CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

GENERAL LISTINGS

A005	Consultation	56.10
A905	Limited consultation	44.65

Special palliative care consultation

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

A945	Special palliative care consultation	132.50

Payment rules:

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

A006	Repeat consultation	42.35
A003	General assessment*	61.00

Note:
*Not to be billed for an assessment provided in the patient's home.

A004	General re-assessment	30.70

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 pelvic examination is normal part of the foregoing services. However, the add-on code E430 can be billed in addition to these services when a papanicolaou smear is performed outside hospital.

Emergency Department equivalent - partial assessment

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

A888	Emergency Department equivalent - partial assessment	28.55

[Commentary:
For services described by Emergency Department equivalent - partial assessment, the only fee code payable is A888.]

Payment rules:

1. Hypnotherapy or counselling rendered to the same patient by the same physician on the same day as A888 are not eligible for payment.
2. No premiums are payable for a service rendered in an Emergency Department equivalent.

House call assessment

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

A901 House call assessment 41.75

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

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

House call assessment - Pronouncement of death in the home

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

A902 House call assessment - Pronouncement of death in the home 41.75

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

Note:
For special visit premiums, please see pages GP47 to GP52 of the General Preamble.

A903 Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period) 61.00

Note:
The amount payable for an admission general assessment (C003) or general re-assessment (C004) for an elective surgery patient for whom a pre-operative assessment has already been claimed, within 30 days of this pre-operative assessment is nil.

On-call admission assessment

On-call admission assessment is the first hospital in-patient admission general assessment per patient per 30-day period if:

a. the physician is a general practitioner or family physician participating in the hospital's on-call roster whether or not the physician is on-call the day the service is rendered;

b. the admission is non-elective;

and

c. the physician is the most responsible physician with respect to subsequent in-patient care.

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

A933 On-call admission assessment 79.20

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

General/Family Physician Emergency Department Assessment

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

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

A100	General/Family Physician Emergency Department Assessment	76.90

Payment rule:
No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instruction:
For claims payment purposes, the hospital master number associated with the emergency department must be submitted on the claim.

[Commentary:

1. Services described as A100 rendered in an emergency department not funded under an ED AFA may be payable under other existing fee schedule codes.
2. In the event the patient is subsequently admitted to hospital, and the general/family physician remains the MRP for the patient, the General/Family Physician Emergency Department Assessment constitutes the admission assessment. See General Preamble GP29 for additional information.]

Certification of death

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

A771	Certification of death	17.75
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP23)	31.95
A007	Intermediate assessment or well baby care.	31.95
A001	Minor assessment	17.75

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Mini assessment

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

A008	Mini assessment	10.25

Annual health examination

K017	- child after second birthday*	30.40

Note:
*For Annual Adult/Adolescent health examinations - see General Preamble GP18.

Periodic Oculo-visual Assessment

See General Preamble GP24 for definitions and conditions

A110	- aged 19 years and below	40.15
A112	- aged 65 years and above	40.15

Identification of patient for a Major Eye Examination

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

E077	- identification of patient for a Major Eye Examination . . . . . add	10.25

Note:

1. This service is limited to a maximum of one every four fiscal years by the same physician for the same patient unless the patient seeks a major eye examination from an optometrist or general practitioner other than the one to whom the original requisition was provided.
2. This service is limited to a maximum of one per fiscal year by any physician to the same patient.

A Major Eye Examination

A Major Eye Examination is a complete evaluation of the eye and vision system for patients aged 20 to 64 inclusive. The examination must include the following elements:

- **a.** relevant history (ocular medical history, relevant past medical history, relevant family history)
- **b.** a comprehensive examination (visual acuity, gross visual field testing by confrontation, ocular mobility, slit lamp examination, ophthalmoscopy and, where indicated, ophthalmoscopy through dilated pupils and tonometry)
- **c.** visual field testing by the same physician where indicated
- **d.** refraction, and if needed, provision of a refractive prescription
- **e.** advice and instruction to the patient
- **f.** submission of the findings of the assessment in writing to the patient's primary care physician or by a registered nurse holding an extended certificate of registration (RN(EC)) if requested
- **g.** Any other medically necessary components of the examination (including eye-related procedures) not specifically listed above

A115 A Major Eye Examination. 42.15

Note:

1. This service is only insured if the patient is described in (a) or (b) below:

a. A patient has one of the following medical conditions:

- **i.** diabetes mellitus, type 1 or type 2
- **ii.** glaucoma
- **iii.** cataract
- **iv.** retinal disease
- **v.** amblyopia
- **vi.** visual field defects
- **vii.** corneal disease
- **viii.** strabismus

or

b. The patient must have a valid "request for eye examination requisition" completed by another physician or by a registered nurse holding an extended certificate of registration (RN(EC)).

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

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

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

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

[Commentary:
Assessments rendered solely for the purpose of refraction for patients aged 20 to 64 are not insured services.]

Midwife-Requested Assessment (MRA)

Midwife-Requested Assessment (MRA) is an assessment of a mother or newborn provided by a physician upon the written request of a midwife because of the complex, obscure or serious nature of the patient's problem and is payable:

a. to a family physician or obstetrician for such an assessment in any setting;

or

b. to an anaesthetist for an urgent or emergency assessment rendered only on behalf of a hospital in-patient.

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

A813 Midwife-Requested Assessment (MRA) 86.60

Midwife-Requested Special Assessment (MRSA)

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

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

or

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

A815 Midwife-Requested Special Assessment (MRSA) 132.50

CONSULTATIONS AND VISITS

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C005	Consultation	56.10
C905	Limited consultation	49.60
C945	Special palliative care consultation - subject to the same conditions as A945	132.50
C006	Repeat consultation	42.35
C003	General assessment	61.00
C813	Midwife-Requested Assessment - subject to the same conditions as A813	86.60
C815	Midwife-Requested Special Assessment - subject to the same conditions as A815	132.50
C004	General re-assessment	30.70
C903	Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period)	61.00
C933	On-call admission assessment - subject to the same conditions as A933	79.20
C777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	31.95
C771	Certification of death - subject to the same conditions as A771.	17.75

Subsequent visits

C002	- first five weeks	per visit	29.20
C007	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C009	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment.	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30).	per visit	29.20
C008	Concurrent care.	per visit	29.20
C010	Supportive care	per visit	17.75
C882	Palliative care (see General Preamble GP36)	per visit	29.20

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

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

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

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

H001	Newborn care in hospital and/or home	52.20

Low birth weight baby care (uncomplicated)

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

EMERGENCY DEPARTMENT - PHYSICIAN ON DUTY

Note:
See General Preamble GP36 for definitions and conditions for Physician on Duty.

In-patient interim admission orders

In-patient interim admission orders is payable to an emergency department (ED) physician who is on-call or on duty in the emergency department for writing in-patient interim admission orders pending admission of a "non-elective" patient by a different most responsible physician (see General Preamble GP4).

Comprehensive assessment and care

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

It also includes the following as indicated:

a. interpretation of any laboratory and/or radiological investigation;

and

b. any necessary liaison with the following: the family physician, family, other institution (e.g. nursing home), and other agencies (e.g. Home Care, VON, CAS, police, or detoxification centre).

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

Multiple systems assessment

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

Re-assessment

A re-assessment is an assessment rendered in a Emergency Department at least two hours after the original assessment or re-assessment (including appropriate investigation and treatment), which indicates that further care and/or investigation is required and performed.

