DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

SPECIFIC ELEMENTS

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

A. Where the services are not identified with prefix #, the specific elements are those listed in the General Preamble GP15.

B. Where the services are identified with prefix #, the specific elements are those listed in the General Preamble GP15 except for specific element H. In place of H includes providing premises, equipment, supplies and personnel for any aspect(s) of the specific elements that is (are) performed in a place other than the place in which the included procedures are performed.

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

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

Non-Invasive Diagnostic Procedures (other than Laboratory Medicine)

Some non-invasive diagnostic procedures are divided into a technical component and a professional component that, for some services, may have two levels identified as P_1 and P_2. In addition to the common elements, the components of non-invasive diagnostic procedures include the following specific elements.

For Professional Component P_1

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

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

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

D. Interpreting the results of the diagnostic procedure.

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

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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

For Professional Component P_2

A. Interpreting the results of the diagnostic procedure.

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

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

For Technical Component

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

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

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

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

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

G. Providing premises, equipment, supplies and personnel for all specific elements of the technical and professional components except for the premises for any aspect(s) of A and D of the P_1 professional component and A of the P_2 professional component that is(are) not performed at the place in which the procedure is performed.

Where the listings refer to the "professional component" the reference is to P_1 unless specifically identified as P_2. Where the only professional component provided is P_2, the specific elements A and C listed for the professional component (P_1) are further specific elements of the technical component.

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

1. for services not identified with prefix #, the combination of the specific elements listed for the professional component (P_1) and for the technical component.

2. for services identified with prefix #, the combination of the specific elements listed for the professional component (P_1) and specific elements A through E of the technical component.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

THERAPEUTIC AND INVASIVE DIAGNOSTIC PROCEDURES

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

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

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

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

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

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

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

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

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

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

OTHER TERMS AND DEFINITIONS

Procedural benefits are payable in addition to a consultation or assessment except where they are specifically listed as included in these services. When a procedure(s) is the sole reason for a visit, add G700, the basic fee-per-visit premium for those procedures marked (+) regardless of the number of procedures carried out during that visit. However, G700 is not payable in situations where the referring physician both:

1. Has a financial interest in the diagnostic or therapeutic facility; and

2. Has examined or is about to examine the patient in connection with the problem to which the procedure relates.

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

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

		Fee

Note:
If a patient presents for an allergy injection and has an acute infectious condition, albeit of the respiratory system, or some other unrelated condition which would have otherwise required a separate office visit, the physician is entitled to claim the appropriate assessment fee as well as the injection fee. If a patient requires a brief assessment of his allergic condition as well as the allergy injection, the physician should claim the injection and the basic fee, in which case the specific elements of the service include those of an assessment (see General Preamble GP15) .

# G185	Drug(s) desensitisation - in a hospital where full cardioresuscitative equipment is readily available because a significant risk of life-threatening anaphylaxis exists. The service must be performed under direct and ongoing physician attendance	184.95
+ G200	Acute desensitisation, e.g. ATS, penicillin	8.65
+ G201	Direct nasal tests, to a maximum of 3 per year . . . . . per test	1.60

Hyposensitisation, including assessment and supervision

G202	- one or more injections	3.83
G212	- when sole reason for visit (G700 plus G202)	8.95
G205	Insect venom desensitisation (immunotherapy) - per injection (maximum of 5 per day). In addition to G205, after the initial major assessment only, a minor or partial assessment may be claimed once per day if rendered. . . .	12.80

Ophthalmic tests

+ G203	- direct, to maximum of 3 per year . . . . . per test	1.60
+ G204	- quantitative	12.40

Patch test

G206	- maximum of 60 per patient, per year. . . . . per test	2.39
G198	- for industrial or occupational dermatoses, to a maximum of 90 per patient, per year. . . . . per test	2.39
+ G207	Bronchial provocative testing - per session, to a maximum of 6 per year	14.15

Serial oral (not sublingual) and parenteral provocation testing

For food colours, food additives and drugs performed by a double or single blind technique, placebo control, measured by objective parameters and to include documentation (maximum 5 sessions per year). Unit means one hour or major part thereof. See General Preamble GP6 for definitions and time-keeping requirements.

G208	Serial oral (not sublingual) and parenteral provocation testing per test . . . . . per unit	13.80

Note:
In the event the allergic response is respiratory, only one pulmonary function test is eligible for payment the same day as G208.

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

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

			T	P
	Skin testing			
G209	- technical component, to a maximum of 50 per year	per test	0.71	
G197	- professional component, to a maximum of 50 per year	per test		0.17

			Fee
G199	Insect venom skin testing including physician interpretation.		17.00
G195	Local anaesthetic hypersensitivity skin test		17.00
G196	Hypersensitivity skin test for validated drugs or agents excluding foods and inhalants		17.00
E582	- when testing with penicillin minor determinant mixture outside a hospital setting, to G196	add	32.20

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

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

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

c. assessment of ice cube cold challenges,

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

e. vibration effect of light and water,

f. histamine or methacholine

G213	Physical urticaria challenges	13.80

		Fee	Anae

SPECIFIC ELEMENTS

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

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

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

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

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

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

		Fee	Anae
	Vascular Cannulation		
Z459	Arterial puncture	9.10	
# G268	Cannulation of artery for pressure measurements including cut down as necessary	31.25	
# G269	Cannulation of central vein for pressure measurements or for feeding line - not to be billed with right heart catheterization (Z439) or with Swan-Ganz catheter insertion	31.25	
# G270	Intraosseous infusion	23.90	
# G309	Umbilical artery catheterization (including obtaining of blood sample)	45.55	
	Venipuncture		
+ G480	- infant	9.25	
+ G482	- child	6.25	
+ G489	- adolescent or adult	2.32	
+ G483	Therapeutic venisection	9.70	
G282	Umbilical vein catheterization (including obtaining of blood sample)	19.90	
# Z438	Insertion of Swan-Ganz catheter (not included in anaesthetic, respiratory or critical care benefits)	162.50	6
# G304	- when dye dilution densitometry done in addition, to a maximum of 3, per Swan-Ganz insertion	49.35	
G360	- when thermal dilution studies rendered in addition to Z438	49.35	
	Note: Thermal dilution studies must be rendered personally by the physician and are limited to a maximum of one per day to a maximum of 5 days per hospital admission at the same institution.		
# Z456	Insertion of implantable central venous catheter	135.50	6
# Z457	Surgical removal or repair of implanted central venous catheter	39.45	6
# Z446	Insertion of subcutaneous venous access reservoir	135.50	6
# Z447	- revision same site	59.70	6
# E684	- when performed in infant or child, to Z456 or Z446 ..... add	172.65	

