

Schedule of Facility Fees

for
Independent Health Facilities

Under the
Independent Health Facilities Act

NUCLEAR MEDICINE – IN VIVO

Code	F
<u>CARDIOVASCULAR SYSTEM</u>	
Venography	
J802/J602	96.35
- peripheral and superior vena cava	
First Transit	
J804/J604	16.10
J867/J667	57.30
- without blood pool images	
- with blood pool images	
Cardioangiography	
J806/J606	95.10
- first pass for shunt detection, cardiac output and transit studies	
Myocardial Perfusion Scintigraphy	
J807/J607	217.55
J866/J666	43.50
J808/J608	80.10
J809/J609	43.50
- resting, immediate post stress	
- application of SPECT (maximum one per examination) add	
- delayed	
- application of SPECT (maximum two per examination) add	
Myocardial scintigraphy	
J810/J610	88.25
- acute infarction, injury	
Myocardial wall motion	
J811/J611	95.10
J812/J612	48.15
J813/J613	135.15
J814/J614	48.15
- studies	
- repeat same day (to a maximum of three repeats)	
- studies with ejection fraction	
- repeat same day (to a maximum of three repeats)	
Note: J811/J611 and/or J812/J612 rendered in conjunction with J813/J613 and/or J814/J614 are insured services payable at nil.	
J815/J615	121.70
Detection of venous thrombosis using radioiodinated fibrinogen up to ten days	
<u>ENDOCRINE SYSTEM</u>	
Adrenal scintigraphy	
J816/J616	385.90
J868/J668	451.30
J869/J669	555.35
- with iodocholesterol	
- with iodocholesterol and dexamethasone suppression	
- with MIBG	
Thyroid scintigraphy	
J818/J618	64.15
J871/J671	103.10
- with Tc99m or I-131	
- with I-123	
Thyroid	
J817/J617	28.65
J870/J670	14.65
- uptake	
- repeat	

NUCLEAR MEDICINE – IN VIVO

Code		F
<u>ENDOCRINE SYSTEM (continued)</u>		
Parathyroid scintigraphy		
J820/J620	-dual isotope technique with T1201 and Tc99m Iodine	234.70
J872/J672	Metastatic survey with I-131	240.60
<u>GASTROINTESTINAL SYSTEM</u>		
Schilling test		
J821/J621	- single isotope	44.65
J823/J623	- dual isotope	48.15
Malabsorption test		
J824/J624	- with C ¹⁴ substrate	57.30
J873/J673	- with whole body counting	137.70
Gastrointestinal		
J825/J625	- protein loss	82.45
J874/J674	- blood loss using – Cr ⁵¹	61.90
J829/J629	- transit	103.10
Calcium absorption		
J826/J626	- Ca ⁴⁵	61.90
J875/J675	- Calcium ⁴⁷ absorption/excretion	253.10
J827/J627	Oesophageal motility studies – one or more	118.90
Gastro-oesophageal		
J876/J676	- reflux	56.70
J877/J677	- aspiration	40.15
Abdominal scintigraphy – for gastrointestinal bleed		
J830/J630	- Tc99m sulphur colloid or Tc ⁰⁴	87.00
J878/J678	- labelled RBCs	143.20
J879/J679	- LeVeen shunt patency	66.30
J831/J631	Biliary scintigraphy	114.50
J832/J632	Liver/spleen scintigraphy	80.10
J833/J633	Salivary gland scintigraphy	96.25
<u>GENITOURINARY SYSTEM</u>		
J834/J634	Dynamic renal imaging	96.25
Computer assessed renal function		
J835/J635	- includes first transit	121.70
J880/J680	- repeat after pharmacological intervention	44.85

