sleep medicine set out in the *CPSO* Standards. The service, if delegated in whole or in part, is delegated to a physician whose qualifications comply with the criteria for physicians practicing sleep medicine set out in the *CPSO* Standards; and
- **b.** A physician meeting the qualifications above is accessible at all times during the sleep study;
  - **i.** to make applicable decisions about the patient in connection with the performance of the procedure; and
  - **ii.** to insure that all elements of the *technical component* of the procedure including set-up and monitoring are carried out in accordance with generally accepted standards of practice as set out in the *CPSO* Standards.

2. A claim for the *professional component* P1 of the service is *only eligible for payment* if the physician interpreting the sleep study is personally accessible and meets the requirements under payment rule #1(b) above.

[Commentary:
1. Special visit premiums are *not eligible for payment* in conjunction with sleep studies.

2. Physical presence by the physician is not required. However, if the physician is physically present, the physician’s physical presence is a specific element of the *technical* and *professional component*s.]

Medical record requirements:
1. Records of the *technical component* must conform to the standards for facilities and facility operators (including records required prior to data analysis) as set out in the *CPSO* Standards, or the *technical component* is *not eligible for payment*.

2. Records of the *professional component* must conform to the *CPSO* record standards (including records required at data analysis, and reports) as set out in the *CPSO* Standards, or the *professional component* is *not eligible for payment*.

SLEEP STUDIES

H	P1	P2

A. Incomplete overnight sleep studies

If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with generally accepted standards as set out in the CPSO Standards, the professional fee is not eligible for payment and the service constitutes one of the following, as determined by time in bed (total study time):

J898	Sleep study less than 1 hour	92.65
J899	Sleep study between 1 and 4 hours	185.40
J990	Sleep study more than 4 hours	370.75

Payment rules:

1. A maximum of one of any of J898, J899 and J990 is eligible for payment, per patient ,per facility, per *12 month period*.

2. J898, J899 and J990 are not included in the limits for overnight studies set out below.

B. Overnight sleep studies in non-specialized facilities

Level 1

Is an overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG).

Initial diagnostic study

"Initial diagnostic study" means the first overnight sleep study rendered to an insured person as an insured service in Ontario for the purpose of establishing the diagnosis of a sleep disorder (and includes a split night study). Every overnight diagnostic sleep study rendered before July 1, 2010 for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes an "initial diagnostic study" and is deemed to have been rendered on July 1, 2010.

Initial diagnostic study - Level 1

J896	- diagnostic study	370.75	121.90	
J696	- diagnostic study	370.75		65.40

Note:

1. A maximum of one initial diagnostic study is eligible for payment per patient per lifetime.

2. All subsequent overnight sleep studies constitute "repeat diagnostic" or "therapeutic" studies.

Repeat diagnostic study

"Repeat diagnostic study" means an overnight diagnostic sleep study rendered:

a. for the purpose of obtaining a second opinion at a different facility than the facility where the preceding study was rendered, provided that the following conditions are met:

i. prior to the repeat diagnostic study, the patient has been assessed by a physician who practices sleep medicine at the different facility,

[Commentary:
The different facility requirement above applies to a repeat diagnostic study rendered at a hospital, a hospital off-site premise or an independent health facility.]

ii. where the previous study was rendered at an independent health facility and the repeat diagnostic study is rendered at a different independent health facility (the "different facility") than the independent health facility where the preceding study was rendered (the "first facility"), neither the owner nor the operator of the different facility is, at the time the repeat study is rendered, an associate of the owner or operator of the first facility, where "associate" has the same meaning as in the *Independent Health Facilities Act*; or

b. for one or more of the following purposes, after pre-study assessment by a physician practicing sleep medicine:

i. re-evaluation of a previous negative or inconclusive diagnostic sleep study as indicated by persistent or progressive symptoms;

ii. re-evaluation, other than primarily for Positive Airway Pressure therapy (PAP) adjustment, of patients previously diagnosed with a primary sleep disorder in which there has been symptom development suggesting another co-morbid sleep disorder; or

iii. re-evaluation of patients with an established diagnosis of a sleep disorder other than a sleep related breathing disorder who have significant symptom progression or non-response to therapy.

[Commentary:
1. In the case of patients with previously diagnosed sleep related breathing disorders, although PAP treatment may be adjusted during a repeat study, a repeat study is *not eligible for payment* if rendered primarily for PAP treatment adjustment.

2. Examples of sleep disorders other than a sleep related breathing disorder are Narcolepsy, Id*iop*athic hypersomnia and Periodic Limb Movement Disorder.]

Repeat diagnostic study - Level 1

J897	- diagnostic study	370.75	121.90	
J697	- diagnostic study	370.75		65.40

Payment rules:

1. Repeat diagnostic studies are limited to one per patient, per facility, per *12-month period* except where prior approval has been given.

2. Repeat diagnostic studies performed in the same facility that performed the initial diagnostic study are *not eligible for payment* in the *12 month period* following an initial diagnostic study except where prior approval has been given.

Therapeutic study

Except as described in note #3 on page J90, "Therapeutic Study" means a sleep study rendered after pre-study assessment by a physician practicing sleep medicine, for any of the following purposes:

a. To establish optimal settings for nasal positive airway pressure therapy (CPAP/BiPAP/ASV etc.) and/or oxygen therapy for sleep related breathing disorders;

[Commentary:
Examples of sleep related breathing disorders are obstructive sleep apnea syndrome (OSAS), central sleep apnea syndrome (CSAS), Cheyne-Stokes breathing, complex sleep apnea syndrome, or hypoventilation syndromes.]

b. To evaluate the response to surgical procedures for the treatment of OSAS;

c. To determine the efficacy of oral appliance therapy for OSAS;

d. To evaluate the efficacy of positional therapy for the treatment of OSAS;

e. To evaluate the efficacy of substantial weight loss for the treatment of OSAS; or

f. To titrate ventilatory settings for patients with respiratory control disorders, neuromuscular or neurodegenerative diseases.