Fee

FOR ANTICOAGULANT SUPERVISION - LONG-TERM, TELEPHONE ADVICE

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

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

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

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

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

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

G271	Anticoagulant supervision - long-term, telephone advice	per month	10.60

		Fee	Anae
	BLOOD TRANSFUSIONS		
# G275	Exchange transfusion	205.45	
	Note: Assistant at exchange transfusion (see General Preamble GP54).		
# G280	Intra-uterine fetal transfusion - initial or subsequent	186.90	
G276	Donor cell pheresis (platelets or leukocytes)	15.35	
	Therapeutic plasma exchange		
# G277	- initial and repeat, to a maximum of 5 per year. . . . . each	74.55	
# G278	- more than 5 per year . . . . . each	38.00	
# G272	Manual plasmapheresis (see General Preamble GP12)	I.C	
	CARDIOVERSION		
# Z437	Cardioversion (electrical) - limit of three sessions per patient . . . . . per day	66.00	6
	CARDIAC CATHETERIZATION		
	When more than one procedure is carried out at one sitting, the additional procedures are to be claimed at 50% of the listed benefits. (Z439 to G288, excluding G262 and G263).		
	HAEMODYNAMIC/FLOW/METABOLIC STUDIES		
	Right heart		
# Z439	- pressures only	166.90	6
	Left heart		
# Z440	- retrograde aortic	210.55	6
# Z441	- transeptal	297.15	6
# G296	Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab	110.95	
	Note: When G296 is done in addition to Z438 use code G304 instead.		
# G299	Oximetry	110.95	
# G289	Fick determination	110.95	
# G300	Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations	110.95	
# G301	Exercise studies during catheterization	122.40	
# G306	Isotope studies during cardiac catheterization	110.95	
# G305	Intracardiac phonocardiography	122.40	

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

		Fee	Anae
	Electrophysiology/Pacing		
	Endocardial activation mapping (includes insertion of electrodes and arrhythmia induction)		
# G176	- atrial	334.25	
# G177	- ventricular	416.80	
# G178	- catheter ablation therapy	352.05	
# G179	- repeated	111.20	
G115	External cardiac pacing (temporary transthoracic) once per 24-hour period	46.30	
	Note: G115 not to be claimed with G521, G522, G523, G395 and G391.		
# G249	Electrophysiologic measurements (includes one or all of sinus node recovery times, conduction times and refractory periods), includes insertion of electrodes	231.65	
	ARRHYTHMIAS		
	Induction of arrhythmias		
	To include programmed electrical stimulation, drug provocation and termination of arrhythmia, if necessary - once per patient per 24 hours		
# G261	- atrial	331.05	
# G259	- ventricular	383.30	
	Note: G261, G259 not to be claimed with G521, G522, G523, G395 and G391.		
# G366	Testing of arrhythmias inductability by acute administration of anti-arrhythmic drugs to a maximum of 2 per 24 hours.	148.50	
# Z443	Insertion of temporary endocardial electrode	154.10	6
# Z431	Repositioning of temporary endocardial electrode	64.25	6
	Endomyocardial Biopsy		
# G288	- transvascular, right or left	200.00	
	Tilt Table Testing of Vasomotor syncope		
# G314	- to include arterial cannulation, provocative and blocking drugs, physician must be continually present	112.00	

Fee

PREAMBLE

1. ECGs may be requested by a Registered Nurse in the Extended Class (RN(EC)) in non-urgent and non-acute circumstances. Physicians and hospitals should use Fee Codes G313 and G310 for requests by RN(EC)s.

2. An ECG ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department is insured when the ECG is rendered:

   a. in connection with a dental surgical procedure provided by an oral and maxillofacial surgeon in a hospital and it is medically necessary for the patient to receive the dental surgical procedure in a hospital;

   or

   b. on the order of an oral and maxillofacial surgeon who has reasonable grounds to believe that a dental surgical procedure, performed by an oral and maxillofacial surgeon, will be required in connection with the ECG and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.

G175 Insertion of oesophageal electrode in monitoring position 21.85

		T	P
	Electrocardiogram - twelve lead		
+ G310	- technical component.	6.75	
G313	- professional component - must include written interpretation.		9.75

STRESS TESTING

Maximal stress ECG

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

G315	- technical component.	33.65	
G319	- professional component		62.65

Dobutamine stress test

G174	- technical component, when rendered outside of hospital . . . . . add	37.00	

Dipyramidole Thallium Stress Test

G111	- technical component.	41.10	
G112	- professional component		75.00

		T	P

CONTINUOUS ECG MONITORING (E.G. HOLTER)

Level 1

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

G651	- technical component - 12 to 35 hours recording	24.50	
G652	- technical component - 12 to 35 hours scanning	33.55	
G650	- professional component - 12 to 35 hours recording		47.90
G682	- technical component - 36 to 59 hours recording	49.00	
G683	- technical component - 36 to 59 hours scanning	67.05	
G658	- professional component - 36 to 59 hours recording		71.85
G684	- technical component - 60 or more hours recording	73.50	
G685	- technical component - 60 or more hours scanning	100.60	
G659	- professional component - 60 or more hours recording		95.85

Level 2

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

G654	- technical component - 12 to 35 hours recording	23.40	
G655	- technical component - 12 to 35 hours scanning	16.00	
G653	- professional component - 12 to 35 hours recording		34.10
G686	- technical component - 36 to 59 hours recording	46.75	
G687	- technical component - 36 to 59 hours scanning	32.00	
G656	- professional component - 36 to 59 hours recording		51.15
G688	- technical component - 60 hours to 13 days recording	70.15	
G689	- technical component - 60 hours to 13 days scanning	48.05	
G657	- professional component - 60 hours to 13 days recording		68.20

Note:

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

		T	P	P2
	Cardiac Loop Monitoring (per 14 day test)			
	Patient interactive technology continuously capable of capturing retrospective real-time ECG data and of transferring this data to a remote base station for analysis and interpretation.			
G692	- technical component, recorder	233.65		
G693	- technical component, base station functions	168.20		
G690	- professional component, interpretation		122.25	
	[Commentary: The technical fees for these procedures will be subject to a joint review by the Ministry and the Ontario Medical Association on or before December 31, 2004.]			
	Event Recorder			
G661	- technical component	4.10		
G660	- professional component		8.65	
	Interpretation of telephone transmitted ECG rhythm strip			
G311	- technical component	1.97		
G320	- professional component (P_2)			4.30
	Single chamber reprogramming including electrocardiography			
G284	- technical component	9.00		
G283	- professional component		11.30	
	Dual chamber reprogramming including electrocardiography			
G181	- technical component	11.85		
G180	- professional component		16.95	
	Pacemaker pulse wave analysis including electrocardiography			
G308	- technical component	9.00		
G307	- professional component		9.55	
	Automatic implantable defibrillator			
	Non-programmable including electrocardiography, interrogation and analysis			
G317	- professional component		27.80	
	Programmable including electrocardiography, interrogation and reprogramming			
G321	- professional component		47.65	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

NON- INVASIVE CARDIOGRAPHY

			Fee
	BLOOD FLOW STUDY (DOPPLER OR OTHER) - UNI- OR BILATERAL		
G517	Ankle pressure determination - not to be claimed during surgery or during the patient's post-operative stay in hospital		10.05

		T	P
	Phlebography and/or carotid pulse tracing (with systolic time intervals)		
G519	- technical component	10.60	
G518	- professional component		11.20
	Impedance plethysmography		
G121	- technical component	12.85	
G120	- professional component		7.00
	Digital photoplethysmography		
G127	- technical component, per extremity	12.85	
G126	- professional component, per extremity		7.00

		T	P1	P2

PROFESSIONAL COMPONENTS

P_1 is the professional fee for the performance of some or all of the procedure by a suitably trained physician or alternatively, the same physician being physically present in the echocardiography laboratory to supervise the procedure, interpret the results and provide a written report. P_2 is the professional fee for interpretation of the results (the video tape must be reviewed in its entirety by the physician) and provision of a written report by a suitably trained physician.