Payment rules:

1. This service is not eligible for payment under any of the following circumstances:

a. for discharge assessments;

b. when the patient is admitted by the physician on duty in the emergency department;

or

c. when the reassessment leads directly to a referral for consultation.

2. This service is limited to three per patient per day and two per physician per patient per day. Services in excess of these limits are not eligible for payment.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

H065	Consultation in Emergency Medicine	65.10
H105	In-patient interim admission orders	21.00

Note:

1. H105 is payable in addition to the initial ED consultation or assessment provided that each service is rendered separately by the ED physician.
2. H105 is an insured service payable at nil if the hospital admission assessment is payable to the ED physician.

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

H102	Comprehensive assessment and care	37.20
H103	Multiple systems assessment	32.25
H101	Minor assessment	15.00
H104	Re-assessment	15.00

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

H132	Comprehensive assessment and care	46.30
H133	Multiple systems assessment	40.10
H131	Minor assessment	18.70
H134	Re-assessment	18.70

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

H152	Comprehensive assessment and care	63.30
H153	Multiple systems assessment	53.80
H151	Minor assessment	25.50
H154	Re-assessment	25.50

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

H122	Comprehensive assessment and care	73.90
H123	Multiple systems assessment	62.30
H121	Minor assessment	29.80
H124	Re-assessment	29.80

When any other service is rendered by the physician on duty in premium hours (and assessments may not be claimed), apply one of the following premiums per patient visit

H112	- nights (00:00h to 08:00h)	17.10
H113	- daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays	9.90

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W105	Consultation	56.10
W106	Repeat consultation	42.35

Admission assessment

W102	- Type 1	61.00
W104	- Type 2	17.75
W107	- Type 3	30.70
W109	Annual physical examination	61.00
W777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	31.95
W771	Certification of death - subject to same conditions as A771	17.75
W004	General re-assessment of patient in nursing home (per the *Nursing Homes Act*)	17.75

Note:
W004 may be claimed 6 months after Annual Health Examination (per the *Nursing Homes Act*).

W903	Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period)	61.00
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP23)	31.95

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W002	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W001	- additional subsequent visits (maximum 4 per patient per month) . . . . . per visit	13.40
W882	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W003	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W008	- additional subsequent visits (maximum 2 per patient per month) . . . . . per visit	13.40
W872	- palliative care (see General Preamble GP36) . . . . per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

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

W010	Monthly management fee (per patient per month) (see General Preamble GP37 to GP38).	85.70

Primary mental health care

Primary mental health care is not to be billed in conjunction with other consultations and visits rendered by a physician during the same patient visit unless there are clearly different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.

K005	Individual care	per unit	51.70

Counselling

Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.

Individual care

K013	- first three units of K013 and K040 combined per patient per provider per 12-month period	per unit	51.70
K033	- additional units per patient per provider per 12-month period	per unit	31.95

Group counselling - 2 or more persons

K040	- where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12-month period	per unit	51.70
K041	- additional units where any group member has received 3 or more units of any counselling paid under codes K013 and K040 combined per provider per 12-month period	per unit	31.95
K014	Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons	per unit	51.70
K015	Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons.	per unit	51.70

Psychotherapy

Includes narcoanalysis or psychoanalysis or treatment of sexual dysfunction - see General Preamble GP39.

Note:
Psychotherapy outside hospital and hypnotherapy may not be claimed as such when provided in conjunction with a consultation or other assessments rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.

K007	Individual care	per unit	51.70
	Group - per member - first 12 units per day		
K019	- 2 people	per unit	25.85
K020	- 3 people	per unit	17.25
K012	- 4 people	per unit	13.00
K024	- 5 people	per unit	10.70
K025	- 6 to 12 people	per unit	9.10
K010	- additional units per member (maximum 6 units per patient per day)	per unit	8.20
	Family		
K004	- 2 or more family members in attendance at the same time	per unit	56.10

Hypnotherapy

Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.

K006	Individual care*	per unit	51.70
K011	Group - for induction and training for hypnosis (maximum 8 people) - per member	per unit	9.10

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

Certification of Mental Illness

See General Preamble GP27 for definitions and conditions.

Form 1

Application for psychiatric assessment in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K623	Application for psychiatric assessment	85.65

Form 3

Certification of involuntary admission in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K624	Certification of involuntary admission.	105.45
K629	All other re-certification(s) of involuntary admission including completion of appropriate forms	31.30

Note:

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

Community Treatment Order (CTO)

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

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

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

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

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

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

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

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

and

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

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

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

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

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

and

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

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for Definitions and time-keeping requirements. A single all-inclusive claim for *CTO Initiation* or *CTO Renewal* is submitted once per patient per physician per initiation or renewal in any six month period on an Independent Consideration basis. A single all-inclusive claim for *CTO Supervision* is submitted once per patient per month on an Independent Consideration basis. The form provided by the MOHLTC for elapsed times must be completed and submitted with each claim and a copy retained on the patient's permanent medical record. The total number of allowable units rendered per claim shall be determined by adding the actual elapsed time of each insured activity rounded to the nearest minute, dividing by 30 and rounding to the nearest whole unit. In the absence of a claim in accordance with these requirements, the amount payable for CTO services is nil.

K887	CTO initiation including completion of the CTO form and all preceding CTO services directly related to CTO initiation	per unit	69.80
K888	CTO supervision including all associated CTO services except those related to initiation or renewal	per unit	69.80
K889	CTO renewal including completion of the CTO form and all preceding CTO services directly related to CTO renewal	per unit	69.80

Note:

1. Travel to visit an insured person within the usual geographic area of the physician's practice is a common element of insured services. Time units for any CTO services based in whole or in part on travel time are therefore insured but payable at nil.
2. Travel time and expenses related to appearances before the Consent and Capacity Board are not insured.

Interviews

Not to be claimed when the information being obtained is part of the history normally included in the consultation or assessment of the patient. The interview must be a booked, separate appointment lasting at least 20 minutes. Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.

K002 Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the *Health Care Consent Act*, conducted for a purpose other than to obtain consent . . . . . per unit 51.70

K003 Interviews with Children's Aid Society (CAS) or legal guardian on be half of the patient in accordance with the *Health Care Consent Act,* conducted for a purpose other than to obtain consent . . . . . per unit 51.70

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

K008 Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities . . . . . per unit 51.70

Note:
K008 is claimed using the child's health number. Psychological testing is not an insured service.

Case conference

A case conference is participation in a conference lasting 20 minutes or more with medical and/or paramedical personnel regarding a hospital in-patient.

K121 Case conference . . . . . per unit 51.70

Payment rules:

1. This service is a time based service. Time units are calculated based on units - units means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.
2. This service is limited to a maximum of 2 case conferences per patient per physician per 12 month period.
3. The case conference must be pre-booked.
4. This service is payable only for case conferences for which the subject is a hospital in-patient.
5. This service is payable for each physician participating in the case conference.

[Commentary:

1. One common medical record in the patient's hospital chart for the case conference signed or initialed by all physician participants (including listing the time the service commenced and terminated for each participant if different) would satisfy the record-keeping requirements for billing purposes.
2. Case conferences rendered in circumstances described in regulation 552, section 24(1) paragraph 6 (see Appendix A) are uninsured.]

