

DIAGNOSTIC AND THERAPEUTIC

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 GP15.
- B. Where the services are identified with prefix #, the *specific elements* are those listed in the General Preamble GP15 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.

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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.

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 components 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 components, 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

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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

Procedural benefits are payable in addition to a consultation or assessment except where they are specifically listed as included in these 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 payable in situations where the referring physician both:

1. Has a financial interest in the diagnostic or therapeutic facility; and
2. Has examined or is about to examine the patient in connection with the problem to which the procedure relates.

Note:

G700 is not payable for a service provided in a hospital department.

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

DIAGNOSTIC AND THERAPEUTIC

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 GP15).

# 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	4.10
G212 - when sole reason for visit (including first injection)	9.30

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	12.80
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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	2.39
G198 - for industrial or occupational dermatoses, to a maximum of 125 per patient, per year	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	13.80
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Payment rules:

- G208 is a time base service. Unit means one hour or major part thereof.
- 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 GP6 for definitions and time keeping requirements.

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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 yearper test 0.71

G197 - professional component, to a maximum of 50 per yearper test 0.17

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

DIAGNOSTIC AND THERAPEUTIC

ANAESTHESIA

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.

Note:

Despite paragraph b. listed under Basic Units on GP69, no anaesthesia service other than E023C is *eligible for payment* when rendered in support of Z432.

[Commentary:

Refer to E023C on GP75 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

DIAGNOSTIC AND THERAPEUTIC

CARDIOVASCULAR

Fee

Anae

Vascular cannulation

Z459	Arterial puncture.....	9.55	
# G268	Cannulation of artery for pressure measurements including cut down as necessary.....	31.25	

Note:

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.....	9.25	
+ G482	- child	7.00	
+ G489	- adolescent or adult	2.90	
+ 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
# G304	- when dye dilution densitometry done in addition, to a maximum of 3, per Swan-Ganz insertion	49.35	
G360	- when thermal dilution studies rendered in addition to Z438	49.35	

Note:

1. Thermal dilution studies must be *rendered personally by the physician* and are limited to a maximum of one per *day* to a maximum of 5 days per hospital admission at the same institution.

2. G304 is *not eligible for payment* with anaesthesia services rendered for a surgical procedure.

# Z456	Insertion of implantable central venous catheter.....	135.50	6
# Z457	Surgical removal or repair of implanted central venous catheter	39.45	6
# Z446	Insertion of subcutaneous venous access reservoir	135.50	6
# Z447	- revision same site.....	59.70	6
# E684	- when performed in infant or child, to Z456 or Z446..... add	172.65	

DIAGNOSTIC AND THERAPEUTIC

CARDIOVASCULAR

Fee

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	12.00
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DIAGNOSTIC AND THERAPEUTIC

CARDIOVASCULAR

Fee

Anae

BLOOD TRANSFUSIONS

G275 Exchange transfusion..... 205.45

Note:

Assistant at exchange transfusion (see General Preamble GP64).

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 GP12)..... 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

Note:

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

When more than one procedure is carried out at one sitting, the additional procedures are to be claimed 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 6

Z441 - transeptal..... 297.15 6

G296 Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab 110.95

Note:

1. When G296 is done in addition to Z438 use code G304 instead.

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

G299 Oximetry..... 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

DIAGNOSTIC AND THERAPEUTIC

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 - per graft injection..... 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 arteriosus with umbrella 377.55 20

Z461 - mitral valvuloplasty for rheumatic stenosis..... 566.20

Note:

Z448 to Z461 includes angiography *with or without* pressure measurements.

DIAGNOSTIC AND THERAPEUTIC

CARDIOVASCULAR

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:

G261 and/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:

- 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 Idiopathic ventricular tachycardia/premature ventricular ectopics (e.g. fascicular, ARVD, bundle branch reentry, aortic cusp, outflow tract, etc.)
Other	Congenital heart disease arrhythmia

- 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).]

DIAGNOSTIC AND THERAPEUTIC

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	- transeptal left heart catheterization, with or without pressure measurements, with or without dye injection.....	297.15	6
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Note:

1. Z424 is *only eligible for payment* when rendered with G176, G177 and/or G178.
2. Z424 is *eligible for payment* for each transeptal catheter placement to a maximum of 2.

# Z422	- retrograde aortic left heart catheterization with or without pressure measurement(s)	210.55	6
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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	
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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	
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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	
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Tilt table testing of vasomotor syncope

# G314	- to include arterial cannulation, provocative and blocking drugs, physician must be continually present.....	112.00	
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DIAGNOSTIC AND THERAPEUTIC

ELECTROCARDIOGRAPHY (ECG)

Fee

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.