	Complete study - 1 dimension			
G560	- technical component	34.75		
G561	- professional component (P_1)		35.55	
G562	- professional component (P_2)			26.30
	Complete study - 2 dimension			
G566	- technical component	59.55		
G567	- professional component (P_1)		55.85	
G568	- professional component (P_2)			41.95
	Complete study - 1 and 2 dimensions			
G570	- technical component	76.45		
G571	- professional component (P_1)		74.10	
G572	- professional component (P_2)			55.40
	Limited study - 1 or 2 dimensions, for follow-up studies - not to be claimed in conjunction with pregnancy study			
G574	- technical component	16.45		
G575	- professional component (P_1 or P_2)		17.45	17.45
	Cardiac Doppler study, with or without colour doppler, in conjunction with complete 1 and 2 dimension echocardiography studies			
G577	- technical component	45.15		
G578	- professional component (P_1)		36.90	

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

	Transoesophageal echocardiography		
G581	- professional component (P_1)		25.00

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

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

Fee

LIFE THREATENING EMERGENCY SITUATION

The service rendered when a physician provides resuscitation in emergency situation: cardiac arrest, multiple systems major trauma, cardio-respiratory failure, resuscitation of newborn (see Preamble relating to Obstetrics), severe shock, coma. The specific elements are those of an assessment, including immediate crisis-related examination, ongoing monitoring of the patient's condition and the usual resuscitative procedures as required: defibrillation, cardioversion, cutdowns, intravenous lines, arterial and/or venous catheters, pressure infusion sets and pharmacological agents, urinary catheters, C.V.P. lines, blood gases, nasogastric intubation with or without anaesthesia endotracheal intubation and tracheal toilet. Time is to be measured as the period of constant attendance excluding time required for any separately billable intervention.

Amount payable per physician per life threatening emergency situation for the first three physicians for which a claim is submitted and paid.

G521	- first ¼ hour	82.25
G523	- second ¼ hour	41.10
G522	- after first ½ hour (per ¼ hour or major part thereof)	27.05
G391	Amount payable per physician per life threatening emergency situation for the fourth and subsequent physicians for which a claim is submitted and paid (per ¼ hour or major part thereof)	21.10

OTHER RESUSCITATION

The service rendered when a physician provides resuscitation in emergency situations other than those listed above and only includes the following resuscitative procedures: cutdowns, intravenous lines, arterial and/or venous catheters pressure infusion sets and pharmacological agents, urinary catheters, C.V.P. lines, blood gases, nasogastric intubation with or without anaesthesia, with or without lavage, endotracheal intubation and tracheal toilet. Time is to be measured as the period of constant attendance excluding time required for any separately billable intervention. When G395 is claimed in conjunction with G521, G522 or G523 for services rendered to the same patient by the same physician same day the amount payable for G395 is reduced to the amount payable for G391.

Amount payable per physician per other resuscitation for the first three physicians for which a claim is submitted and paid.

G395	- first ¼ hour	42.25
G391	- after first ¼ hour (per ¼ hour or major part thereof)	21.10

Note:
Consultation or assessments rendered before or after provision of resuscitative care or neonatal intensive care may be claimed on a fee-for-service basis but not when claiming Critical, Ventilatory, Neonatal Intensive Care or Comprehensive Care fees. When claiming Critical, Ventilatory, Neonatal Intensive Care or Comprehensive Care fees, no other Critical Care codes may be claimed by the same physician(s).

G303	Transthoracic pacemaker - insertion	51.25
G211	Endotracheal intubation for resuscitation (not to be claimed when followed by a surgical procedure at which time it is included in the anaesthetic procedure)	35.85

CRITICAL CARE PER DIEM LISTINGS

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

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

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

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

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

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

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

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

		Fee

CRITICAL CARE (INTENSIVE CARE AREA)

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

Physician-in-charge

# G400	- 1st day		211.15
# G401	- 2nd to 30th day, inclusive	per diem	132.00
# G402	- 31st day onwards	per diem	52.80

VENTILATORY SUPPORT (INTENSIVE CARE AREA)

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

Physician-in-charge

# G405	- 1st day		183.10
# G406	- 2nd to 30th day, inclusive	per diem	91.50
# G407	- 31st day onwards	per diem	60.95

COMPREHENSIVE CARE (INTENSIVE CARE AREA)

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

Physician-in-charge

# G557	- 1st day		308.00
# G558	- 2nd to 30th day, inclusive	per diem	192.45
# G559	- 31st day onwards	per diem	76.95

Fee

NEONATAL INTENSIVE CARE

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

Level A

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

# G600	- 1st day	307.70
# G601	- 2nd to 30th day, inclusive per diem	153.80
# G602	- 31st day onwards, per diem	76.85
# G603	- Neonatal low volume intensive care - payable in lieu of G600 or G604 if sole newborn to maximum of 25 services per physician per fiscal year	461.55
# G604	- Neonatal low birth weight intensive care - payable in lieu of G600 or G603 for newborn less than 750 grams in weight or 26 weeks gestational age	461.55

Level B

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

# G610	- 1st day	211.15
# G611	- 2nd day onwards, per diem	105.55

Level C

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

# G620	- 1st day	133.40
# G621	- 2nd day onwards, per diem	66.70

Note:

1. Physician-in-charge is the physician(s) daily providing the Neonatal Intensive Care.
2. These are team fees which apply to neonatologists /paediatricians/anaesthetists providing complete care. If infant has been transferred from one level to another in either direction, up or down, second day benefits apply.

Fee

HYPERBARIC THERAPY

Hyperbaric Therapy - being in constant attendance with the patient (either inside or outside the chamber) for the time billed to provide hyperbaric therapy. The specific elements are those of an assessment, including ongoing monitoring of the patient's condition and intervening as appropriate. Separately billable interventions may be claimed in addition to these fees.

Note:
Consultation(s) or assessment(s) and special visit premium(s) may be claimed on a per patient basis when these services are rendered.

Physician in chamber with patient

# G800	- per dive, first ¼ hour	56.55
# G801	- after first ¼ hour (per ¼ hour or major part thereof)	28.25
# G802	- after 2 hours in chamber (per ¼ hour or major part thereof)	56.55
# G803	For each additional patient treated in the chamber, increase the above fee(s) by 20%	

Physician not in chamber with patient

# G804	- per dive, first ¼ hour	42.25
# G805	- after first ¼ hour (per ¼ hour or major part thereof)	21.20
# G806	For each additional patient treated, per quarter hour, per patient	4.40

Note:
Hyperbaric therapy is not an insured benefit for treatment of some conditions. Please refer to Medical Consultant for qualifying diagnoses.