SLEEP STUDIES

		H	P1	P2
	Therapeutic study for sleep related breathing disorders - Level 1			
J895	- therapeutic study	370.75	121.90	
J695	- therapeutic study	370.75		65.40

1. There is a limit of one therapeutic study (either J895 or J695) per patient during any two consecutive *12 month period*s except where prior approval has been given.

2. J895/J695 rendered to the same patient during the same 12 - hour period as J896/J696 or J897/J697 is *not eligible for payment*.

Subject to the prior approval requirements, an additional therapeutic study in excess of the above limits may be payable when necessary to evaluate a change in the treatment modality for a sleep related breathing disorder.]

Note:

1. For payment purposes, repeat diagnostic studies or therapeutic studies for indications or in circumstances other than listed above, or in excess of the limits set out above require prior approval.

2. A repeat diagnostic study rendered without the required pre-study assessment by a physician practicing sleep medicine, is *not eligible for payment*.

3. A therapeutic study rendered without a pre-study assessment by a physician practicing sleep medicine is *not eligible for payment* except:

- **a.** For the therapeutic study that immediately follows an initial diagnostic or repeat diagnostic study where:
  - **i.** the time interval is such that it is unlikely the clinical circumstances of the patient has changed; and
  - **ii.** the physician practicing sleep medicine has previously assessed the patient and documented the applicable decisions with respect to the performance of the therapeutic study; or
- **b.** In exceptional circumstances where the physician can demonstrate to the ministry upon request that the *CPSO* standards are satisfied with the use of a clinical protocol or approved medical directive.

[Commentary:

1. An example of an exceptional circumstance may be where a patient is required to travel a long distance to a sleep facility and requires an initial diagnostic or repeat diagnostic study followed by a therapeutic study on a subsequent night. For payment purposes, a pre-study assessment by a physician practicing sleep medicine is not required provided the therapeutic study is rendered in accordance with a clinical protocol or medical directive that has been approved by an authority other than a physician affiliated with the sleep facility (e.g. a Medical Advisory Committee for a sleep clinic affiliated with a hospital). The physician should be prepared to provide any necessary supporting documentation to the ministry upon request.

2. Prior approval, where required, will typically be dependent on the physician demonstrating that the study is generally accepted as necessary for the patient under the circumstances.

3. Sleep studies that require prior approval also require a pre-study assessment by a physician practicing sleep medicine. It is this assessment upon which the request for prior approval is considered.

4. Prior approval requires a written request accompanied by supporting documentation including the pre-study assessment and the relevant previous sleep study reports.

5. Split-night sleep studies are claimed as J896/J696 or J897/J697 only, as appropriate to the study rendered.]

C. Overnight sleep studies rendered in specialized facilities

A specialized facility is:

a. a facility where patients are on ventilatory support and that specializes in the treatment of *adult*s with conditions such as amyotropic lateral sclerosis or polio; or

b. a paediatric hospital where there is a Paediatric ICU and that treats children with respiratory control disorders.

Level 1

Overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG).

Specialized facility diagnostic study

J890	- diagnostic study	370.75	121.90	
J690	- diagnostic study	370.75		65.40

Specialized facility therapeutic study

J889	- therapeutic study	370.75	121.90	
J689	- therapeutic study	370.75		65.40

Payment rules:

1. J889/J689 rendered to the same patient during the same 12 - hour period as J890/J690 is *not eligible for payment*.

2. Except where prior approval is given, overnight sleep studies rendered in specialized facilities are limited to two per patient, per *12 month period* for any combination of such studies.

3. For services rendered on or after July 1, 2010, the *12 month period* is determined from July 1, 2009 onwards.

D. Daytime sleep studies

J893	Multiple sleep latency test	68.95	49.90
J894	Maintenance of wakefulness test	68.95	49.90

Payment rules:

1. J894 rendered to same patient same *day* as J893 is *not eligible for payment*.

2. A maximum of one J893 and a maximum of one J894 are payable per *12 month period* per facility per patient.

3. If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with *CPSO* Standards, the service is *not eligible for payment*.

4. EEG services (i.e. G414, G415, G418, G541, G543, G540, G545, G542, G546, G554, G555, or G544) are *not eligible for payment* with any overnight or *day*time sleep study (i.e. J898, J899, J990, J896, J696, J897, J697, J895, J695, J890, J690, J889, J689, J893 or J894).

UROLOGY

			Fee	P2
#	G900	Residual urine measurement by ultrasound	12.70	

Note:
Residual urine measurement by ultrasound (G900) is *not eligible for payment* in addition to an ultrasound of the pelvis, intracavity ultrasound, G192 - G194, or G475 when cystometrogram and/or voiding pressure studies are rendered.

[Commentary:
G475 is payable with G900 when uroflow studies are performed (flow rate *with or without* postural studies) with residual urine measurement by ultrasound.]

+	G475	Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including interpretation	23.75	
	G192	Video fluoroscopic multichannel urodynamic assessment to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with simultaneous fluoroscope imaging and recording of filling and voiding phases including interpretation	73.65	
#	G193	Complete multichannel urodynamic assessment - to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with or without pressure-flow studies	43.85	
#	G194	- with EMG ..... add	8.35	
	G477	Interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel) (P2)		5.40
+	G476	Prostatic massage	5.40	