G175 Insertion of oesophageal electrode in monitoring position 21.85

T

P

Electrocardiogram - twelve lead

+ G310	- technical component	6.75	
G313	- professional component - must include written interpretation		9.75

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	33.65	
G319	- professional component		62.65

Dobutamine stress test

G174	- technical component, when rendered outside of hospital.....add	37.00	
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Dipyridole Thallium stress test

G111	- technical component	41.10	
G112	- professional component		75.00

DIAGNOSTIC AND THERAPEUTIC

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	24.50	
G652	- technical component - 12 to 35 hours scanning.....	33.55	
G650	- professional component - 12 to 35 hours recording		47.90
G682	- technical component - 36 to 59 hours recording	49.00	
G683	- technical component - 36 to 59 hours scanning.....	67.05	
G658	- professional component - 36 to 59 hours recording		71.85
G684	- technical component - 60 or more hours recording.....	73.50	
G685	- technical component - 60 or more hours scanning	100.60	
G659	- professional component - 60 or more hours recording.....		95.85

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	23.40	
G655	- technical component - 12 to 35 hours scanning.....	16.00	
G653	- professional component - 12 to 35 hours recording		34.10
G686	- technical component - 36 to 59 hours recording	46.75	
G687	- technical component - 36 to 59 hours scanning.....	32.00	
G656	- professional component - 36 to 59 hours recording		51.15
G688	- technical component - 60 hours to 13 days recording.....	70.15	
G689	- technical component - 60 hours to 13 days scanning	48.05	
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.

DIAGNOSTIC AND THERAPEUTIC

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, recorder	233.65	
G693	- technical component, base station functions.....	168.20	
G690	- professional component, interpretation		122.25

[Commentary:

The technical fees for these procedures will be subject to a joint review by the Ministry and the Ontario Medical Association on or before December 31, 2004.]

Event recorder

G661	- technical component	4.10	
G660	- professional component		8.65

Interpretation of telephone transmitted ECG rhythm strip

G311	- technical component	1.97	
G320	- professional component (P2)		4.30

Single chamber reprogramming including electrocardiography

G284	- technical component	9.00	
G283	- professional component		11.30

Dual chamber reprogramming including electrocardiography

G181	- technical component	11.85	
G180	- professional component		16.95

Pacemaker pulse wave analysis including electrocardiography

G308	- technical component	9.00	
G307	- professional component		9.55

Automatic implantable defibrillator

Non-programmable including electrocardiography, interrogation and analysis

G317	- professional component		27.80
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Programmable including electrocardiography, interrogation and reprogramming

G321	- professional component		47.65
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DIAGNOSTIC AND THERAPEUTIC

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 10.60
 G518 - professional component 11.20

Impedance plethysmography

G121 - technical component 12.85
 G120 - professional component 7.00

Digital photoplethysmography

G127 - technical component, per extremity..... 12.85
 G126 - professional component, per extremity 7.00

DIAGNOSTIC AND THERAPEUTIC

ECHOCARDIOGRAPHY

T

P1

P2

PROFESSIONAL COMPONENTS

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 must be reviewed in its entirety by the physician) and provision of a written report by a suitably trained physician.

Complete study - 1 dimension

G560	- technical component	34.75		
G561	- professional component (P1)		35.55	
G562	- professional component (P2)			26.30

Complete study - 2 dimension

G566	- technical component	59.55		
G567	- professional component (P1)		55.85	
G568	- professional component (P2)			41.95

Complete study - 1 and 2 dimensions

G570	- technical component	76.45		
G571	- professional component (P1)		74.10	
G572	- professional component (P2)			55.40

Limited study - 1 or 2 dimensions, for follow-up studies - not to be claimed in conjunction with pregnancy study

G574	- technical component	16.45		
G575	- professional component (P1 or P2).....		17.45	17.45

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

G577	- technical component	45.15		
G578	- professional component (P1)		36.90	

Note:

G577 payable at nil in the absence of a claim for G578.

Transoesophageal echocardiography

G581	- professional component (P1)		25.00	
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Fee

G579	Saline study (including venipuncture)		11.35	
G580	Insertion of oesophageal transducer.....		45.00	

Note:

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

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

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)	98.70
G523	- second ¼ hour (or part thereof).....	49.30
G522	- after first ½ hour, per ¼ hour (or part thereof)	32.45
G391	Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof).....	25.30

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.

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

Fee

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.]

DIAGNOSTIC AND THERAPEUTIC

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)	50.70
G391	- after first ¼ hour per ¼ hour (or part thereof)	25.30

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.

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

Fee

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.]

[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

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

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.