Hypothermia Induction

# G210	Hypothermia (therapeutic) induction and management	190.75

		Fee

ULTRAVIOLET LIGHT THERAPY

Ultraviolet light therapy (general or local application) and/or Psoralen plus Ultraviolet A (PUVA) is an insured service only for treatment of dermatological conditions (maximum 1 per patient per day). G470 is an insured service payable at nil if rendered in a hospital in-patient or out-patient department or physiotherapy facility listed in Schedule 5 under Regulation 552 of the *Health Insurance Act.*

+ G470	Ultraviolet light therapy	7.85

[Commentary:
See General Preamble GP45 to GP46 for conditions and limitations regarding delegation and supervision of G470.]

		Asst	Fee	Anae
	Note: Team benefits to include listed items. This does not include preliminary investigation of the case.			
	Haemodialysis			
# R849	Initial and acute (includes both medical and surgical components)		621.35	6
# R850	Surgical component alone - insertion of Scribner shunt		313.25	6
G325	Medical component alone		308.00	
# G323	Acute, repeat - for the first 3 services		154.00	
# G083	Continuous venovenous haemodialysis - initial and acute (for the first 3 services)		369.65	
# G091	Continuous arteriovenous haemodialysis - initial and acute (for the first 3 services)		246.45	
# G085	Continuous venovenous haemofiltration - initial and acute (for the first 3 services)		369.65	
# G295	Continuous arteriovenous haemofiltration - initial and acute (for the first 3 services)		246.45	
	Note: Haemodialysis to include haemofiltration, haemoperfusion.			
	Continuous haemodiafiltration			
# G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services)		431.20	
# G092	Continuous arteriovenous haemodiafiltration - initial and acute (for the first 3 services)		308.00	
# G094	Chronic, continuous haemodiafiltration		65.05	
	Slow continuous ultrafiltration			
# G090	Venovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		308.00	
# G294	Arteriovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		184.75	
# G096	Chronic, slow continuous ultrafiltration		65.05	
	Revision of Scribner shunt			
# Z450	- single		102.55	6
# Z451	- both		152.40	6
# Z452	De-clotting of Scribner shunt		93.60	
# R843	Removal of cannula or A.V. shunt		81.45	6
# R827	Creation of A.V. fistula	6	440.00	6
	Note: R827 - see also listing under Cardiovascular System, Veins - Repair.			
# R841	Obliteration of A.V. fistula		82.55	6

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DIALYSIS

		Fee	Anae
	Bypass graft for haemodialysis		
# R851	- synthetic	444.70	7
# R840	- autogenous vein	424.10	7
# R833	Ligation or removal of bypass graft	82.55	6
	Subclavian or external jugular catheter for haemodialysis		
# G324	- insertion	93.60	
# G336	- revision	15.35	
# R848	Dialysis cannula insertion under vision into central line (excluding percutaneous)	219.15	6
# G099	Percutaneous insertion of permanent jugular/femoral dialysis catheter (including subcutaneous positioning)	135.80	
# G327	Insertion of femoral catheter for dialysis	70.25	
# G312	Thrombolytic instillation into temporary and permanent percutaneous catheters	15.40	
	Peritoneal dialysis		
# G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	199.55	
# G331	Repeat acute (up to 48 hours) - for the first 3 services	179.60	
# R852	Insertion of peritoneal cannula by laparotomy	186.95	6
# R885	Removal of peritoneal cannula by laparotomy	186.95	6
	Tenckhoff type peritoneal catheter		
# R853	- insertion, chronic by trocar	93.60	6
# R854	- removal	50.90	

CHRONIC DIALYSIS TEAM FEE

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

a. the patient's principal treatment centre;

or

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

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

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

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

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

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

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

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

D. All related case conferences.

The team fee does not include:

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

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

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

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

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

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

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

		Fee
	Chronic Dialysis Weekly Team Fee	
# G860	Hospital haemodialysis	134.05
# G861	Hospital peritoneal dialysis	134.05
# G862	Hospital self-care haemodialysis or satellite haemodialysis	134.05
# G863	Independent health facility haemodialysis	134.05
# G864	Home peritoneal dialysis	134.05
# G865	Home haemodialysis	134.05
# G866	Intermittent haemodialysis - at an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above)	65.05

Note:

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

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

Fee

HOME/SELF-CARE HAEMOPHILIA

Services rendered by the specialist in charge of the patient.

Haemophilia Infusion

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

G100 Haemophilia Infusion, per patient . . . . . per week 29.85

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

HOME/SELF-CARE VENTILATION

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

a. services rendered by most responsible physician;

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

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

G101 Home/self-care ventilation, per patient . . . . . per week 29.85

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

		Fee
+ G493	ACTH test - single or multiple, per injection	6.25
+ G337	Antidiuretic hormone response test including the 8 hour water deprivation test	16.95
+ G338	Clonidine suppression test (for the investigation of pheochromocytoma) - with physician present - includes venipunctures	24.90

Glucagon test

+ G494	- (Type A) for carbohydrate response	10.20
+ G495	- (Type B) for hypertension, pheochromocytoma and insulinoma provocative test (including cold pressor test)	42.30
G358	Growth hormone exercise stimulation test with physician present (includes venipunctures)	24.90
+ G340	Histamine test to include a control cold pressor test	45.45
+ G341	Hypertonic saline infusion test	16.95
+ G342	Implantation of hormone pellets	31.05
+ G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination	49.80

Insulin supervision

Insulin supervision is the provision of medical advice, direction or information pertaining to insulin management by telephone, fax or electronic mail personally by a physician to a patient newly started on 3 or more daily insulin injections or insulin pump. The date of service, questions and responses must be recorded in the patient's medical record or the service is not eligible for payment.

G500	Insulin supervision	10.60

Payment rules:

1. This service is not eligible for payment if rendered on the same day as a consultation or visit by the same physician to the same patient.
2. Insulin supervision is limited to a maximum of once per patient per week for the first month after initiation of insulin therapy, once per patient every two weeks for the next two months and once per patient per month for 12 additional months.

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

Open circuit indirect calorimetry

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

G515	Open circuit indirect calorimetry	46.30

		P1	P2
	Measurement of thermic effect of feeding		
	To follow 1 hour measurement of resting energy expenditure, subject is given a balanced test meal and then calorimetry measurements are taken for two hours, to include timed urine samples (2-3 hours) and urine nitrogen excretion measurements in a steady state condition, interpretation of results in context of patient's clinical status and written report.		
G516	Measurement of thermic effect of feeding	36.90	
	Oesophageal motility study(ies) with manometry		
G350	- standard, with physician in continuous attendance (P_1)	89.45	
G343	- interpretation only (P_2)		19.90
	Oesophageal acid perfusion test and/or provocative drug testing		
G353	- with physician in continuous attendance (P_1)	33.80	
G252	- interpretation only (P_2)		10.75
	Oesophageal pH study for reflux, with installation of acid		
G251	- standard, with physician in continuous attendance (P_1)	33.80	
G351	- with 24 hour monitoring		39.80
G346	- tracing interpretation only (P_2)		19.90
	Anal-rectal manometry		
G354	- with physician in continuous attendance (P_1)	45.30	
G253	- interpretation only (P_2)		10.65