NUCLEAR MEDICINE – IN VIVO

Code	F
<u>GENITOURINARY SYSTEM (continued)</u>	
J836/J636	Static renal scintigraphy 32.25
J837/J637	ERPF by blood sample method 40.15
J838/J638	GFR by blood sample method 40.15
J839/J639	Cystography for vesicoureteric reflux 120.55
Testicular and scrotal scintigraphy	
J840/J640	- includes first transit 82.45
<u>HAEMATOPOIETIC SYSTEM</u>	
J841/J641	Plasma volume 43.50
J843/J643	Red cell volume 48.15
J847/J647	Ferrokinetics – clearance, turnover, and utilization 400.95
J848/J648	Red cell, white cell or platelet survival 102.60
J849/J649	Red cell survival with serial surface counts 148.25
Bone marrow scintigraphy	
J881/J681	- whole body 113.70
J882/J682	- single site 84.85
In-111 leukocyte scintigraphy	
J883/J683	- whole body 364.30
J884/J684	- single site 320.80
<u>MUSCULOSKELETAL SYSTEM</u>	
Bone scintigraphy	
J850/J650	- general survey 103.70
J851/J651	- single site 84.85
Gallium scintigraphy	
J852/J652	- general survey 177.55
J853/J653	- single survey 123.70
Application of Tomography (SPECT)	
J819/J619	- where each SPECT image represents a different organ or body area, to J852, J652, maximum three images per examination add 43.50
<p>Note: J850/J650 and J851/J651 are not to be billed together. J804/J604 may be claimed in addition to J850/J650 or J851/J651 for blood pool study.</p>	
<u>NERVOUS SYSTEM</u>	
CSF circulation	
J857/J657	- with Tc99m or I-131 HAS 120.25
J885/J685	- with In-111 308.20

NUCLEAR MEDICINE – IN VIVO

Code		F
<u>NERVOUS SYSTEM (continued)</u>		
J886/J686	- via shunt puncture	88.55
J858/J658	Brain scintigraphy	90.40
<u>RESPIRATORY SYSTEM</u>		
J859/J659	Perfusion lung scintigraphy	85.90
J887/J687	Ventilation lung scintigraphy	107.70
J860/J660	Perfusion and ventilation scintigraphy – same day	171.85
<u>MISCELLANEOUS</u>		
J861/J661	Radionuclide lymphangiogram	112.20
J862/J662	Ocular tumour localization	75.60
J864/J664	Tear duct scintigraphy	97.35
J865/J665	Total body counting	187.95
Application of Tomography (SPECT), other than to J808/J608 or J852/J652		
J866/J666	- maximum one per Nuclear Medicine examination	add 43.50
<u>SCINTIMAMMOGRAPHY</u>		
<p>Scintimammography is not eligible for payment unless at least one of the following conditions is met:</p> <ol style="list-style-type: none"> a. the patient has a dense breast(s) and one or both of the following risk factors: <ol style="list-style-type: none"> i. a first degree relative with breast cancer diagnosed prior to age 50; <li style="text-align: center;">or ii. a first degree relative with breast cancer diagnosed over age 50 and patient is within 5 years of the age when the relative was diagnosed with breast cancer. b. architectural distortion of the breasts due to prior breast surgery, radiotherapy, chemotherapy or the presence of breast prosthesis rendering mammography interpretation difficult; c. malignant breast lesion when mammography is unable to exclude multifocal disease; <li style="text-align: center;">or d. solitary lesion identified on mammography of greater than 1 cm 		
Scintimammography		
J863/J663	- unilateral or bilateral	99.95
<p>Note: For the purpose of this provision, “dense breast(s)” means (a) breast(s) occupied by over 75% fibroglandular tissue as noted on mammography.</p>		