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

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.....	211.15
# G401	- 2nd to 30th day, inclusiveper diem	138.60
# G402	- 31st day onwardsper diem	55.45

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.....	183.10
# G406	- 2nd to 30th day, inclusiveper diem	96.10
# G407	- 31st day onwardsper diem	64.00

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.....	308.00
# G558	- 2nd to 30th day, inclusiveper diem	202.05
# G559	- 31st day onwardsper diem	80.80

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

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	338.45
# G601	- 2nd to 30th day, inclusiveper diem	169.20
# G602	- 31st day onwards,per diem	84.55
# 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	507.70
# 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.....	507.70

Level B

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

# G610	- 1st day	232.25
# G611	- 2nd day onwards,per diem	116.10

Level C

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

# G620	- 1st day	146.75
# G621	- 2nd day onwards,per diem	73.35

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.

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

Fee

HYPERBARIC OXYGEN THERAPY (HBOT)

The service rendered when a physician, in constant attendance in the same room as the patient(s), 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 chamber with patient(s), per session per patient

# G800	- first ¼ hour	70.00
# G801	- after first ¼ hour (per ¼ hour or major part thereof)	35.00
# G802	- after 2 hours in chamber (per ¼ hour or major part thereof)	70.00

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

# G804	- first ¼ hour	60.00
# G805	- after first ¼ hour (per ¼ hour or major part thereof)	30.00

Payment rules:

1. A separate 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:

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

DIAGNOSTIC AND THERAPEUTIC

CRITICAL CARE

Fee

[Commentary:

As of October 1, 2009, 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]

Hypothermia induction

G210 Hypothermia (therapeutic) induction and management 190.75

DIAGNOSTIC AND THERAPEUTIC

DERMATOLOGY

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 facility listed in *Schedule 5* under Regulation 552 of the *Health Insurance Act*.

+ G470 Ultraviolet light therapy..... 7.85

[Commentary:

See General Preamble GP50 to GP51 for conditions and limitations regarding delegation and supervision of G470.]

DIAGNOSTIC AND THERAPEUTIC

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	6
	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	6
# Z451	- both	152.40	6
# Z452	De-clotting of Scribner shunt.....	93.60	
# R843	Removal of cannula or A.V. shunt.....	81.45	6
# R827	Creation of A.V. fistula	6 440.00	6

Note:

R827 - see also listing under Cardiovascular System, Veins - Repair.

# R841	Obliteration of A.V. fistula	82.55	6
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DIAGNOSTIC AND THERAPEUTIC

DIALYSIS

	Fee	Anae
Bypass graft for haemodialysis		
# R851 - synthetic	444.70	7
# R840 - autogenous vein	424.10	7
# R833 Ligation or removal of bypass graft	82.55	6
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)	135.80	
# G327 Insertion of femoral catheter for dialysis	77.30	
# G312 Thrombolytic instillation into temporary and permanent percutaneous catheters	15.40	
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	205.65	6
# R885 Removal of peritoneal cannula by laparotomy	205.65	6
Tenckhoff type peritoneal catheter		
# R853 - insertion, chronic by trocar	124.50	6
# R854 - removal	50.90	

DIAGNOSTIC AND THERAPEUTIC

DIALYSIS

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 Sunday 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 weekly 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 specialists 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.

DIAGNOSTIC AND THERAPEUTIC

DIALYSIS

Fee

Chronic dialysis weekly team fee

# G860 Hospital haemodialysis	136.75
# G861 Hospital peritoneal dialysis.....	136.75
# G862 Hospital self-care haemodialysis or satellite haemodialysis	136.75
# G863 Independent health facility haemodialysis.....	136.75
# G864 Home peritoneal dialysis	136.75
# G865 Home haemodialysis.....	136.75
# G866 Intermittent haemodialysis - at an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above).....	66.35

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 weekly team fee paid at the full amount, regardless of the number of treatments rendered.

DIAGNOSTIC AND THERAPEUTIC

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

DIAGNOSTIC AND THERAPEUTIC

ENDOCRINOLOGY AND METABOLISM

Fee

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.

[Commentary:

1. The clinical decisions(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
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DIAGNOSTIC AND THERAPEUTIC

GASTROENTEROLOGY

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

DIAGNOSTIC AND THERAPEUTIC

GASTROENTEROLOGY

	Fee
G254 Management of post liver or pancreas transplant immunosuppression - in lieu of non-emergency hospital visits - (once per day to a maximum of two weeks) per visit	21.00
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	8.60
+ 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	6.75
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.

DIAGNOSTIC AND THERAPEUTIC

GYNAECOLOGY

	Fee
G367 Artificial insemination	31.95
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	11.15
+ G362 Insertion of laminaria tent.....	6.25
E870 - when laminaria tent supplied by the physician.....	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	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 G7.]

Papanicolaou Smear

+ G365 - periodic - maximum one per patient per 12 month period, excluding smears provided in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment.....	6.75
+ G394 - additional - for follow-up of abnormal or inadequate smears.....	6.75
E430 - when papanicolaou smear is performed outside of hospital	11.15

Note:

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

Z463 Removal of Norplant	65.30
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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
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[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.]