HIV primary care

Primary care of patients infected with the Human Immunodeficiency Virus which includes any combination of common and specific elements of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP42. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for HIV Primary Care, the HIV Primary Care service is included (in addition to the common elements) as a specific element of the other insured service. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

K022 HIV primary care . . . . . per unit 51.70

Fibromyalgia/chronic fatigue syndrome care

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

K037 Fibromyalgia/chronic fatigue syndrome care. . . . . per unit 51.70

Payment rules:

1. K037 is a time based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP6, GP40 for definitions and time-keeping requirements.
2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K037 to the same patient by the same physician.

Palliative care support

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

K023 Palliative care support . . . . . per unit 51.70

Payment rules:

1. With the exception of A945/C945, any other services listed under the "Family Practice & Practice in General" in the "Consultations and Visits" section of the Schedule are not eligible for payment when rendered with this service.
2. Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee.
3. When the duration of A945 or C945 exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 units occurs 50 minutes after the start time for A945 or C945.
4. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

Genetic assessment

A Genetic assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

K016 Genetic assessment . . . . . per unit 61.05

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

Sexually Transmitted Disease (STD) or potential blood-borne pathogen management

Sexually transmitted disease (STD) or potential blood-borne pathogen management is a time based all-inclusive service for the purpose of providing assessment and counselling to a patient suspected of having a STD or to a patient with a potential blood-borne pathogen (e.g. following a "needle-stick" injury). This service is claimed in units - unit means ½ hour or major part thereof - see the General Preamble GP6, GP40 for definitions and time keeping requirements.

K028 STD management . . . . . per unit 51.70

Payment rules:

1. K028 is not eligible for payment when rendered with any consultation, assessment or visit by the same physician on the same day.

2. K028 is limited to a maximum of two units per patient per physician per day and four units per patient, per physician, per year.

Insulin Therapy Support (ITS)

ITS is a time-based all-inclusive visit fee per patient per day for the purpose of providing assessment, support and counselling to patients on intensive insulin therapy requiring at least 3 injections per day or using an infusion pump. The service includes any combination of common and specific elements of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP42. ITS rendered same patient same day as any other consultation or visit by the same physician is an insured service payable at nil. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements. Maximum 6 units per patient, per physician, per year.

K029 Insulin Therapy Support (ITS) . . . . . per unit 51.70

Diabetic Management Assessment (DMA)

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

K030 Diabetic Management Assessment 37.00

Initial discussion with patient re: smoking cessation

Initial discussion with patient re: smoking cessation is the service rendered to a patient who currently smokes by the primary care physician most responsible for their patient's ongoing care, in accordance with the guidelines and subject to the conditions below.

E079 Initial discussion with patient, to eligible services . . . . . add 15.40

Payment rules:

1. E079 is only eligible for payment when rendered in conjunction with one of the following services: A001, A003, A004, A005, A006, A007, A008, A903, A905, K005, K007, K013, K017, P003, P004, P005, P008, W001, W002, W003, W004, W008, W010, W102, W104, W107, W109 or W121.

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

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

[Commentary:
A copy of a flow sheet meeting the medical record requirements and guidelines of the CTI program is available at www.oma.org or www.omacti.org. Physicians may complete the flow sheet or alternatively document that an initial discussion consistent with the 5A's model of the CTI program has taken place.]

Smoking cessation follow-up visit

Smoking cessation follow-up visit is the service rendered by a primary care physician in the 12 months following E079 that is dedicated to a discussion of smoking cessation, in accordance with the guidelines and subject to the conditions below.

K039 Smoking cessation follow-up visit 33.45

Payment rules:

1. K039 is only eligible for payment when E079 is payable to the same physician in the preceding 12 month period.

2. K039 is limited to a maximum of two services in the 12 months following E079.

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

[Commentary:
A copy of a flow sheet meeting the medical record requirements and guidelines of the CTI program is available at www.oma.org or www.omacti.org. Physicians may complete the flow sheet or alternatively document that an initial discussion consistent with the 5A's model of the CTI program has taken place.]

Sexual assault examination

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

K018	- female	308.70
K021	- male	243.50

Ontario Hepatitis C Assistance Program (OHCAP)

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

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

***Health Protection and Promotion Act* - Physician Report**

K031	Completion of Physician Report in accordance with Section 22.1 of the *Health Protection and Promotion Act*	102.50

Specific neurocognitive assessment

A specific neurocognitive assessment is an assessment of neurocognitive function rendered personally by the physician where all of the following requirements are met:

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

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

and

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

K032	Specific neurocognitive assessment	51.70

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

Home care application

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

K070	Application	25.65

Home care supervision

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

K071	Acute home care supervision (maximum 1 every week for the first 8 weeks following admission to home care program)	17.75
K072	Chronic home care supervision (maximum 2 per month commencing in the 9th week following admission to the home care program)	17.75

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO)

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

K035	Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation	34.85

Claims submission instruction:
Claims in excess of one per 12 month period by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

Northern Health Travel Grant Application Form

K036	Completion of Northern Health Travel Grant Application Form	10.25

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

Long-Term Care Application

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

K038	Completion of Long-Term Care health report form	41.00

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

ALLERGY

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

CLINICAL INTERPRETATION BY AN IMMUNOLOGIST

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

K399 Clinical interpretation by an immunologist 29.05

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

CONSULTATIONS AND VISITS

ANAESTHESIA (01)

GENERAL LISTINGS

Consultation

A015 Consultation 103.85

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

A016 Repeat consultation 50.75

Limited consultation for acute pain management

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

A215 Limited consultation for acute pain management in association with special visit to hospital in-patient 46.20

Claims submission instruction:

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

[Commentary:
This service is not eligible for payment if performed for management of chronic pain or management of routine post-operative pain.]

A013 Specific assessment 46.20
A014 Partial assessment 30.60

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C015 Consultation - subject to the same conditions as A015 . . . . . 103.85
C016 Repeat consultation 50.75
C215 Limited consultation for acute pain management - subject to the same conditions as A215 . . . . . 46.20

C013 Specific assessment 46.20
C014 Specific re-assessment 27.25

Subsequent visits

C012 - first five weeks . . . . . per visit 29.20
C017 - sixth to thirteenth week inclusive (maximum 3 per patient per week) . . . . . per visit 29.20
C019 - after thirteenth week (maximum 6 per patient per month) . . . . . per visit 29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C018	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

CONSULTATIONS AND VISITS

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine Section

GENERAL LISTINGS

A605	Consultation	132.50
A675	Limited consultation	82.90
A606	Repeat consultation	82.90
A603	Medical specific assessment	64.05
A604	Medical specific re-assessment	50.50
A601	Complex medical specific re-assessment	58.45
A608	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C605	Consultation	132.50
C675	Limited consultation	82.90
C606	Repeat consultation	82.90
C603	Medical specific assessment	64.05
C604	Medical specific re-assessment	50.50
C601	Complex medical specific re-assessment	58.45

Subsequent visits

C602	- first five weeks	per visit	29.20
C607	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C609	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C608	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

CONSULTATIONS AND VISITS

CARDIOVASCULAR & THORACIC SURGERY (09)

GENERAL LISTINGS

A095	Consultation	71.30
A935	Special surgical consultation (see General Preamble GP17)	132.50
A096	Repeat consultation	46.30
A093	Specific assessment	41.20
A094	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C095	Consultation	86.60
C935	Special surgical consultation (see General Preamble GP17)	132.50
C096	Repeat consultation	46.30
C093	Specific assessment	41.20
C094	Specific re-assessment	25.85