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC RADIOLOGY

Code		F
SPECIAL EXAMINATIONS (continued)		
Bronchogram		
X158	- unilateral	31.18
X159	- bilateral	41.35
X122	Cholangiogram, percutaneous trans-hepatic	31.77
BONE MINERAL DENSITY (BMD) MEASUREMENT		
Dual-energy X-Ray Absorptiometry (DXA) – by axial technique only		
Definition:		
For the purpose of second and subsequent testing,		
<p>“high risk patient” means a patient;</p> <ol style="list-style-type: none"> 1. at risk for accelerated bone loss (in the absence of other risk factors, patient age is deemed not to place a patient at high risk for accelerated bone loss); 2. with osteopenia or osteoporosis on any previous BMD testing; <p style="text-align: center;">or</p> <ol style="list-style-type: none"> 3. with bone loss in excess of 1% per year as demonstrated by previous BMD testing. 		
<p>“low risk patient” means a patient who is not a high risk patient</p>		
Definition/Required Elements of Service:		
BMD measurement by DXA is an insured service only when all the following conditions have been met:		
<ol style="list-style-type: none"> 1. the service is rendered for the prevention and management of osteoporosis or osteopenia; 2. when more than one site is measured, the sites include both hip and spine and where measurement of both hip and spine is not technically feasible the site measured consists of either hip or spine. 		
[Commentary:		
Measurement of hip and spine would be considered not technically feasible due to prosthesis or deformity.]		
Baseline Test		
X145	- one site	46.14
X146	- two or more sites	59.44
Second test - low risk patient		
X152	- one site	46.14
X153	- two or more sites	59.44
Subsequent test - low risk patient		
X142	- one site	46.14
X148	- two or more sites	59.44

DIAGNOSTIC RADIOLOGY

Code	F
BONE MINERAL DENSITY (BMD) MEASUREMENT (continued)	
Subsequent test - high risk patient	
X149	46.14
X155	59.44
<p>Payment rules:</p> <ol style="list-style-type: none"> 1. Patients are limited to one baseline test (X145 or X146) in their lifetime. 2. Second test – low risk patient (X152/X153) is limited to a maximum of one test rendered not earlier than 36 months following the baseline test (X145/X146). 3. Subsequent test – low risk patient (X142/X148) is <i>not eligible for payment</i> when rendered earlier than 60 months following the second or any subsequent test. 4. Any combination of services described by X152 or X153 that were rendered to a patient between July 1, 2007, and April 1, 2008, for which claims were submitted and paid as insured services under the <i>Health Insurance Act</i> constitutes, a “second test – low risk patient” for the purpose of determining service maximums for a second or subsequent test – low risk patient, and is deemed to have been rendered on July 1, 2010. 5. Any service described by X152 or X153 rendered between April 1, 2008, and July 1, 2010, for which a claim was submitted and paid as an insured service under the <i>Health Insurance Act</i> constitutes a subsequent test – low risk patient for the purpose of determining service maximums for second or subsequent test – low risk patient and is deemed to have been rendered on July 1, 2010. 6. Subsequent test - high risk patients (X149/X155) is limited to a maximum of one test every 12 months unless the ordering physician obtains written prior authorization from a <i>medical consultant</i>. <p>[Commentary: Authorization will be dependent on the ordering physician demonstrating that the test is generally accepted as necessary for the patient under the circumstances.]</p> <p>[Commentary:</p> <ol style="list-style-type: none"> 1. Baseline, second test and subsequent tests should be ordered only in accordance with current practice guidelines. In those situations where testing is ordered on a particular patient for reasons that vary from the guidelines, the ordering physician should ensure that the patient’s medical record sufficiently explains the justification for the test in this particular case. 2. In the event a patient with a previous normal baseline test (X145/X146) or second test (X152/X153) or normal subsequent test – low risk patient (X142/X148) meets any of the criteria listed for high risk patients as stated above, the patient would be eligible for subsequent test – high risk patient services (X149/X155) subject to the restriction stated in payment rule #6. 3. The 2002 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada (reviewed in 2006) can be found at http://www.cmaj.ca/cgi/reprint/167/10_suppl/s1.pdf. 4. Individuals under age 65 without one major or two minor risk factors typically do not benefit from BMD measurement.] 	