DIAGNOSTIC AND THERAPEUTIC

HAEMATOLOGY

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 perweek 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.

DIAGNOSTIC AND THERAPEUTIC

HOME AND SELF CARE SERVICES

Fee

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 29.85

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 31.95

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.

DIAGNOSTIC AND THERAPEUTIC

INJECTIONS OR INFUSIONS

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	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 a maximum of one treatment per condition, per patient every 10 weeks. 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.]

DIAGNOSTIC AND THERAPEUTIC

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	19.90	
G371 - each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5	10.00	
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	15.00	

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.

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.

CHEMONUCLEOLYSIS

Lateral discography

# Z454 - first disc	74.75	6
G368 - if lumbosacral disc included	54.40	add
# G386 - second and subsequent discs	38.45	each

Injection for chemonucleolysis

# G392 - initial injection	50.75	
# G393 - any subsequent injection at other levels	25.35	each
G396 Injections of extensive keloids	24.90	
# Z455 - under general anaesthesia	44.70	6

INTRAMUSCULAR, SUBCUTANEOUS OR INTRADERMAL

G372 - with visit (each injection)	2.90
G373 - sole reason (first injection)	6.35
G372 - each additional injection	2.90

Note:

G372, G373 includes interpretation.

DIAGNOSTIC AND THERAPEUTIC

INJECTIONS OR INFUSIONS

Fee

ACTIVE IMMUNIZATION

Injection of unspecified agent

G538 - with visit (each injection)	4.10
G539 - sole reason (first injection)	9.00
G538 - each additional injection	4.10

Injection of influenza agent

G590 - with visit	4.10
G591 - sole reason	9.00
G538 - each additional injection with non-influenza agents	4.10

Payment rules:

Where G539 is rendered to the same patient during the same visit at which G591 is rendered, the amount payable for G539 is reduced to amount payable for G538.

INTRALESIONAL INFILTRATION

+ G375 - one or two lesions	8.85
+ G377 - 3 or more lesions	13.30
G383 - extensive (see General Preamble GP12)	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

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

DIAGNOSTIC AND THERAPEUTIC

INJECTIONS AND INFUSIONS

Fee

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

G536 Compression sclerotherapy (includes multiple injections, compression bandaging and one post injection visit utilizing principles of Fegan)..... 77.85
G537 Repeat compression sclerotherapy..... 26.05

Note:

1. Only the injection of veins greater than 5mm in diameter and associated with physical symptomatology are insured. This service is only insured when *rendered personally by the physician*.
2. 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 GP15). Not to be claimed in addition to hospital visits.

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

DIAGNOSTIC AND THERAPEUTIC

INJECTIONS OR INFUSIONS

Fee

CHEMOTHERAPY

Chemotherapy (marrow suppressant) - with each injection 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, consistent with generally accepted professional standards and/or protocols at the time of injection and for the duration of the infusion.

+ G381	Single injection (for agents other than doxorubicin, cisplatin, bleomycin or high dose methotrexate)	14.90
G281	- each additional injection (other than above drugs).....	7.50

Chemotherapy and patient assessment provided by physician in hospital-based clinics or to in-patients (the following benefits include patient assessment for a 24 hour period, drug administration and establishment of intravenous).

G339	Single agent intravenous chemotherapy i.e. doxorubicin, daunorubicin, epirubicin, mitoxintrone, cisplatin or bleomycin (greater than 10 units per metre square)	50.55
G345	Taxol, rituximab, trastuzumab, bortezomib, docetaxel administration or multiple agent intravenous chemotherapy including at least one of either doxorubicin, daunorubicin, epirubicin, mitoxintrone, cisplatin or bleomycin (greater than 10 units per metre square)	67.65
G359	Special single agent chemotherapy utilizing either high-dose methotrexate with folinic acid rescue - methotrexate given in a dose of greater than 1 g/m ² , high dose cisplatin greater than 75 mg/m ² given concurrently with hydration and osmotic diuresis, high dose cytosine, arabinoside (greater than 2g/m ²), or high dose cyclophosphamide (greater than 1g/m ²)	95.90
G075	Test dose (bleomycin and l-asparaginase) once per patient per drug	27.80
G382	Supervision of chemotherapy (marrow suppressant) for malignant or autoimmune disease by telephone - monthly .	12.15
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)	239.25

DIAGNOSTIC AND THERAPEUTIC

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 (atheromatous plaque; varicosity); Bartholin gland cyst; bone (other than pathologic fracture); bursa or synovial cyst; carpal tunnel tissue; cartilage (shavings); cholesteatoma; colostomy stoma; conjunctiva (pterygium); cornea; diverticulum (digestive tract); Dupuytren contracture tissue; femoral head (other than fracture); fissure or fistula; gallbladder; ganglion cyst; haematoma; haemorrhoid; hydatid of Morgagni; intervertebral disc; joint loose body; meniscus; mucocele (salivary); neuroma (traumatic; Morton); nasal or sinusoidal polyp (inflammatory); skin (acrochordon/tag; cyst; foreskin, other than neonate; debridement; pilonidal cyst or sinus); soft tissue (lipoma, debridement); spermatocele; tendon or tendon sheath; testicular appendage; thrombus or embolus; uterine contents (induced abortion); varicocele; vas deferens (other than sterilization).