Subsequent visits

C092	- first five weeks	per visit	29.20
C097	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C099	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C098	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W095	Consultation	71.30
W096	Repeat consultation	46.30

CONSULTATIONS AND VISITS

CLINICAL IMMUNOLOGY (62)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A625	Consultation	132.50
A525	Limited consultation	82.90
A626	Repeat consultation	82.90
A623	Medical specific assessment	64.05
A624	Medical specific re-assessment	50.50
A621	Complex medical specific re-assessment	58.45
A628	Partial assessment	30.60

E078 - chronic disease assessment premium (see General Preamble GP21) . . . . . add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C625	Consultation	132.50
C525	Limited consultation	82.90
C626	Repeat consultation	82.90
C623	Medical specific assessment	64.05
C624	Medical specific re-assessment	50.50
C621	Complex medical specific re-assessment	58.45

Subsequent visits

C622	- first five weeks	per visit	29.20
C627	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C629	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

CONSULTATIONS AND VISITS

CLINICAL IMMUNOLOGY (62)

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C628	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

GENERAL LISTINGS

A055	Consultation	82.90
A405	Limited consultation	58.25

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C055	Consultation	82.90
C405	Limited consultation	58.25

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W055	Consultation	75.35
W405	Limited consultation	58.25

GENERAL LISTINGS

A025	Consultation	66.15
A026	Repeat consultation	44.45
A023	Specific assessment	38.70
A024	Partial assessment	20.40

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C025	Consultation	66.15
C026	Repeat consultation	44.45
C023	Specific assessment	38.70
C024	Specific re-assessment	24.80

Subsequent visits

C022	- first five weeks	per visit	29.20
C027	- sixth to thirteenth week (maximum 3 per patient per week)	per visit	29.20
C029	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C028	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W025	Consultation	66.15
W026	Repeat consultation	44.45

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W022	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W021	- additional subsequent visits (maximum 6 per patient per month) . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W023	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W028	- additional subsequent visits (maximum 3 per patient per month) . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

EMERGENCY DEPARTMENT - PHYSICIAN ON DUTY

H055	Consultation (see General Preamble GP17)	97.60

Note:

1. See General Preamble GP36 for definitions and conditions for physicians on duty.
2. All other consultations and visits - use the listings for Family Practice & Practice In General.

CONSULTATIONS AND VISITS

GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A415	Consultation	132.50
A545	Limited consultation	82.90
A416	Repeat consultation	82.90
A413	Medical specific assessment	64.05
A414	Medical specific re-assessment	50.50
A411	Complex medical specific re-assessment	58.45
A418	Partial assessment	30.60

E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C415	Consultation	132.50
C545	Limited consultation	82.90
C416	Repeat consultation	82.90
C413	Medical specific assessment	64.05
C414	Medical specific re-assessment	50.50
C411	Complex medical specific re-assessment	58.45

Subsequent visits

C412	- first five weeks	per visit	29.20
C417	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C419	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C418	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

CONSULTATIONS AND VISITS

GENERAL SURGERY (03)

GENERAL LISTINGS

A035	Consultation	86.60
A935	Special surgical consultation (see General Preamble GP17)	132.50
A036	Repeat consultation	46.30
A033	Specific assessment	41.20
A034	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C035	Consultation	86.60
C935	Special surgical consultation (see General Preamble GP17)	132.50
C036	Repeat consultation	46.30
C033	Specific assessment	41.20
C034	Specific re-assessment	25.85

Subsequent visits

C032	- first five weeks	per visit	29.20
C037	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C039	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C038	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W035	Consultation	86.60
W036	Repeat consultation	46.30

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W032	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W031	- additional subsequent visits (maximum of 6 per patient per month) . . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W033	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W038	- subsequent visits per month (maximum of 3 per patient per month) . . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

CONSULTATIONS AND VISITS

GENERAL THORACIC SURGERY (64)

GENERAL LISTINGS

A645	Consultation	86.60
A935	Special surgical consultation (see General Preamble GP17)	132.50
A646	Repeat consultation	46.30
A643	Specific assessment	41.20
A644	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C645	Consultation	86.60
C935	Special surgical consultation (see General Preamble GP17)	132.50
C646	Repeat consultation	46.30
C643	Specific assessment	41.20
C644	Specific re-assessment	25.85

Subsequent visits

C642	- first five weeks	per visit	29.20
C647	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C649	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C648	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

CONSULTATIONS AND VISITS

GENERAL THORACIC SURGERY (64)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W645	Consultation	86.60
W646	Repeat consultation	46.30

GENERAL LISTINGS

A225	Consultation*	147.80
A325	Limited consultation	82.90
A226	Repeat consultation	82.90
A221	Genetic minor assessment	30.60

Genetic assessment

A Genetic Assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

K016	Genetic assessment, patient or family	per unit	61.05

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

Genetic care

Genetic care is a time based service payable for rendering a genetic assessment. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

K222	Genetic care, patient or family	per unit	61.05

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

Clinical interpretation by a Geneticist

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

K223	Clinical interpretation	28.80

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

GENETICS (22)

Genetic family counselling

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

K044	Genetic family counselling	per unit	51.70

Note:
Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time keeping requirements.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C225	Consultation*	147.80
C325	Limited consultation	82.90
C226	Repeat consultation	82.90

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W225	Consultation*	147.80
W325	Limited consultation	82.90
W226	Repeat consultation	82.90

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

CONSULTATIONS AND VISITS

GERIATRICS (07)

GENERAL LISTINGS

A075	Consultation	147.80

Comprehensive geriatric consultation

A comprehensive geriatric consultation is a consultation performed by a physician with a certificate of special competence in Geriatrics on a patient at least 75 years of age where the physician spends at least 75 minutes with the patient exclusive of time spent rendering any other service to the patient.

A775	Comprehensive geriatric consultation	195.55

Payment rules:

1. The consultation must be scheduled at least one day before the service is rendered.

2. A comprehensive geriatric consultation is only eligible for payment if this service has not been rendered on the same patient by the same consultant within the previous 2 years.

A375	Limited consultation	82.90
A076	Repeat consultation	82.90
A073	Medical specific assessment	64.05
A074	Medical specific re-assessment	50.50
A071	Complex medical specific re-assessment	58.45
A078	Partial assessment	30.60

E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C075	Consultation	147.80
C775	Comprehensive geriatric consultation - subject to the same conditions as A775	195.55
C375	Limited consultation	82.90
C076	Repeat consultation	82.90
C073	Medical specific assessment	64.05
C074	Medical specific re-assessment	50.50
C071	Complex medical specific re-assessment	58.45

Subsequent visits

C072	- first five weeks	per visit	29.20
C077	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C079	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C078	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W075	Consultation	147.80
W775	Comprehensive geriatric consultation - subject to the same conditions as A775	195.55
W375	Limited consultation	82.90
W076	Repeat consultation	82.90

Admission assessment

W272	- Type 1	61.00
W274	- Type 2	17.75
W277	- Type 3	30.70
W279	Annual physical examination	61.00
W074	General reassessment of patient in nursing home (as per the *Nursing Homes Act*)*	17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W072	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W071	- additional subsequent visits (maximum of 6 per patient per month) . . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W073	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W078	- subsequent visits per month (maximum of 3 per patient per month) . . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