DIAGNOSTIC RADIOLOGY

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

DIAGNOSTIC ULTRASOUND

Code	F
<u>HEAD AND NECK</u>	
Brain	
J122/J422 - complete, B-mode	47.20
Echography – ophthalmic (excluding vascular study)	
J102/J402 - quantitative, A-mode	22.40
J103/J403 - B-scan immersion	43.95
J107/J407 - B-scan contact	21.75
J108/J408 - biometry (Axial length – A-mode)	22.80
Face and/or neck	
J105/J405 - excluding vascular study	47.30
Note: J105/J405 is <i>not eligible for payment</i> when rendered for ultrasound imaging of the sinus(es).	
<u>THORAX, ABDOMEN AND RETROPERITONEUM</u>	
Thorax	
J125/J425 Chest masses, pleural effusion – A & B-mode	48.75
Abdomen and Retroperitoneum	
Abdominal scan	
J135/J435 - complete	48.75
J128/J428 - limited study (e.g. gallbladder only, aorta only or follow-up study)	32.10
<u>PREGNANCY</u>	
Complete	
J159/J459 - on or after 16 weeks gestation (maximum one per normal pregnancy)	48.75
J160/J460 - for high risk pregnancy or complications of pregnancy	48.75
J166/J466 - multiple gestation, for each additional fetus, to J160/J460	41.45
Gestational age for Maternal Serum Screening Program	
J157/J457 - before 16 weeks gestation (maximum one per normal pregnancy)	32.10
Limited	
J158/J458 - for high risk pregnancy or complications of pregnancy	32.10
J167 - fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158, add	32.10
Note: J167 is <i>only eligible for payment</i> when rendered by a physician for assessment of fetal anemia or intrauterine growth retardation measuring below the 10 th percentile	
J168/J468 - nuchal translucency for Prenatal Genetic Screening (maximum one per pregnancy)	39.00
J169/J469 - multiple gestation, for each additional fetus, to J168/J468 add	33.15

DIAGNOSTIC ULTRASOUND

Code	F
<u>PREGNANCY (continued)</u>	
Payment rules: Ultrasound services listed under the headings “Abdomen and Retroperitoneum” or “Pelvis” or “Pregnancy” rendered on the same day to the same patient by any physician as J168/J468 are <i>not eligible for payment</i> .	
<u>PELVIS</u>	
Pelvis	
J162/J462	48.75
- complete*	
J138/J438	48.75
Intracavitary ultrasound* (e.g. transrectal, transvaginal)	
Note: *For ovulation induction purposes, the limit is one per cycle. Additional ultrasounds may be claimed as J164/J464.	
J165	99.95
Transvaginal sonohysterography – may include saline or other intracavitary contrast media except Echovist for demonstration of tubal patency	
J476	232.90
Transvaginal sonohysterography – including Echovist contrast media for demonstration of tubal patency	
Note: J138/J438 and J161/J461 rendered in conjunction with J165 are insured services payable at nil.	
J163/J463	32.10
- limited study – for other than pregnancy	
Intracavitary ultrasound	
J161/J461	32.10
- limited – for other than pregnancy	
J164/J464	24.40
Follicle monitoring studies	
<u>VASCULAR SYSTEM</u>	
Extra-cranial vessel assessment – above the aortic arch	
Bilateral carotid and/or subclavian and/or vertebral arteries only	
J190/J490	42.65
- doppler scan or B scan	
J201/J501	55.05
- duplex scan i.e. simultaneous real time, B-mode imaging and spectral analysis	
Peripheral vessel assessment (distal to inguinal ligament or axilla), artery and/or vein evaluation per extremity. Not to be billed routinely with J190, J191 or J192.	
J193/J493	22.05
- doppler scan or B scan, unilateral	
J202/J502	28.50
- duplex scan i.e. simultaneous real time, B-mode imaging and spectral analysis, unilateral	

DIAGNOSTIC ULTRASOUND

Code	F	
<u>VASCULAR SYSTEM (continued)</u>		
Venous assessment		
J198/J498	- bilateral – includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manoeuvres and permanent record	7.40
Note: Note to be claimed during surgery or during patient's post-operative stay in hospital.		
Doppler evaluation of organ transplantation		
J205/J505	- arterial and/or venous	22.05
Duplex evaluation of portal hypertension		
J206/J506	- must include doppler interrogation and documentation of superior mesenteric vein, splenic vein, portal veins, hepatic veins and hepatic arteries	22.05
Note: Not to be billed unless study specifically requested by referring physician.		
Duplex assessment of patency obstruction, and flow direction of vascular shunts		
J207/J507	- must include doppler interrogation and documentation of vascular shunts	22.05
Note: Not to be billed unless study specifically requested by referring physician.		
<u>VASCULAR LABORATORY FEES</u>		
Ankle pressure measurements		
J200/J500	- requires a minimum of 4 segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings - unilateral or bilateral	20.40
J196/J496	- with exercise and/or quantitative measurement, to J200/J500	add 8.00
Note:		
1. G517 is <i>not eligible for payment</i> in addition to J200/J500.		
2. This service is <i>only eligible for payment</i> when the device used produces a hard copy output.		
[Commentary:		
For ankle pressure determination and ankle-arm index, see G517 under Cardiovascular Diagnostic & Therapeutic Procedures of the Schedule of Benefits.]		
Penile pressure recordings		
J197/J497	- two or more pressures	6.85
Penile Doppler Evaluation		
J199/J499	- Doppler scan	6.85