DIAGNOSTIC AND THERAPEUTIC

LABORATORY MEDICINE

L864 SURGICAL PATHOLOGY, LEVEL 4.

Gross and microscopic examination of the following specimens:

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

L865 SURGICAL PATHOLOGY, LEVEL 5.

Gross and microscopic examination of the following specimens:

Adrenal gland (resection); bone (biopsy or curettings, pathologic fracture); brain (biopsy); 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 (biopsy or wedge or partial resection); lung (wedge biopsy); lymph nodes (regional resection; sentinel); mediastinum (biopsy); myocardium (biopsy); odontogenic neoplasm; ovary *with or without* fallopian tube (neoplasm); pancreas (biopsy); placenta (third trimester); prostate (other than transurethral resection or radical resection); salivary gland; small intestine (resection, other than neoplasm); soft tissue mass (other than lipoma; biopsy or simple excision); stomach (partial or total resection, other than neoplasm); testis (biopsy); 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 leiomyoma or prolapse, see L864.
2. For uterine neoplasm, see L866.

DIAGNOSTIC AND THERAPEUTIC

LABORATORY MEDICINE

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); stomach (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 leiomyoma); 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 components 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).

DIAGNOSTIC AND THERAPEUTIC

LABORATORY MEDICINE

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	61.25
L806	Bronchial, oesophageal, gastric, endometrial or other brushings and washings	29.00
L808	Imprint, touch preparation and/or direct smear	29.35
L815	Sputum per specimen for general and/or specific assessment e.g. cellular abnormalities, asbestos bodies, lipids, haemosiderin	28.45
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	18.25
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

DIAGNOSTIC AND THERAPEUTIC

LABORATORY MEDICINE

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.....	11.85
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)	15.75
L826	Blood film interpretation (special stain)	11.85
L802	Bone marrow interpretation (Romanowsky stain)	44.45
Z403	Bone marrow aspiration	33.90

DIAGNOSTIC AND THERAPEUTIC

LABORATORY MEDICINE

	Fee
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

LABORATORY MEDICINE IN PRIVATE OFFICE

The following services may be claimed when rendered by physicians who perform these tests in their own offices on their own patients.

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

G001 Cholesterol, total	5.50
G002 Glucose, quantitative or semi-quantitative	2.01
G481 Haemoglobin screen and/or haematocrit (any method or instrument)	1.32
G003 Lactic dehydrogenase (LDH) total.....	4.20
G004 Occult blood	1.52
G005 Pregnancy test	3.88
G006 SGOT	4.05
G007 Urea nitrogen (BUN)	2.42
G008 Uric acid	2.42
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.....	1.86
G011 Fungus culture including KOH preparation and smear	12.60
G012 Wet preparation (for fungus, trichomonas, parasites)	1.86
G014 Rapid streptococcal test.....	4.60

DIAGNOSTIC AND THERAPEUTIC

NEPHROLOGY

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	121.45
# G409 11th to 21st day, inclusive	60.70

Note:

G412, G408, G409 includes complete patient care.

DIAGNOSTIC AND THERAPEUTIC

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 weeks.
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:

- a. 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.
 - b. For obstetrical continuous conduction anaesthesia, see P014C, E111C 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. No guidance (e.g. nerve stimulation, ultrasound) used for nerve block services is *eligible for payment*.

DIAGNOSTIC AND THERAPEUTIC

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

10. When a physician renders an anaesthesia service in support of a nerve block procedure performed by another physician, the anaesthesia service is *only eligible for payment* as one of the following:

E030C Procedural sedation4 basic units

Note:

Extra units listed on GP73 are not payable with E030C.

E031C General anaesthesia or deep sedation4 basic units

Note:

Extra units listed on GP73 are *eligible for payment* with E031C.

[Commentary:

Z432C is *not eligible for payment* for an anaesthesia service in support of nerve block procedures.]

11. For the purposes of anaesthesia services described in paragraph 10:

- a. **Procedural Sedation** is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- b. **Deep Sedation** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- c. **General Anaesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

DIAGNOSTIC AND THERAPEUTIC

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
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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
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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*.

DIAGNOSTIC AND THERAPEUTIC

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 visit fee

Payment rules:

G247 is *only eligible for payment* to the physician most responsible for providing management and supervision of continuous catheter infusions for analgesia for a hospital in-patient, or to a physician substituting for that physician.