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

W010	Monthly management fee (per patient per month) (see General Preamble GP37 to GP38).	85.70

CONSULTATIONS AND VISITS

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A615	Consultation	132.50
A655	Limited consultation	82.90
A616	Repeat consultation	82.90
A613	Medical specific assessment	64.05
A614	Medical specific re-assessment	50.50
A611	Complex medical specific re-assessment	58.45
A618	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C615	Consultation	132.50
C655	Limited consultation	82.90
C616	Repeat consultation	82.90
C613	Medical specific assessment	64.05
C614	Medical specific re-assessment	50.50
C611	Complex medical specific re-assessment	58.45

Subsequent visits

C612	- first five weeks	per visit	29.20
C617	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C619	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C618	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP36) per visit	29.20

CONSULTATIONS AND VISITS

INTERNAL & OCCUPATIONAL MEDICINE (13)

GENERAL LISTINGS

A135	Consultation	132.50
A435	Limited consultation	82.90
A136	Repeat consultation	82.90
A133	Medical specific assessment	64.05
A134	Medical specific re-assessment	50.50
A131	Complex medical specific re-assessment	58.45
A138	Partial assessment	30.60

E078 - chronic disease assessment premium (see General Preamble GP21) . . . . . add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C135	Consultation	132.50
C435	Limited consultation	82.90
C136	Repeat consultation	82.90
C133	Medical specific assessment	64.05
C134	Medical specific re-assessment	50.50
C131	Complex medical specific re-assessment	58.45

Subsequent visits

C132	- first five weeks . . . . . per visit	29.20
C137	- sixth to thirteenth week inclusive (maximum 3 per patient per week) . . . . . per visit	29.20
C139	- after thirteenth week (maximum 6 per patient per month) . . . . . per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30) . . . . . per visit	29.20
C138	Concurrent care . . . . . per visit	29.20
C982	Palliative care (see General Preamble GP36) . . . . . per visit	29.20

CONSULTATIONS AND VISITS

INTERNAL & OCCUPATIONAL MEDICINE (13)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W235	Consultation	132.50
W435	Limited consultation	82.90
W236	Repeat consultation	82.90

Admission assessment

W232	- Type 1	61.00
W234	- Type 2	17.75
W237	- Type 3	30.70
W239	Annual physical examination	61.00
W134	General re-assessment of patient in nursing home (as per the *Nursing Homes Act*)*	17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W132	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W131	- additional subsequent visits (maximum of 6 per patient per month) . . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W133	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W138	- subsequent visits per month (maximum of 3 per patient per month) . . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

CONSULTATIONS AND VISITS

LABORATORY MEDICINE (28)

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

GENERAL LISTINGS

A285	Consultation	102.00
A286	Limited consultation	71.20
A586	Repeat consultation	71.20
A283	Medical specific assessment	55.55
A284	Partial assessment	30.60

E078 - chronic disease assessment premium (see General Preamble GP21) . . . . . add 50%

Diagnostic consultation

A diagnostic laboratory medicine consultation is the service rendered when tissue, slides, and/or specimens prepared in one institution or facility are referred to a second laboratory medicine physician in a different institution or facility, for a written opinion. The specific elements are the same as for the L800 series of codes (see pages J37 to J39).

A585	Diagnostic consultation	64.70

Payment rules:

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C285	Consultation	102.00
C286	Limited consultation	71.20
C586	Repeat consultation	71.20
C283	Medical specific assessment	55.55
C585	Diagnostic consultation - subject to the same conditions as A585	64.70
C288	Concurrent care . . . . . per visit	29.20

CONSULTATIONS AND VISITS

NEUROLOGY (18)

GENERAL LISTINGS

A185	Consultation	147.80
A385	Limited consultation	82.90
A186	Repeat consultation	82.90
A183	Medical specific assessment	64.05
A184	Medical specific re-assessment	50.50
A181	Complex medical specific re-assessment	58.45
A188	Partial assessment	30.60

E078 - chronic disease assessment premium (see General Preamble GP21) . . . . . add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C185	Consultation	147.80
C385	Limited consultation	82.90
C186	Repeat consultation	82.90
C183	Medical specific assessment	64.05
C184	Medical specific re-assessment	50.50
C181	Complex medical specific re-assessment	58.45

Subsequent visits

C182	- first five weeks	per visit	29.20
C187	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C189	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C188	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W185	Consultation	147.80
W385	Limited consultation	82.90
W186	Repeat consultation	82.90
W184	General re-assessment of patient in nursing home (as per the *Nursing Homes Act*)*	17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W182	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W181	- additional subsequent visits (maximum of 6 per patient per month) . . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W183	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W188	- subsequent visits per month (maximum of 3 per patient per month) . . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

CONSULTATIONS AND VISITS

NEUROSURGERY (04)

GENERAL LISTINGS

A045	Consultation	107.00
A935	Special surgical consultation (see General Preamble GP17)	132.50
A046	Repeat consultation	51.45
A043	Specific assessment	51.45
A044	Partial assessment	26.50

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C045	Consultation	107.00
C935	Special surgical consultation (see General Preamble GP17)	132.50
C046	Repeat consultation	51.45
C043	Specific assessment	51.45
C044	Specific re-assessment	26.50

Subsequent visits

C042	- first five weeks	per visit	29.20
C047	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C049	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C048	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W045	Consultation	107.00
W046	Repeat consultation	51.45

GENERAL LISTINGS

Consultation

A635 Consultation 71.30

Special Nuclear Medicine consultation

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

A835 Special nuclear medicine consultation 132.50

Payment rule:
When a nuclear medicine consultation or repeat consultation is rendered in conjunction with a nuclear medicine study, only the P_2 professional fee is payable for the study (rather than the P_1 professional fee).

Diagnostic consultation

A diagnostic nuclear medicine consultation is the service rendered:

a. when nuclear medicine studies rendered at one institution or facility are referred to a nuclear medicine specialist in a different institution or facility for a written opinion. In this case, the specific elements are the same as the nuclear medicine professional component P_2 (see page B1);

or

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

A735 Diagnostic consultation 29.20

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

A636 Repeat consultation 49.55
A638 Partial assessment 30.60

CONSULTATIONS AND VISITS

NUCLEAR MEDICINE

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C635	Consultation	71.30
C835	Special nuclear medicine - subject to the same conditions of A835	132.50
C735	Diagnostic consultation - subject to the same conditions as A735	29.20
C636	Repeat consultation	49.55

CONSULTATIONS AND VISITS

OBSTETRICS & GYNAECOLOGY (20)

GENERAL LISTINGS

A205	Consultation*	86.60
A935	Special surgical consultation (see General Preamble GP17)	132.50
A206	Repeat consultation*	45.85
A203	Specific assessment*	40.25
A204	Partial assessment	22.45

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 pelvic examination is normal part of the foregoing services. However, the add-on code E430 can be billed in addition to these services when a papanicolaou smear is performed outside hospital.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C205	Consultation*	86.60
C935	Special surgical consultation (see General Preamble GP17)	132.50
C206	Repeat consultation*	45.85
C203	Specific assessment*	40.25
C204	Specific re-assessment*	25.15

Subsequent visits

C202	- first five weeks	per visit	29.20
C207	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C209	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C208	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP36) per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W305	Consultation*	86.60
W306	Repeat consultation*	45.85

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

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

GENERAL LISTINGS

A235	Consultation	71.30
A935	Special surgical consultation (see General Preamble GP17)	132.50
A236	Repeat consultation	45.85
A233	Specific assessment	42.15
A234	Partial assessment	22.45

Periodic Oculo-visual Assessment

A237	- aged 19 years and below	42.15
A239	- aged 65 years and above	42.15

Note:
See General Preamble GP24 for definitions and conditions.