DIAGNOSTIC ULTRASOUND

Code	F
<u>VASCULAR LABORATORY FEES (continued)</u>	
<p>Note: Penile Doppler is only insured for the following indications:</p> <ol style="list-style-type: none"> 1. priapism; 2. trauma; 3. revascularization; 4. primary erectile dysfunction; or 5. failure of both oral and injectable therapy for erectile dysfunction. <p>[Commentary: Penile Doppler performed for other indications is not an insured service.]</p>	
Transcutaneous tissue	
J203/J503	24.10
J204/J504	13.20
<u>MISCELLANEOUS</u>	
Extremities	
J182/J482	25.50
Breast	
J127/J427	23.70
Scrotal	
J183/J483	47.30
<u>ULTRASONIC GUIDANCE</u>	
<p>SPECIFIC ELEMENTS In addition to the <i>common elements</i>, the components of Ultrasonic Guidance include the following <i>specific elements</i>.</p> <ol style="list-style-type: none"> A. Preparing the patient for the procedure. B. Assisting at the performance of the procedure. C. Making arrangements for follow-up care. D. Discussion with, and providing information and advice to the patient or <i>patient's representative(s)</i>, whether by telephone or otherwise, on matters related to the service. E. Providing premises, equipment, supplies and personnel for all <i>specific elements</i> of the technical and professional components except for the premises for any aspect(s) of A and D of the <i>professional component</i> that is(are) not performed at the place in which the procedure is performed. 	
J149	47.30
<p>Note: J138/J438 and J161/J461 performed during the same visit as J149 is an insured service payable at nil.</p>	

PULMONARY FUNCTION STUDIES

Code		F
Functional residual capacity		
J311	- by gas dilution method	16.30
J307	- by body plethysmography	17.50
Note: J311 not to be claimed same patient same day as J307.		
J305	Lung compliance (pressure volume curve of the lung from TLC to FRC)	51.95
J306	Airways resistance by plethysmography or estimated using oesophageal catheter	16.20
J303	Extra pulmonary airways resistance by plethysmography	16.20
J340	Maximum inspiratory and expiratory pressures	2.81
J310	Carbon monoxide diffusing capacity by single breath method	21.40
J308	Carbon dioxide ventilatory response	19.90
Stage I		
J315	Graded exercise to maximum tolerance (exercise must include continuous heart rate, oximetry and ventilation at rest and at each workload)	62.45
E450	- J315 plus J301 or J304 before and/or after exercise	add 13.30
E451	- J315 plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise	add 18.10
Stage II		
J316	Repeated steady state graded exercise (must include heart rate, oximetry, ventilation, VO ₂ , VCO ₂ , BP, ECG, end tidal and mixed Venous CO ₂ at rest, 3 levels of exercise and recovery)	90.00
J330	Assessment of exercise induced asthma (workload sufficient to achieve heart rate 85% of predicted maximum; performance of J301 or J304 before exercise and 5-10 minutes post exercise)	33.35
J319	Blood gas analysis – pH, PO ₂ , PCO ₂ , bicarbonate and base excess	11.25
J318	Arterialized venous blood sample collection (e.g. ear lobe)	3.79
J320	A-a oxygen gradient requiring measurement of RQ by sampling mixed expired gas and using alveolar air equation	27.55
J331	Estimate of shunt (Qs/Qt) breathing pure oxygen	27.55
J313	Mixed venous PCO ₂ , by the rebreathing method	11.25
Oxygen saturation		
J323	- by oximetry at rest, with or without O ₂	4.20
J332	- by oximetry at rest and exercise, or during sleep with or without O ₂	17.60
J334	- J332 with at least two levels of supplemental O ₂	30.55
J336	- with single blind assessment of exercise on room air and with supplemental oxygen	30.55
Note:		
1. J323 is <i>not eligible for payment</i> when rendered with J332, J315, J316 or any overnight sleep study.		
2. J332 is <i>not eligible for payment</i> when rendered with J315, J316, or any overnight sleep study.		
3. J336 is <i>only eligible for payment</i> for evaluation of a patient to determine eligibility for funding under the Ontario Home Oxygen Program.		
4. J336 is not payable in addition to J332 or J334.		