[Commentary:

G247 is *not eligible for payment* for visits to patients receiving only intravenous pain management.]

DIAGNOSTIC AND THERAPEUTIC

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

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. 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

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*.

DIAGNOSTIC AND THERAPEUTIC

NERVE BLOCKS DIAGNOSTIC AND THERAPEUTIC

PREAMBLE

1. Nerve blocks listed in this section are *eligible for payment* only when rendered for purposes other than acute pain management as described in the Nerve Blocks for Acute Pain Management section listed on J51.

[Commentary:

Nerve blocks for chronic pain management or diagnostic nerve blocks, for example, would be *eligible for payment* using nerve block codes in this section only. Nerve blocks listed elsewhere in the *Schedule* are not payable in lieu of any nerve block service listed in this section.]

2. 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*.
3. 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.
4. When a physician renders an anaesthesia service in support of a nerve block procedure performed by another physician, the anaesthesia service is *only eligible for payment* as one of the following:

E030C Procedural sedation 4 basic units

Note:

Extra units listed on GP73 are not payable with E030C.

E031C General anaesthesia or deep sedation 4 basic units

Note:

Extra units listed on GP73 are *eligible for payment* with E031C.

5. For the purposes of anaesthesia services described in paragraph 4:
 - a. **Procedural Sedation** is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
 - b. **Deep Sedation** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
 - c. **General Anaesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
6. Local infiltration used as an anesthetic for any procedure is *not eligible for payment*.

DIAGNOSTIC AND THERAPEUTIC

NERVE BLOCKS DIAGNOSTIC AND THERAPEUTIC

	Fee
G214 Brachial plexus.....	54.65
G215 Celiac ganglion.....	84.00
G239 Differential intrathecal spinal block.....	127.60
G216 Lumbar epidural or caudal epidural block.....	75.10
G245 Lumbar epidural or intrathecal injection of sclerosing solution..	165.60
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.]

DIAGNOSTIC AND THERAPEUTIC

NERVE BLOCKS DIAGNOSTIC AND THERAPEUTIC

Fee

Introduction of epidural catheter for analgesia

# G246 Lumbar.....	77.25
# G117 Thoracic.....	96.65
# G119 Cervical.....	115.95
# E833 - with insertion of subcutaneous port, G117, G119 or G246.....add	116.10

Percutaneous nerve block catheter insertion for continuous infusion analgesia

G279 Percutaneous nerve block catheter insertion.....	80.00
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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 GP33.]

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
# G374 I.V. regional guanethidine.....	54.30
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.....	84.00
G228 Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves.....	54.65
G123 - for each additional one (to a maximum of 4).....add	27.45

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*.

DIAGNOSTIC AND THERAPEUTIC

NERVE BLOCKS DIAGNOSTIC AND THERAPEUTIC

	Fee
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
G232 Spheno-palatine ganglion, by injection.....	55.10
G233 Splanchnic.....	55.10
G234 Stellate ganglion.....	55.10
G256 Superior laryngeal nerve.....	34.10
G235 Supraorbital.....	34.10
Sympathetic block(s) (lumbar or thoracic)	
G236 - unilateral.....	55.10
G237 - bilateral.....	82.45
G238 Transverse scapular nerve.....	55.10
G217 Trigeminal ganglion.....	84.75
E958 - when alcohol or other sclerosing solutions are used, the appropriate nerve block fees as listed above with the exception of fee codes G245 and G246add 50%	

DIAGNOSTIC AND THERAPEUTIC

NEUROLOGY

Fee

Lumbar epidural injection

# G273	- of adrenal steroid	74.20
# G274	- post laminectomy into operative site	90.80
Z804	Lumbar puncture	67.60
# Z805	- with instillation of medication or other therapeutic agent.....	75.10

Note:

Z805 is *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*.

[Commentary:

For epidural blood patch, refer to the Nerve Blocks for Acute Pain Management section of the *Schedule*.]

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

NEUROLOGY

Fee

# 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
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DIAGNOSTIC AND THERAPEUTIC

NEUROLOGY

	Fee
G417 - inserting subtemporal needle electrodes.....add	15.90

T

P

ELECTROENCEPHALOGRAPHY

An 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 - technical component	25.00	
G416 - with activating or sleep inducing drugs and/or sleep deprivation - technical component	add	15.00
G415 - professional component		23.15
G418 - professional component (16 - 21 channel EEG)		38.90

Note:

Use code G416 for sleep recording but not for overnight recording.
See sleep studies sub-section for overnight recording.

Prolonged EEG Monitoring

Videotape recording of clinical signs in association with spontaneous EEG. Unit means ¼ hour or major part thereof. See General Preamble GP6 for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG.

G540 - technical component	per unit	9.30
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	23.70	
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	47.50	
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	8.50
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Note:

G544 limited to a maximum of 3.