			Fee
G254	Management of post liver or pancreas transplant immunosuppression - in lieu of non-emergency hospital visits - (once per day to a maximum of two weeks) . . . . . per visit		21.00
G349	Oesophageal tamponade (Blakemore bag) - insertion.		45.30
	Gastric lavage		
+ G355	- diagnostic		9.60
G356	- therapeutic - with or without ice water lavage		33.80
# Z520	Change of gastrostomy tube		8.60
+ G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin) - procedure and supervision		19.55
G352	Biliary tract provocative test with cholecystokinin.		9.60
# G322	Nasogastric intubation under general anaesthesia		9.60

		T	P
	Hydrogen breath test		
G167	- technical component.	6.75	
G166	- professional component		10.45

		P
# G332	Capsule endoscopy	122.25

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

		Fee
G367	Artificial insemination	31.95
G363	Cervical mucous penetration test	22.00
+ G364	Postcoital test of cervical mucous	17.60
G378	Insertion of intrauterine contraceptive device	25.50
E542	- when performed outside hospital . . . add	11.15
+ G362	Insertion of laminaria tent	6.25
E870	- when laminaria tent supplied by the physician . . . . . add	8.35
G334	Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (not eligible for payment same day as visit), to a maximum of 10 per cycle . . . . . per call	4.05
G399	Transvaginal sonohysterography, introduction of catheter, with or without injection of contrast media	44.15

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

[Commentary:
See Diagnostic Ultrasound section page G7.]

Papanicolaou Smear

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

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

Z463	Removal of Norplant	65.30

Pessary

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

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

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

Payment rules:

1. When used to determine the injection site, EMG or ultrasound services other than G877, G878, G879 or G880 are not eligible for payment with Botulinum toxin services.
2. All Botulinum toxin services are limited to a maximum of one treatment per condition, per patient every 10 weeks.

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

			Fee	Anae
+	G369	B.C.G. inoculation, following tuberculin tests	5.30	
+	G370	Bursa, joint, ganglion or tendon sheath and/or aspiration	19.90	
	G371	- each additional site or area, to a maximum of 3	10.00	

Note:
G370, G371 is not eligible for payment in addition to surgical benefits when performed at time of surgery.

CHEMONUCLEOLYSIS

Lateral discography

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

Injection for chemonucleolysis

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

INTRAMUSCULAR, SUBCUTANEOUS OR INTRADERMAL

	G372	- with visit (each injection)	2.32	
	G373	- sole reason (first injection)	5.30	
	G372	- each additional injection	2.32	

Note:
G372, G373 includes interpretation.

		Fee
	ACTIVE IMMUNIZATION	
	Injection of unspecified agent	
G538	- with visit (each injection)	3.83
G539	- sole reason (first injection)	8.65
G538	- each additional injection	3.83
	Injection of influenza agent	
G590	- with visit	3.83
G591	- sole reason	8.65
G538	- each additional injection with non-influenza agents	3.83

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

INTRALESIONAL INFILTRATION

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

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

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

INTRAVENOUS

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

Note:

1. G376 or G379 apply to cryoprecipitate infusion.

2. G376 or G379 may not be claimed with x-rays as they are included in the service.

3. Except for G381 or G281, injections into established I.V. apparatus may not be claimed.

G389	Infusion of gamma globulin, initiated by physician, including preparation per patient, per day	13.90
+ G380	Cutdown including cannulation as necessary	27.05

		Fee
G387	Intravenous local anaesthetic infusion for central neuropathic pain	125.00

Payment rules:

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

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

[Commentary:

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

SCLEROTHERAPY

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

Note:

1. Only the injection of veins greater than 5mm in diameter and associated with physical symptomatology are insured. This service is only insured when rendered personally by the physician.
2. Assistant units nil for G536, G537.

SPECIFIC ELEMENTS

For Management of Parenteral Alimentation

In addition to the common elements, this service includes the specific elements of assessments (see General Preamble GP15). Not to be claimed in addition to hospital visits.

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

Fee

CHEMOTHERAPY

Chemotherapy (marrow suppressant) - with each injection supervised by a physician for intravenous infusion for treatment of malignant or autoimmune disease. The physician must be available to intervene in a timely fashion, consistent with generally accepted professional standards and/or protocols at the time of injection and for the duration of the infusion.

+ G381	Single injection (for agents other than doxorubicin, cisplatin, bleomycin or high dose methotrexate)	13.90
G281	- each additional injection (other than above drugs)	7.00

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

G339	Single agent intravenous chemotherapy i.e. doxorubicin, daunorubicin, epirubicin, mitoxintrone, cisplatin or bleomycin (greater than 10 units per metre square).	47.20
G345	Taxol, rituximab, trastuzumab, bortezomib, docetaxel administration or multiple agent intravenous chemotherapy including at least one of either doxorubicin, daunorubicin, epirubicin, mitoxintrone, cisplatin or bleomycin (greater than 10 units per metre square)	63.15
G359	Special single agent chemotherapy utilizing either high-dose methotrexate with folinic acid rescue - methotrexate given in a dose of greater than 1 g/m^2, high dose cisplatin greater than 75 mg/m^2 given concurrently with hydration and osmotic diuresis, high dose cystosine, arabinoside (greater than 2g/m^2), or high dose cyclophosphamide (greater than 1g/m^2)	89.55
G075	Test dose (bleomycin and l-asparatiginase) once per patient per drug	27.80
G382	Supervision of chemotherapy (marrow suppressant) for malignant or autoimmune disease by telephone - monthly.	11.35
G390	Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy)	223.40

SPECIFIC ELEMENTS

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

A. Interpretation of the results of the laboratory procedure.

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

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

DEFINITIONS

L861 SURGICAL PATHOLOGY, LEVEL 1.

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

L862 SURGICAL PATHOLOGY, LEVEL 2.

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

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

L863 SURGICAL PATHOLOGY, LEVEL 3.

Gross and microscopic examination of the following specimens:

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

L864 SURGICAL PATHOLOGY, LEVEL 4.

Gross and microscopic examination of the following specimens:

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

L865 SURGICAL PATHOLOGY, LEVEL 5.

Gross and microscopic examination of the following specimens:

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

Note:

1. For uterine leiomyoma or prolapse, see L864.

2. For uterine neoplasm, see L866.

L866 SURGICAL PATHOLOGY, LEVEL 6.

Gross and microscopic examination of the following specimens:

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

L867 SURGICAL PATHOLOGY

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

Payment rules:

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

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

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

- **a.** services listed under Anatomic Pathology - Surgical Pathology,
- **b.** services listed under Anatomic Pathology – Cytopathology;

or

- **c.** a Diagnostic Laboratory Medicine Consultation (A585/C585) as listed in the "Consultation and Visits" section of the Schedule.