Major Eye Examination

A115	Major eye examination (see page A5)	42.15

Orthoptic assessment

Orthoptic assessment must include quantitative measurement of all 11 positions of gaze (straight ahead, up, down, left, right, up-left, up-right, down-left, down-right, tilt-right and tilt-left), sensory testing for binocular vision, suppression, cyclodeviation, and retinal correspondence. Orthoptic assessments are payable in addition to an ophthalmology consultation or visit and only when medically necessary e.g. suspicion of strabismus, orbital fracture, thyroid disease etc. All findings must be documented in writing in the patient's permanent record. Orthoptic Assessment that does not include all measurements or in the absence of a written record is an insured service payable at nil.

A230	Orthoptic assessment	25.00

Retinopathy of Prematurity (ROP) Assessment

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

a. 9 months of age or younger,

or

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

A250	Retinopathy of prematurity assessment	120.00

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

Vision Rehabilitation – Initial Assessment and Follow-up Assessment

Definitions

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

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

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

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

Initial Vision Rehabilitation Assessment

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

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

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

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

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

A252	Initial vision rehabilitation assessment.	240.00

Follow-up Vision Rehabilitation Assessment

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

A254 Follow-up vision rehabilitation assessment 120.00

Payment rules:
For A252 and A254:

1. No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A252 or A254.

2. A252 is limited to two (2) per patient per five (5) year period per physician.

3. A254 is only payable when the patient has received an A252.

4. A254 is limited to ten (10) per patient per five (5) year period from the date of the most recent A252.

5. If the minimum required number of components for A252 or A254 are not rendered, the amount payable for the service will be reduced to a lesser fee.

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

Special Ophthalmologic Assessment

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

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

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

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

and

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

A251 Special ophthalmologic assessment 120.00

Payment rules:

1. No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A251.

2. This service is limited to a maximum of 2 services per patient per physician per 12 month period.

Medical record requirements:
For A251:

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

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C235	Consultation	71.30
C935	Special surgical consultation (see General Preamble GP17)	132.50
C236	Repeat consultation	45.85
C233	Specific assessment	42.15
C234	Specific re-assessment	25.45
C250	Retinopathy of prematurity assessment - subject to the same conditions as A250	120.00

OPHTHALMOLOGY (23)

Subsequent visits

C232	- first five weeks	per visit	29.20
C237	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C239	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment.	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area.	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30).	per visit	29.20
C238	Concurrent care.	per visit	29.20
C982	Palliative care (see General Preamble GP36).	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W535	Consultation.	71.30
W536	Repeat consultation	45.85

GENERAL LISTINGS

A065	Consultation	71.30
A935	Special surgical consultation (see General Preamble GP17)	132.50
A066	Repeat consultation	45.85
A063	Specific assessment	39.70
A064	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C065	Consultation	71.30
C935	Special surgical consultation (see General Preamble GP17)	132.50
C066	Repeat consultation	45.85
C063	Specific assessment	39.70
C064	Specific re-assessment	25.15

Subsequent visits

C062	- first five weeks . . . per visit	29.20
C067	- sixth to thirteenth week inclusive (maximum 3 per patient per week) . . . per visit	29.20
C069	- after thirteenth week (maximum 6 per patient per month) . . . per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) . . . per visit	29.20
C068	Concurrent care . . . per visit	29.20
C982	Palliative care (see General Preamble GP36) . . . per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W065	Consultation	71.30
W066	Repeat consultation	45.85

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W062	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W061	- additional subsequent visits (maximum of 6 per patient, per month) . . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W063	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W068	- subsequent visits per month (maximum of 3 per patient per month) . . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

CONSULTATIONS AND VISITS

OTOLARYNGOLOGY (24)

GENERAL LISTINGS

A245	Consultation	71.30
A935	Special surgical consultation (see General Preamble GP17)	132.50
A246	Repeat consultation	45.85
A243	Specific assessment	39.70
A244	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C245	Consultation	71.30
C935	Special surgical consultation (see General Preamble GP17)	132.50
C246	Repeat consultation	45.85
C243	Specific assessment	39.70
C244	Specific re-assessment	25.15

Subsequent visits

C242	- first five weeks	per visit	29.20
C247	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C249	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C248	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W345	Consultation	71.30
W346	Repeat consultation	45.85

GENERAL LISTINGS

A265	Consultation	147.80

Neurodevelopmental consultation

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

A667	Neurodevelopmental consultation	300.00

Payment rule:
This service is limited to a maximum of one per patient, per physician every two years.

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

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

Prenatal consultation

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

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

A665	Prenatal consultation	82.90
A565	Limited consultation	82.90
A266	Repeat consultation	82.90
A263	Medical specific assessment	64.05
A264	Medical specific re-assessment	50.50
A661	Complex medical specific re-assessment	58.45
A261	Level 1 - Paediatric assessment	19.50
A262	Level 2 - Paediatric assessment	35.15
E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

Annual health examination

K267	- child after second birthday	30.40
K269	- adolescent	61.00

Note:
Diagnostic interview and/or counselling with child and/or parent - see listings in Family Practice & Practice in General.

Paediatric Psychotherapy

Definition: Paediatric Psychotherapy is psychotherapy rendered by paediatricians to patients aged 17 or less meeting the criteria outlined below. Unit means ½ hour or major part thereof - see General Preamble GP6, GP39 to GP43 for definitions and time-keeping requirements.

K122	- individual paediatric psychotherapy, per unit	65.65
K123	- family psychotherapy, per unit	68.80

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

a. a minimum of two years experience in a paediatric practice where a minimum of 50% of the paediatric patients received psychotherapy services, or

b. fellowship training in psychiatry

[Commentary:
Services rendered by physicians who do not meet either of these requirements are still insured but payable under another fee schedule code e.g. individual psychotherapy (K007) or family psychotherapy (K004).]

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C265	Consultation	147.80
C667	Neurodevelopmental consultation - subject to same conditions as A667	300.00
C665	Prenatal consultation - subject to the same conditions as A665	82.90
C565	Limited consultation	82.90
C266	Repeat consultation	82.90
C263	Medical specific assessment	64.05
C264	Medical specific re-assessment	50.50
C661	Complex medical specific re-assessment	58.45

Subsequent visits

C262	- first six weeks, per visit	29.20
C267	- seventh to thirteenth week inclusive (maximum 3 per patient per week), per visit	29.20
C269	- after thirteenth week (maximum 6 per patient per month), per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30), per visit	29.20
C268	Concurrent care, per visit	29.20
C982	Palliative care (see General Preamble GP36), per visit	29.20

Attendance at maternal delivery

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

H267 Attendance at maternal delivery 63.45

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

H261 Newborn care in hospital or home 57.90

Low birth weight newborn uncomplicated care

H262	- initial . . . . . per newborn	61.00
H263	- thereafter . . . . . per visit	17.75

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W265	Consultation.	147.80
W667	Neurodevelopmental consultation - subject to same conditions as A667	300.00
W565	Limited consultation.	82.90
W266	Repeat consultation.	82.90

Admission assessment

W562	- Type 1	61.00
W564	- Type 2	17.75
W567	- Type 3	30.70
W269	Annual physical examination	30.70

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W262	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W261	- additional subsequent visits per month (maximum 6 per patient per month) . . . . . per visit	13.40
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

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

CONSULTATIONS AND VISITS

PHYSICAL MEDICINE & REHABILITATION (31)

GENERAL LISTINGS

A315	Consultation	149.55
A515	Limited consultation	82.90
A316	Repeat consultation	82.90
A313	Medical specific assessment	64.05
A310	Medical specific re-assessment	50.50
A311	Complex medical specific re-assessment	58.45
A318	Partial assessment	30.60

E078 - chronic disease assessment premium (see General Preamble GP21) . . . . . add 50%

Comprehensive physical medicine and rehabilitation consultation

A comprehensive physical medicine and rehabilitation consultation is a consultation in which the physician provides all the elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient.