DIAGNOSTIC AND THERAPEUTIC

NEUROLOGY

T

P1

P2

EVOKED POTENTIALS

Upper or lower limbs

G140	- technical component	41.20		
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%.

DIAGNOSTIC AND THERAPEUTIC

OPHTHALMOLOGY

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	41.60	6

[Commentary:

Follow up services are payable in addition to contact lens fitting (G424) for children 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	
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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	
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Note:

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

DIAGNOSTIC AND THERAPEUTIC

OPHTHALMOLOGY

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	20.90	
G438 - professional component		22.15

Dark adaptation curve (Goldmann adaptometer or equivalent)

G851 - technical component	31.35	
G437 - professional component		22.90

Electro-retinography with report

G852 - technical component	34.00	
+ G439 - professional component		24.00

Fluorescein angiography

G853 - technical component	22.50	
+ G425 - professional component		23.90

Fluorescein angioscopy

G854 - technical component	6.55	
+ 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	6.45	
G428 - professional component		6.85

Tonography (to include tonometry) with or without water

G856 - technical component	9.30	
G433 - professional component		9.90

Visual fields - kinetic (with permanent record)

G857 - technical component	4.50	
G436 - professional component		4.80

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	13.65	
G432 - professional component		14.50

DIAGNOSTIC AND THERAPEUTIC

OPHTHALMOLOGY

Fee

Corneal Pachymetry

Corneal pachymetry – ultrasound measurement of corneal thickness 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 Salzmann'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.

DIAGNOSTIC AND THERAPEUTIC

OPHTHALMOLOGY

Fee

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.

Optical coherence tomography (OCT)

G817 OCT unilateral or bilateral, interpretation only 50.00

G818 OCT unilateral or bilateral, when the physician performs the procedure and/or supervises and interprets the results 70.00

Payment rules:

1. OCT is an insured service for the diagnosis and management of retinal disease and for retinal monitoring in the management of glaucoma.
2. When rendered for glaucoma monitoring, OCT is limited to a maximum of two services (for any combination of G817 and G818) per patient per 12 month period.
3. When rendered for the diagnosis and management of retinal disease, OCT is limited to a maximum of six services (for any combination of G817 and G818) per patient per 12 month period.

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.]

DIAGNOSTIC AND THERAPEUTIC

OPHTHALMOLOGY

	T	P1	P2
Visuale evoked response - simple			
G149 - technical component	18.05		
G147 - professional component (P1)		15.35	
G148 - interpretation only (P2)			6.05
Visual evoked response - threshold			
G152 - technical component	30.85		
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.

DIAGNOSTIC AND THERAPEUTIC

OPHTHALMOLOGY

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

DIAGNOSTIC AND THERAPEUTIC

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 <i>not eligible for payment</i> when rendered in addition to Z906, Z907, Z908 or Z913.	
+ G403 Particle repositioning manoeuvre for benign paroxysmal positional vertigo	21.15

DIAGNOSTIC AND THERAPEUTIC

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 GP50 to GP51.
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.]

DIAGNOSTIC AND THERAPEUTIC

OTOLARYNGOLOGY

T

P

BASIC DIAGNOSTIC HEARING TESTS

Pure tone threshold audiometry with or without bone conduction

G440	- technical component	10.55	
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	18.35	
G526	- professional component		15.70

ADVANCED DIAGNOSTIC HEARING TESTS

Impedance audiometry by manual or automated methods

G442	- technical component	3.34	
+ 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	22.25	
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	8.00	
G530	- professional component, to a maximum of 1.....per test		5.95

T

P1

P2

Cortical evoked audiometry

G143	- technical component	36.90	
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	36.90	
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.

DIAGNOSTIC AND THERAPEUTIC

OTOLARYNGOLOGY

T

P

Electrocochleography (per ear): to include myringotomy if performed

G815 - technical component	36.90	
G816 - professional component		104.45

DIAGNOSTIC BALANCE TESTS

Positional testing with electronystagmography (ENG)

G104 - technical component	19.05	
G105 - professional component		20.65

Caloric testing with ENG

G451 - technical component	19.05	
+ G533 - professional component		18.30

Fee

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

DIAGNOSTIC AND THERAPEUTIC

PALLIATIVE CARE

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
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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.]

DIAGNOSTIC AND THERAPEUTIC

PALLIATIVE CARE

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 55.05

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.]

DIAGNOSTIC AND THERAPEUTIC

PHYSICAL MEDICINE

T

P1

P2

ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

PREAMBLE

1. When patients are referred directly to EMG and/or nerve conduction facilities for diagnostic testing, then consultation or assessment by the diagnostic physician is an insured service payable at nil 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.