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

[Commentary:

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

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

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

		Fee
	INTERPRETATION OF ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY	
	Anatomic Pathology - Surgical Pathology	
L861	Surgical Pathology, Level 1	5.20
L862	Surgical Pathology, Level 2	8.45
L863	Surgical Pathology, Level 3	14.30
L864	Surgical Pathology, Level 4	48.65
L865	Surgical Pathology, Level 5	103.20
L866	Surgical Pathology, Level 6	149.95
L867	Surgical Pathology, Unlisted specimens	46.65
L822	Operative consultation, with or without frozen section	74.00
L823	- each subsequent frozen section or direct smear and/or selection of tissue for biochemical assay e.g. estrogen receptors . . . add	39.45
L801	Metabolic bone studies	95.30
L833	Nerve teasing	49.35
	Anatomic Pathology - Cytopathology	
L812	Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation	4.60
L805	Aspiration biopsy e.g. lung, breast, thyroid, prostate	44.45
L806	Bronchial, oesophageal, gastric, endometrial or other brushings and washings	19.80
L808	Imprint, touch preparation and/or direct smear	14.60
L815	Sputum per specimen for general and/or specific assessment e.g. cellular abnormalities, asbestos bodies, lipids, haemosiderin	16.40
L804	Smear, specific assessment e.g. eosinophils, asbestos bodies, amniotic fluid cells for estimation of fetal maturation	4.80
L810	Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	13.20
L824	Synovial fluid analysis, including description, viscosity, mucin clot, cell count, and compensated polarized light microscopy for crystals	24.70
L825	Compensated polarized light microscopy for synovial fluid crystals	12.80
L819	Seminal fluid analysis for infertility, including count, motility and morphology	13.60
L848	Seminal fluid analysis - quantitative kinetic studies, including velocity linearity and lateral head amplitude	29.65
L820	Smear for spermatozoa	6.05

		Fee
	Cytogenetics	
L807	Smear for sex chromatin (Barr Body) or Neutrophil drumsticks	4.95
L811	Y chromosome	6.05
L803	Karyotype	73.95
	Special Procedures and Interpretation - Histology or Cytology	
L834	Histochemistry of muscle - 1 to 3 enzymes	23.70
L835	- each additional enzyme add	7.95
L841	Enzyme histochemistry and interpretation - per enzyme	11.85
L837	Immunohistochemistry and interpretation - per marker	11.85
L868	Special histochemistry for identification of microorganisms	35.05
L869	Special histochemistry for identification of elements other than microorganisms	15.55
L817	Anti-tissue antibodies and interpretation - per case	6.05
L842	- anti-tissue antibodies, screening dilution, titration and interpretation add	8.45
L849	Interpretation and handling of decalcified tissue	12.80
L843	Special microscopy of tissues including polarization, interference phase contrast, dark field, autofluorescence or other microscopy and interpretation	19.80
L844	Special microscopy of fluids (polarization, interference, phase contrast, dark field, autofluorescence or other microscopy and interpretation)	12.80
L845	Specimen radiography or microradiography and interpretation	14.80
L832	X-ray diffraction analysis and interpretation	23.70
L816	Electron microscopy by TEM, STEM or SEM technique	148.00
L831	- analytical electron microscopy, elemental detection or mapping, electron diffraction, per case add	49.35
L836	Morphometry per parameter	24.70
L846	Flow cell cytometry and interpretation - per marker	11.85
L847	Caffeine - halothane contracture test and other confirmatory tests for malignant hyperthermia	65.15
	Biochemistry and Immunology	
L827	Interpretation of carcinoembryonic antigen (CEA)	5.30
L828	Interpretation of hormone receptors for carcinoma to include estrogen and/or progesterone assays	7.95
	Haematopathology	
L800	Blood film interpretation (Romanowsky stain)	12.80
L826	Blood film interpretation (special stain)	11.85
L802	Bone marrow interpretation (Romanowsky stain)	44.45
Z403	Bone marrow aspiration	33.90

Note:

1. If Z403 and Z408 are both performed through the same site or with the same biopsy needle, only Z408 is eligible for payment. Maximum of 1 Z408 per patient, per day.
2. If the aspiration does not result in any material for examination, the service is not eligible for payment.

[Commentary:
If Z408 and Z403 are performed through different sites, both services are payable.]

		Fee
L830	Terminal transferase by immunofluorescence	11.85
L838	Leukocyte phenotyping by monoclonal antibody technique	19.80
L829	Haemoglobinopathy interpretation (payable for abnormal results only)	12.90

LABORATORY MEDICINE IN PRIVATE OFFICE

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

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

G001	Cholesterol, total	5.50
G002	Glucose, quantitative or semi-quantitative	2.01
G481	Haemoglobin screen and/or haematocrit (any method or instrument)	1.32
G003	Lactic dehydrogenase (LDH) total	4.20
G004	Occult blood	1.52
G005	Pregnancy test	3.88
G006	SGOT	4.05
G007	Urea nitrogen (BUN)	2.42
G008	Uric acid	2.42
G009	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)	4.30
G010	One or more parts of above without microscopy	1.86
G011	Fungus culture including KOH preparation and smear	12.60
G012	Wet preparation (for fungus, trichomonas, parasites)	1.86
G014	Rapid streptococcal test	4.60

Fee

SPECIFIC ELEMENTS

Nephrological Management of Donor Procurement

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

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

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

C. Prescribing and providing appropriate pre-nephrectomy immunotherapy.

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

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

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

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

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

Nephrological Component of Renal Transplantation

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

# G412	1st day following transplantation	211.20
# G408	2nd to 10th day, inclusive . . . . . per diem	105.60
# G409	11th to 21st day, inclusive . . . . . per diem	52.80

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

PREAMBLE

1. Nerve blocks are insured services payable at nil when used as local anaesthetic for insured procedures. See General Preamble GP62.

2. When a physician administers an anaesthetic, nerve block and/or other medication prior to, during, or immediately after a procedure which the physician performs on the same patient, the administration of the anaesthetic or nerve block and/or other medication is an insured service payable at nil. However, when a physician administers an ankle, brachial plexus, pudendal, femoral, intercostal, sciatic, ilioinguinal, iliohypogastric, ulnar, median or radial block in addition to performing a procedure, the block is payable as G224 in addition to the fee for the procedure. With the exception of a bilateral pudendal nerve block, this fee is payable once per region, per side where bilateral procedures are performed. When an epidural is inserted for pain relief, the block is payable as G125 (see below).

3. Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of 8 per patient per day for any combination of nerve blocks. The ninth and subsequent nerve blocks per patient per day are insured services payable at nil. Nerve blocks which are defined as a bilateral procedure are counted as two services for the purpose of the overall daily maximum.

4. G243, G244, G241, G242, G231 and/or G223 claimed in addition to or in lieu of G260 and rendered to the same anatomical site during the same visit are insured services payable at nil.

[Commentary:

1. Time units are not applicable to nerve blocks.

2. If one physician gives the anaesthetic and another does the nerve block, the anaesthetic is payable as Z432 - see anaesthesia - Diagnostic and Therapeutic Procedures.]