A425 Comprehensive physical medicine and rehabilitation consultation 197.30

Payment rule:
A comprehensive physical medicine and rehabilitation consultation is limited to one every 2 years by the same physician.

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

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C315	Consultation	149.55
C515	Limited consultation	82.90
C316	Repeat consultation	82.90
C313	Medical specific assessment	64.05
C314	Medical specific re-assessment	50.50
C311	Complex medical specific re-assessment	58.45
C425	Comprehensive physical medicine and rehabilitation consultation – subject to the same conditions as A425	197.30

Subsequent visits

C312	- first five weeks	per visit	29.20
C317	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C319	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area		55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C318	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W515	Consultation	149.55
W310	Limited consultation	82.90
W516	Repeat consultation	82.90
W425	Comprehensive physical medicine and rehabilitation consultation - subject to the same conditions as A425	197.30

Admission assessment

W512	- Type 1	61.00
W514	- Type 2	17.75
W517	- Type 3	30.70
W419	Annual physical examination	61.00
W314	General re-assessment of patient in nursing home*	17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP35)

Chronic care or convalescent hospital

W312	- first 4 subsequent visits per patient per month . . . . per visit	29.20
W311	- additional subsequent visits (maximum of 6 per patient per month) . . . . . per visit	13.80
W982	- palliative care (see General Preamble GP36) . . . . per visit	29.20

Nursing home or home for the aged

W313	- first 2 subsequent visits per patient per month . . . . per visit	22.55
W318	- subsequent visits per month (maximum of 3 per patient per month) . . . . . per visit	13.80
W972	- palliative care (see General Preamble GP36) . . . . per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP35). . . . . per visit	22.55

Team management in a Rehabilitation Unit

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

H312	- first twelve weeks . . . . . per visit	29.20
H317	- from thirteenth to twenty-sixth week (maximum 3 per patient per week) . . . . . per visit	29.20
H319	- twenty-seventh week onwards (maximum 6 per patient per month) . . . . . per visit	29.20

Rehabilitation counselling

Rehabilitation counselling one or more persons. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

H313	Rehabilitation counselling	65.65

Physiatric management

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

K313	Physiatric management	6.10

Payment rules:

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

[Commentary:

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

CONSULTATIONS AND VISITS

PLASTIC SURGERY (08)

GENERAL LISTINGS

A085	Consultation	71.30
A935	Special surgical consultation (see General Preamble GP17)	132.50
A086	Repeat consultation	45.85
A083	Specific assessment	39.70
A084	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C085	Consultation	71.30
C935	Special surgical consultation (see General Preamble GP17)	132.50
C086	Repeat consultation	45.85
C083	Specific assessment	39.70
C084	Specific re-assessment	25.15

Subsequent visits

C082	- first five weeks	per visit	29.20
C087	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C089	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C088	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W085	Consultation	71.30
W086	Repeat consultation	45.85

GENERAL LISTINGS

A195	Consultation	162.95
A895	Consultation in association with special visit to hospital or long-term care in-patient	190.15

Geriatric psychiatric consultation

Geriatric psychiatric consultation is payable to a psychiatrist for a patient aged 75 years or older and must include all the elements of A195 and a minimum of 75 minutes of direct contact with the patient exclusive of discussion with caregivers or any separately payable services. The consultation must be scheduled a minimum of 24 hours prior to the visit. The start and stop time must be recorded in the patient's permanent medical record. Maximum one per patient per physician every 5 years. Geriatric psychiatric consultations that do not conform with the above or are delegated in a clinic teaching unit to an intern, resident or fellow are payable as a lesser consultation or visit.

A795	Geriatric psychiatric consultation	195.55

Neurodevelopmental consultation

Neurodevelopmental consultation is payable when the physician provides all the elements of A195 for an adult with complex neurodevelopmental conditions e.g. autism, global developmental disorders etc., and must include a minimum of 120 minutes of direct contact with the patient and caregiver. The start and stop times must be recorded in the patient's permanent medical record. Maximum one per patient per physician every 5 years.

A695	Neurodevelopmental consultation	271.60

Note:
Neurodevelopmental consultations for children or adolescents or for less complex conditions e.g. attention deficit disorder are payable at a lesser fee.

A395	Limited consultation	82.90
A196	Repeat consultation	82.90
A193	Specific assessment	64.05
A194	Partial assessment	30.60

Consultation on behalf of disturbed child (including report)

A197	- consultative interview with parents	173.80
A198	- consultative interview with child	173.80

Note:
A197, A198 are considered as consultations. A197, A198 are not to be used when claiming assessment conference with parents. These should be claimed as family therapy.

EMERGENCY OR OUT-PATIENT DEPARTMENT (ODP)

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

NON-EMERGENCY HOSPITAL SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C895	Consultation	190.15
C395	Limited consultation	82.90
C196	Repeat consultation	82.90
C795	Geriatric psychiatric consultation - subject to same conditions as A795	195.55
C695	Neurodevelopmental consultation - subject to same conditions as A695	271.60
C193	Specific assessment	64.05
C194	Specific re-assessment	50.50

Subsequent visits

C192	- first five weeks	per visit	29.20
C197	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C199	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C198	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W895	Consultation	190.15
W795	Geriatric psychiatric consultation - subject to same conditions as A795	195.55
W695	Neurodevelopmental consultation - subject to same conditions as A695	271.60
W395	Limited consultation	82.90
W196	Repeat consultation	82.90

Assessments under the *Mental Health Act*

See General Preamble GP27 for definitions and conditions.

Consultation for involuntary psychiatric treatment

Consultation for involuntary psychiatric treatment in accordance with the *Mental Health Act.* Unit means ½ hour or major part thereof - see General Preamble GP27, for definitions and time-keeping requirements.

K620	Consultation for involuntary psychiatric treatment . . . . . per unit	69.45

Form 1

Application for psychiatric assessment, in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K623	Application for psychiatric assessment	85.65

Form 3

Certification of involuntary admission in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K624	Certification of involuntary admission.	105.45
K629	All other re-certification(s) of involuntary admission including completion of appropriate forms	31.30

Note:

1. A completed Form 1 *Application by a Physician For Psychiatric Assessment* retained on the patient's medical record is sufficient documentation to indicate that a consultation for involuntary psychiatric treatment has been requested by the referring physician.
2. Consultations or assessments claimed in addition to certification or re-certification same day are payable at nil.
3. Interviews with relatives on behalf of a patient, Children's Aid Society (CAS) staff or legal guardian, etc. - see listings in Family Practice & Practice In General.
4. Certification of incompetence (financial) including assessment to determine incompetence is not an insured benefit.