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	28.10		
G456	- professional component - when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results (P1)		101.85	
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	18.85		
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

Fee

G458	Single fibre electromyography.....		191.70	
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DIAGNOSTIC AND THERAPEUTIC

PHYSICAL MEDICINE

Fee

THERAPEUTIC PROCEDURES

+ G465	Manipulation of major joint(s) or spine by physician - one or more joints.....	13.80
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Note:

For manipulation under *general anaesthesia* - see Musculoskeletal Section.

[Commentary:

Miscellaneous therapeutic procedures are not insured benefits unless otherwise specifically listed in the *Schedule* of Benefits. Miscellaneous therapeutic procedures are defined as physical therapy and therapeutic exercise and *may include* thermal therapy, light therapy, ultrasound therapy, hydrotherapy, massage therapy, electrotherapy, magnetotherapy, transcutaneous nerve stimulation and biofeedback.]

CHEMODENERVATION INJECTION

Chemodeneration 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	28.50
	day add	

Repeat or additional procedure within 30 days of previous chemodeneration injection

G487	- first major nerve and/or its branches	28.50
G488	- each additional major nerve and/or its branches same day	18.80
	day add	

Note:

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

DIAGNOSTIC AND THERAPEUTIC

PSYCHIATRY AND RESPIRATORY DISEASE

Fee

Anae

PSYCHIATRY

Electroconvulsive therapy (ECT) cerebral - single or multiple

# G478	- in-patient.....	71.65	6
# G479	- out-patient	81.85	6

Note:

Electrosleep therapy or Sedac therapy are not insured benefits.

RESPIRATORY DISEASE

G404	Chronic ventilatory care outside an Intensive Care Unit	61.00
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Note:

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

DIAGNOSTIC AND THERAPEUTIC

SLEEP STUDIES

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* of the procedure subject to the conditions stated under the "Diagnostic Services Rendered at a Hospital" on page GP11, is *eligible for payment* only if the service is:

a. rendered at a hospital;

or

b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

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.

OTHER TERMS AND DEFINITION

1. Professional and technical components are claimed separately. Claims for the *technical component* H are submitted using listed fee code with suffix B. Claims for *professional component* P1 are submitted using first listed fee code with suffix C (e.g. J890C), while claims for *professional component* P2 are submitted using second listed fee code with suffix C (e.g. J690C).
2. For services rendered outside a hospital setting, 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*.
3. Overnight sleep studies are limited to a maximum of two per *12 month period* (any combination of study levels) unless written prior authorization is obtained from the Ministry of Health and Long-Term Care Medical Consultant. For services rendered on or after October 1, 1999, the *12 month period* is determined from October 1, 1998 onwards.

DIAGNOSTIC AND THERAPEUTIC

SLEEP STUDIES

H

P1

P2

OVERNIGHT SLEEP STUDIES

All studies require continuous technician attendance during the study period. A physician claiming the P1 fee is responsible for the clinical supervision of the study and for the interpretation of the procedure. Physical presence by the physician is not required. The physician must be accessible to make applicable decisions about the patient in connection with the performance of the procedure. This includes quality control of all elements of the *technical component* of the procedure and ensuring that set-up and monitoring are carried out in accordance with generally accepted standards of practice. The physician claiming the P1 fee may delegate one or more aspects of the foregoing to an appropriately qualified physician in accordance with the Preamble to the Diagnostics and Therapeutics Section. If the physician in his/her sole professional judgment determines that physical presence may be required during a sleep study, remuneration for such attendance is included in the fee. The amount payable for a special visit in association with overnight sleep studies is nil.

Level 1

Overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by plethysmography and additional monitoring to stage sleep (EEG, EOG and sub-mental EMG).

J890	- diagnostic study.....	380.25	128.30	
J690	- diagnostic study.....	380.25		68.85
J889	- therapeutic study for CPAP Titration	380.25	128.30	
J689	- therapeutic study for CPAP Titration	380.25		68.85

Note:

J889/J689 rendered to the same patient during the same 12 - hour period as J890/J690 is an insured service payable at nil.

Level 2

J891	- overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by plethysmography.....	237.80	93.40	
J691	- overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by plethysmography.....	237.80		51.00
J893	Multiple sleep latency test	70.70	52.50	00.00
J894	Maintenance of wakefulness test	70.70	52.50	00.00

Note:

J894 rendered to same patient same *day* as J893 is an insured service payable at nil.

DIAGNOSTIC AND THERAPEUTIC

UROLOGY

	Fee	P2
# G900 Residual urine measurement by ultrasound.....	12.70	
Note: Residual urine measurement by ultrasound (G900) is <i>not eligible for payment</i> 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 <i>with or without</i> 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 or intravesicular, intra-abdominal, and urethral pressures, with or without pressure-flow studies.....	43.85	
# G194 - with EMG	8.35	
G477 Interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel) (P2)		5.40
+ G476 Prostatic massage.....	5.40	

DIAGNOSTIC AND THERAPEUTIC

NOT ALLOCATED