		Fee
G214	Brachial plexus	54.65
G215	Celiac ganglion	84.00
G239	Differential intrathecal spinal block	127.60
G216	Lumbar epidural or caudal epidural block	75.10
G245	Lumbar epidural or intrathecal injection of sclerosing solution	165.60
	Femoral nerve	
G243	- unilateral	54.65
G244	- bilateral	81.95
G260	Combined 3-in-1 block of the femoral, obturator and lateral femoral cutaneous nerves - unilateral	99.65
	Occipital nerve	
G264	- first block per day (maximum 1 per day to a maximum of 16 first blocks per calendar year)	34.10
G265	- each additional unilateral block following G264 per spinal level per day when G264 is payable in full (maximum 3 per day to a maximum of 48 additional blocks per calendar year)	17.10
G291	- first block per day in excess of 16 per calendar year may be payable on an independent consideration (IC) basis upon submission to the ministry of a written recommendation of an independent expert as described below. (maximum 1 per day to a maximum of 16 blocks for a single IC request). A new written recommendation is required on an IC basis each time the number of first blocks exceeds 16	19.85
G292	- each additional unilateral block following G291 per spinal level per day when G291 is payable in full (maximum 3 per day)	10.00

Note:

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

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

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

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

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

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

		Fee
	Introduction of epidural catheter for analgesia	
# G246	Lumbar	77.25
# G125	- concurrent with anaesthesia time units for operative procedure	45.75
# G117	Thoracic	96.65
# G118	- concurrent with anaesthesia time units for operative procedure	57.15
# G119	Cervical	115.95
# E833	- with insertion of subcutaneous port . . . add	116.10
G247	- plus hospital visits for each additional visit rendered, to a maximum fee equivalent to 4 visits per day (see General Preamble GP65)	visit.fee
	Percutaneous peripheral nerve catheter insertion for analgesia	
G279	Percutaneous peripheral nerve catheter insertion	109.30

Payment rule:
Any guidance (e.g. nerve stimulation, ultrasound) used for peripheral nerve catheter insertion is not eligible for payment.

[Commentary:
Maintenance of the catheter may constitute a subsequent visit subject to the limits as outlined on General Preamble GP30.]

G218	Ilioinguinal and iliohypogastric nerves	54.65
G219	Infraorbital	34.20
G220	Intercostal nerve	34.20
G221	- for each additional one . . . add	16.95
G258	Intrapleural block (single injection)	44.25
G257	Intrapleural block (with the introduction of a catheter for the purpose of continuous analgesia)	77.25
G222	Intrathecal spinal	75.10
# G374	I.V. regional guanethidine	54.30
G225	Mental branch of mandibular nerve	34.20
G250	Maxillary or mandibular division of trigeminal nerve	75.10
	Obturator nerve	
G241	- unilateral	54.65
G242	- bilateral	82.45
G227	Other cranial nerve block	84.00
G228	Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves	54.65
G123	- for each additional one (to a maximum of 4) . . . add	27.45
	Pudendal	
G229	- unilateral	54.65
G240	- bilateral	82.45

Note:
For obstetrical continuous conduction anaesthesia, see P014, P015 listed under Referred Services - Obstetrics.

		Fee
G422	Retrobulbar injection (not to be claimed when used as a local anaesthesia)	34.20
	Sciatic nerve	
G230	- unilateral	54.65
G226	- bilateral	82.45
G248	Single shot caudal block done in conjunction with anaesthesia.	15.45
	Somatic or peripheral nerves not specifically listed	
G231	- one nerve or site	34.10
G223	- additional nerve(s) or site(s) add	17.10
G232	Spheno-palatine ganglion, by injection	55.10
G233	Splanchnic	55.10
G234	Stellate ganglion	55.10
G256	Superior laryngeal nerve	34.10
G235	Supraorbital	34.10
	Sympathetic block(s) (lumbar or thoracic)	
G236	- unilateral	55.10
G237	- bilateral	82.45
G238	Transverse scapular nerve	55.10
G217	Trigeminal ganglion	84.75
E958	- when alcohol or other sclerosing solutions are used, the appropriate nerve block fees as listed above with the exception of fee codes G245 and G246 add 50%	

		Fee
	Lumbar epidural injection	
# G273	- of adrenal steroid or autologous blood	74.20
# G274	- post laminectomy into operative site	90.80
Z804	Lumbar puncture	41.00
# Z805	- with instillation of medication	54.90
# G410	Amytal test (Wada)-bilateral - supervision and co-ordination of tests	68.40
# G413	Electrocorticogram - supervision and interpretation	170.85
	Note: G413 payable at nil when claimed with G267 same patient, same day.	
G419	Tensilon test	20.10
# G551	Katzman test (subarachnoid infusion test) including lumbar puncture	170.85
# G267	Intra-operative evaluation of movement disorder patient during functional neurosurgery	270.05
	Note: G267 is not payable with assistant units.	
# G547	Clinical Programming of Deep Brain Stimulator (DBS) - includes one or more visits for DBS checking, minor and major DBS adjustments, and intensive programming. First implantation site (maximum 1 per patient)	185.70
# G549	- additional implantation site(s) (maximum 1 per patient)	157.85
	Electrophysiological assessment	
# G266	- of movement disorders - includes multi-channel recording of EEG and EMG, rectification, averaging, back averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment	278.85
# G548	- of Deep Brain Stimulators - includes measuring electrode impedance, recording EEG and EMG, rectification, averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment	278.85

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

		T	P

ELECTROENCEPHALOGRAPHY

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

+ G414	- technical component.		25.00	
G416	- with activating or sleep inducing drugs and/or sleep deprivation - technical component. . . . . add		15.00	
G415	- professional component			22.60
G418	- professional component (16 - 21 channel EEG)			37.95

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

Prolonged EEG Monitoring

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

G540	- technical component . . . . . per unit		9.30	
G545	- professional component . . . . . per unit			14.70

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

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

G542	- technical component.		23.70	
G546	- professional component			29.70

Ambulatory EEG monitoring

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

G554	- technical component.		47.50	
G555	- professional component			46.60

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

G544	- technical component, per item . . . . . add		8.50	

Note:
G544 limited to a maximum of 3.

NEUROLOGY

		T	P1	P2
	EVOKED POTENTIALS			
	Upper or lower limbs			
G140	- technical component	41.20		
G138	- professional component (P1)		87.35	
G139	- interpretation only (P2)			38.80

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

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

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

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

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

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

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

+ G435	Tonometry	5.10	

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

		T	P

Colour vision detailed assessment

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

G850	- technical component		20.90	
G438	- professional component			22.15

Dark adaptation curve (Goldmann adaptometer or equivalent)

G851	- technical component		31.35	
G437	- professional component			22.90

Electro-retinography with report

G852	- technical component		34.00	
+ G439	- professional component			24.00

Fluorescein angiography

G853	- technical component		22.50	
+ G425	- professional component			23.90

Fluorescein angioscopy

G854	- technical component		6.55	
+ G444	- professional component			7.00

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

Hess screen examination

G855	- technical component		6.45	
G428	- professional component			6.85

Tonography (to include tonometry) with or without water

G856	- technical component		9.30	
G433	- professional component			9.90

Visual fields - kinetic (with permanent record)

G857	- technical component		4.50	
G436	- professional component			4.80

Visual fields - static

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

G858	- technical component		13.65	
G432	- professional component			14.50

Fee

Corneal Pachymetry

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

G813 Corneal pachymetry, professional component. 5.10

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

Keratometry

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

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

or

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

G811 Keratometry, professional component 4.80

Corneal Topography

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

G810 Corneal topography, professional component 4.80

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

Specular Photomicroscopy

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

G812 Specular photomicroscopy, professional component. 4.80

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

		T	P1	P2
	Visual Evoked Response - Simple			
G149	- technical component.	18.05		
G147	- professional component (P_1)		15.35	
G148	- interpretation only (P_2)			6.05
	Visual Evoked Response - Threshold			
G152	- technical component.	30.85		
G150	- professional component (P_1)		24.00	
G151	- interpretation only (P_2)			10.90

Note:
P_1 may only be claimed when physician performs the studies and interprets the results.