PULMONARY FUNCTION STUDIES

Code	F	
PULMONARY FUNCTION STUDIES (continued)		
Medical record requirements: J323, J332, J334 or J336 are <i>not eligible for payment</i> unless a permanent record of the study is maintained.		
J322	Standard O ₂ consumption and CO ₂ production	5.30
J333	Non-specific bronchial provocative test (histamine, methacholine, thermal challenge)	48.25
J335	Antigen challenge test	51.85
Note: For home/self-care ventilation listing – see Diagnostic and Therapeutic Procedures page J27 of the Schedule of Benefits.		

SLEEP STUDIES

Code	F
<p>OVERNIGHT SLEEP STUDIES</p> <p>For the purpose of sleep studies (including overnight sleep studies and daytime sleep studies),</p> <p>“CPSO Standards” means the publication of the College of Physicians and Surgeons of Ontario entitled “Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine” in effect 6 months prior to the date upon which the sleep study was rendered.</p> <p>“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.</p> <p>Terms and Conditions</p> <p>Facility fees for sleep studies meeting the eligibility parameters are payable under the <i>Independent Health Facilities Act</i> and are listed in the Schedule of Facility Fees.</p> <p>Sleep studies are subject to limits set out below. Unless otherwise specifically provided, service(s) in excess of these limits are not insured services except when prior approval to exceed the limit is obtained from the Ministry of Health and Long-Term Care. Despite the foregoing, where prior approval to exceed a limit is not requested from the Ministry of Health and Long-Term Care but the service would otherwise satisfy one or more of the conditions for which prior approval to exceed the limit is routinely granted (had prior approval been requested) any service in excess of the limit is <i>not eligible for payment</i>.</p> <p>[Commentary: Services rendered in excess of a maximum are <i>not eligible for payment</i>.]</p> <p>IHF Facility Fee Payment rules:</p> <p>The <i>facility fee</i> for the procedure is <i>eligible for payment</i> only if it meets all of the following requirements:</p> <ol style="list-style-type: none"> 1. It satisfies the conditions set out under “Sleep Studies Services Rendered at a licensed Independent Health Facility (IHF)”. 2. It is rendered at a licensed IHF. 3. A technician is in constant attendance with the patient(s) during the period of the sleep study. 4. The qualifications of technical staff participating in the sleep study comply with the criteria set out in the CPSO Standards. 5. All equipment and test components comply with the criteria set out in the CPSO Standards. 	

SLEEP STUDIES

Code	F
<p>“Sleep Studies Services Rendered at a licensed Independent Health Facility (IHF)”.</p> <p>A. Incomplete Overnight Sleep Studies</p> <p>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 <i>not eligible for payment</i> and the service constitutes one of the following, as determined by time in bed (total study time):</p>	
J898	92.65
J899	185.40
J990	370.75
<p>Payment rules:</p> <ol style="list-style-type: none"> 1. A maximum of one of any of J898, J899 and J990 is eligible for payment, per patient ,per facility, per <i>12 month period</i>. 2. J898, J899 and J990 are not included in the limits for overnight studies set out below. <p>B. Overnight Sleep Studies in Independent Health Facilities</p> <p>Level 1</p> <p>Is a overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG).</p> <p style="text-align: center;">Initial Diagnostic Study</p> <p>“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 <i>Health Insurance Act</i> constitutes an “initial diagnostic study” and is deemed to have been rendered on July 1, 2010.</p>	
Initial Diagnostic Study – Level 1	
J896/J696	370.75
<p>Note:</p> <ol style="list-style-type: none"> 1. A maximum of one initial diagnostic study is eligible for payment per patient per lifetime. 2. All subsequent overnight sleep studies constitute “repeat diagnostic” or “therapeutic” studies. 	