PSYCHOTHERAPY, FAMILY PSYCHOTHERAPY, HYPNOTHERAPY AND PSYCHIATRIC CARE

Note:

1. For conditions and definitions - see General Preamble GP39 to GP43.
2. For electroconvulsive therapy fees, see Diagnostic and Therapeutic Procedures.
3. When claiming group therapy only services rendered to one group are payable at the same time
4. Unit means ½ hour or major part thereof - see General Preamble GP6, GP40 for definitions and time-keeping requirements.

Psychiatric care

K198	- out-patient	per unit	65.65
K199	- in-patient	per unit	75.70

Family psychiatric care

K196	- out-patient	per unit	68.80
K191	- in-patient	per unit	68.80

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

Psychotherapy

K197	Individual out-patient psychotherapy	per unit	65.65
K190	Individual in-patient psychotherapy	per unit	68.80
K195	Family psychotherapy - out-patients (two or more members)	per unit	68.80
K193	Family psychotherapy - in-patients (two or more members)	per unit	68.80

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

K208	- 2 people	per unit	32.25
K209	- 3 people	per unit	21.50
K203	- 4 people	per unit	16.15
K204	- 5 people	per unit	12.90
K205	- 6 to 12 people	per unit	10.75
K206	- additional units - per member (maximum 6 per patient per day)	per unit	10.20

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

K210	- 2 people	per unit	32.25
K211	- 3 people	per unit	21.50
K200	- 4 people	per unit	16.15
K201	- 5 people	per unit	12.90
K202	- 6 to 12 people	per unit	10.75
K207	- additional units - per member (maximum 6 per patient per day)	per unit	10.20

Hypnotherapy

K192	Individual	per unit	65.65
K194	Group - for induction and training for hypnosis - per member (maximum eight people)	per unit	11.95

GENERAL LISTINGS

Consultation

A diagnostic radiology consultation is the service rendered when:

a. when radiographs made at one institution or facility are referred to a radiologist at a different institution or facility for his/her written opinion. In this case, the specific elements are as for nuclear medicine professional component P_2 (see page B1),

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

or

c. when a radiologist is required to render an opinion prior to an interventional procedure and all of the following requirements are met. In this case, the specific elements are the same as for consultations:

i. the consultation is performed in an area remote from the radiologist's normal procedural suite;

ii. the requirements for a consultation are met;

iii. the consultation is not solely for the purpose of clarifying or obtaining consent;

and,

iv. the associated procedure is one of the following: J021 J025 J040 J041 J046 J048 J049 J050 J055 J056 J057 J058 J059 J063 J065 J066 N107 N118 S233 Z446 Z456 Z562 Z594.

A335 Consultation. 35.70

Payment rule:
A diagnostic radiology consultation is not eligible for payment when radiographs made in a different institution or facility are used for comparison purposes with radiographs made in the consultant's institution or facility.

Special Interventional Radiological Consultation

A special interventional radiological consultation is the service described under part (c) of a regular consultation (A335) in circumstances in which because of the very complex, obscure or serious nature of the problem, the physician is required to spend a minimum of 50 minutes with the patient in consultation.

[Commentary:
The calculation of the 50 minute minimum excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

A365 Special Interventional Radiological Consultation 132.50

Minor assessment

A minor assessment (A331) is the service rendered when a radiologist evaluates a patient on a non-emergent basis resulting in the cancellation or deferral of a planned diagnostic radiology procedure due to procedural difficulties, including lack of patient cooperation, if no other diagnostic radiology procedure is rendered.

A331	Minor assessment	17.75

Minor assessment

A minor assessment (A338) is the service rendered when a radiologist evaluates a patient on a non-emergent basis on the advisability of performing a diagnostic radiological procedure which eventually is not done.

A338	Minor assessment	17.75

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C335	Consultation - subject to the same conditions as A335	35.70
C365	Special Interventional Radiological Consultation - subject to the same conditions as A365	132.50

GENERAL LISTINGS

A345	Consultation	132.50
A745	Limited consultation	82.90
A346	Repeat consultation	82.90
A343	Medical specific assessment	64.05
A340	Medical specific re-assessment	50.50
A341	Complex medical specific re-assessment	58.45
A348	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP21) . . . . . add 50%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C345	Consultation	132.50
C745	Limited consultation	82.90
C346	Repeat consultation	82.90
C343	Medical specific assessment	64.05
C344	Medical specific re-assessment	50.50
C341	Complex medical specific re-assessment	58.45

Subsequent visits

C342	- first five weeks . . . . . per visit	29.20
C347	- sixth to thirteenth week inclusive (maximum 3 per patient per week) . . . . . per visit	29.20
C349	- after thirteenth week (maximum 6 per patient per month) . . . . . per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) . . . . . per visit	29.20
C348	Concurrent care . . . . . per visit	29.20
C982	Palliative care (see General Preamble GP36) . . . . . per visit	29.20

CONSULTATIONS AND VISITS

RESPIRATORY DISEASE (47)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A475	Consultation	132.50
A575	Limited consultation	82.90
A476	Repeat consultation	82.90
A473	Medical specific assessment	64.05
A474	Medical specific re-assessment	50.50
A471	Complex medical specific re-assessment	58.45
A478	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C475	Consultation	132.50
C575	Limited consultation	82.90
C476	Repeat consultation	82.90
C473	Medical specific assessment	64.05
C474	Medical specific re-assessment	50.50
C471	Complex medical specific re-assessment	58.45

Subsequent visits

C472	- first five weeks	per visit	29.20
C477	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C479	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C478	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP36) per visit	29.20

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A485	Consultation	132.50
A595	Limited consultation	82.90
A486	Repeat consultation	82.90
A483	Medical specific assessment	64.05
A484	Medical specific re-assessment	50.50
A481	Complex medical specific re-assessment	58.45
A488	Partial assessment	30.60
E078	- chronic disease assessment premium (see General Preamble GP21)	add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C485	Consultation	132.50
C595	Limited consultation	82.90
C486	Repeat consultation	82.90
C483	Medical specific assessment	64.05
C484	Medical specific re-assessment	50.50
C481	Complex medical specific re-assessment	58.45

Subsequent visits

C482	- first five weeks	per visit	29.20
C487	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C489	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C488	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP36) per visit	29.20

GENERAL LISTINGS

A355	Consultation*	71.30
A935	Special surgical consultation (see General Preamble GP17)	132.50
A356	Repeat consultation*	45.85
A353	Specific assessment*	39.70
A354	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

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

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP34. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

C355	Consultation*	71.30
C935	Special surgical consultation (see General Preamble GP17)	132.50
C356	Repeat consultation*	45.85
C353	Specific assessment*	39.70
C354	Specific re-assessment	25.15

Subsequent visits

C352	- first five weeks	per visit	29.20
C357	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C359	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 to GP32 for terms and conditions.

C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45

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

See General Preamble GP33 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	55.45
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	55.45

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C358	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP36)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP47 to GP52.

W355	Consultation*	71.30
W356	Repeat consultation*	45.85

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

CONSULTATIONS AND VISITS

NOT ALLOCATED