SLEEP STUDIES

Code	F
<p style="text-align: center;">Repeat Diagnostic Study</p> <p>“Repeat Diagnostic Study” means an overnight diagnostic sleep study rendered:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> i. prior to the repeat diagnostic study, the patient has been assessed by a physician who practices sleep medicine at the different facility, <p>[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.]</p> <ul style="list-style-type: none"> 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 <i>Independent Health Facilities Act</i>, <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> b. for one or more of the following purposes, after pre-study assessment by a physician practicing sleep medicine: <ul style="list-style-type: none"> 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 <p>[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 <i>not eligible for payment</i> if rendered primarily for PAP treatment adjustment. 2. Examples of sleep disorders other than a sleep related breathing disorder are Narcolepsy, Idiopathic hypersomnia and Periodic Limb Movement Disorder.]</p>	
J897/J697 - diagnostic study	370.75

SLEEP STUDIES

Code		F
Repeat Diagnostic Study – Level 1 (continued)		
	<p>Payment rules:</p> <ol style="list-style-type: none"> 1. Repeat diagnostic studies are limited to one per patient, per facility, per <i>12 month period</i> except where prior approval has been given. 2. Repeat diagnostic studies performed in the same facility that performed the initial diagnostic study are <i>not eligible for payment</i> in the <i>12 month period</i> following an initial diagnostic study except where prior approval has been given. <p>Therapeutic study</p> <p>“Therapeutic Study” means a sleep study rendered after pre-study assessment by a physician practicing sleep medicine, for any of the following purposes:</p> <ol style="list-style-type: none"> a. To establish optimal settings for nasal positive airway pressure therapy (CPAP/BiPAP/ASV etc.) and/or oxygen therapy for sleep related breathing disorders; <p>[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.]</p> <ol style="list-style-type: none"> b. To evaluate the response to surgical procedures for the treatment of OSAS; c. To determine the efficacy of oral appliance therapy for OSAS; d. To evaluate the efficacy of positional therapy for the treatment of OSAS; e. To evaluate the efficacy of substantial weight loss for the treatment of OSAS; or f. To titrate ventilatory settings for patients with respiratory control disorders, neuromuscular or neurodegenerative diseases. 	
Therapeutic Study for Sleep Related Breathing Disorders – Level 1		
J895/J695	- therapeutic study	370.75
	<p>Payment rules:</p> <ol style="list-style-type: none"> 1. There is a limit of one therapeutic study (either J895 or J695) per patient during any two consecutive <i>12 month periods</i> 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 <i>not eligible for payment</i>. 	
	<p>Note:</p> <ol style="list-style-type: none"> 1. For payment purposes, repeat diagnostic studies or therapeutic studies for indications or in circumstances other than listed above, or in excess of the limits set out below, require prior approval. 2. A repeat diagnostic study rendered without the required pre-study assessment by a physician practicing sleep medicine, is <i>not eligible for payment</i>. 	

SLEEP STUDIES

Code	F
<u>Therapeutic Study for Sleep Related Breathing Disorders – Level 1 (continued)</u>	
<p>3. A therapeutic study rendered without a pre-study assessment by a physician practicing sleep medicine is <i>not eligible for payment</i> except:</p> <ul style="list-style-type: none"> a. For the therapeutic study that immediately follows an initial diagnostic or repeat diagnostic study where: <ul style="list-style-type: none"> 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. 	
<p>[Commentary:</p> <ol style="list-style-type: none"> 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. Daytime Sleep Studies	
J893	69.95
J894	69.95
<p>Payment rules:</p> <ol style="list-style-type: none"> 1. J894 rendered to same patient same <i>day</i> as J893 is <i>not eligible for payment</i>. 2. A maximum of one J893 and a maximum of one J894 are payable per <i>12 month period</i> per facility per patient. 	

SLEEP STUDIES

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