OCULAR PHOTODYNAMIC THERAPY (PDT)

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

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

- **a.** the patient has predominantly classic subfoveal choroidal neovascularization (CNV) secondary to either age-related macular degeneration (AMD), Presumed Ocular Histoplasmosis Syndrome or pathologic myopia. Predominantly means that the area of classic subfoveal CNV is equal to or greater than 50% of the total CNV lesion, as determined by fluorescein angiography and documented by retinal photographs retained on the patient's permanent medical record;
- **b.** treatment is commenced within 30 months after initial diagnosis of predominantly classic subfoveal CNV secondary to AMD, Presumed Ocular Histoplasmosis Syndrome or pathologic myopia;
- **c.** the patient's visual acuity is equal to or worse than 20/40; and
- **d.** for each repeat therapy, recurrent or persistent CNV leakage is detected by fluorescein angiography and documented by retinal photographs retained on the patient's permanent medical record.

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

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

Note:

1. G379 rendered to same patient in conjunction with G460 or G461 is an insured service payable at nil.
2. G460 rendered to same patient same day as G461 is an insured service payable at nil.
3. Assessments and angiography are payable in addition to PDT. Retinal photography is insured as a specific element of the assessment and is not payable separately.

[Commentary:

1. PDT will normally not be administered to each affected eye more frequently than once every 3 months.
2. PDT performed for treatment of clinical conditions other than described above is uninsured.]

		Fee
# G103	Debridement of maxillectomy cavity.	6.05
+ G420	Ear syringing and/or extensive curetting or debridement unilateral or bilateral	11.25
	Note: G420 is not eligible for payment when rendered in addition to Z907.	
+ G403	Particle repositioning maneuvre for benign paroxysmal positional vertigo.	21.15

PREAMBLE

DIAGNOSTIC HEARING TEST

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

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

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

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

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

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

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

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

[Commentary:

1. Delegated DHT services - To qualify for payment, delegated DHT services must comply with the requirements for delegation of insured services described in the General Preamble GP45 to GP46.

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

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

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

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

		T	P
	BASIC DIAGNOSTIC HEARING TESTS		
	Pure tone threshold audiometry with or without bone conduction		
G440	- technical component.	8.80	
G525	- professional component		5.85
	Pure tone threshold audiometry (with or without bone conduction) and speech reception threshold and/or speech discrimination scores.		
G441	- technical component.	12.25	
G526	- professional component		12.70
	ADVANCED DIAGNOSTIC HEARING TESTS		
	Impedance audiometry by manual or automated methods		
G442	- technical component.	2.78	
+ G529	- professional component		1.86

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

	Sound field audiometry (infants and children)		
G448	- technical component.	18.55	
G450	- professional component		5.70

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

	Miscellaneous advanced testing e.g. recruitment, tests of malingering, central auditory and stapedial reflex decay tests - per test		
G443	- technical component, to a maximum of 3 . . . . . per test	8.00	
G530	- professional component, to a maximum of 3 . . . . . per test		5.95

		T	P1	P2
	Cortical Evoked Audiometry			
G143	- technical component.	30.75		
G141	- professional component (P_1)		23.95	
G142	- interpretation only (P_2)			10.85

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

	Brain Stem Evoked Audiometry			
G146	- technical component.	30.75		
G144	- professional component (P_1)		23.95	
G145	- interpretation only (P_2)			15.85

Note:
P_1 may only be claimed when physician performs the studies and interprets the results.

		T	P
	Electrocochleography (per ear): to include myringotomy if performed		
G815	- technical component	30.75	
G816	- professional component		104.45
	DIAGNOSTIC BALANCE TESTS		
	Positional testing with electronystagmography (ENG)		
G104	- technical component	19.05	
G105	- professional component		18.30
	Caloric testing with ENG		
G451	- technical component	19.05	
+ G533	- professional component		18.30

		Fee
G454	Stroboscopy	16.80
G191	Optokinetic tests	12.40
G108	Computerized rotation tests	20.20
	DIAGNOSTIC TASTE TESTS	
+ G452	Electrogustometry or conventional taste tests	14.35
G534	Phonatory airflow study	10.95
G535	- with subglottic pressures	30.55
G532	Air insufflation test to assess benefit of tracheoesophageal puncture	27.70

Fee

TELEPHONE MANAGEMENT OF PALLIATIVE CARE

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

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

Payment Rules:

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

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

PALLIATIVE CARE CASE MANAGEMENT FEE

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

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

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

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

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

G512	Palliative care case management fee	51.70

Payment Rules:

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

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

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

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

[Commentary:

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

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

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

T	P1	P2

ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

PREAMBLE

1. When patients are referred directly to EMG and/or nerve conduction facilities for diagnostic testing, then consultation or assessment by the diagnostic physician is an insured service payable at nil except where a medically necessary consultation or assessment is requested by the referring physician in addition to the EMG.

2. If a physician owns the EMG/NCS equipment and either employs and provides clinical supervision for a technician to perform the procedure or performs the procedure personally, then both the technical and the professional component are payable to the physician.

Schedule A

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

G455	-	technical component	28.10	
G456	-	professional component - when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results (P_1)	99.35	
G459	-	interpretation only (P_2)		21.75

Schedule B

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

G466	-	technical component	18.85	
G457	-	professional component - when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results (P_1)	71.10	
G469	-	interpretation only (P_2)		22.05

		Fee
G458	Single fibre electromyography	191.70

		Fee
	THERAPEUTIC PROCEDURES	
+ G465	Manipulation of major joint(s) or spine by physician - one or more joints	13.80

Note:
For manipulation under general anaesthesia - see Musculoskeletal Section.

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

CHEMODENERVATION INJECTION

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

G485	- first major nerve and/or branches	45.45
G486	- each additional major nerve and/or its branches same day . . . . . add	28.50

Repeat or additional procedure within 30 days of previous chemodenervation injection

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

Note:

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

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

		Fee	Anae
	PSYCHIATRY		
	Electroconvulsive therapy (ECT) cerebral - single or multiple		
# G478	- in-patient.	66.25	6
# G479	- out-patient.	75.70	6

Note:
Electrosleep therapy or Sedac therapy are not insured benefits.

RESPIRATORY DISEASE

G404	Chronic ventilatory care outside an Intensive Care Unit	61.00	

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

		Fee	P2
# G900	Residual urine measurement by ultrasound.	12.70	

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

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

+ G475	Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including interpretation	23.75	
G192	Video fluoroscopic multichannel urodynamic assessment to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with simultaneous fluoroscope imaging and recording of filling and voiding phases including interpretation.	73.65	
# G193	Complete multichannel urodynamic assessment - to include monitoring or intravesicular, intra-abdominal, and urethral pressures, with or without pressure-flow studies	43.85	
# G194	- with EMG . . . . . add	8.35	
G477	Interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel) (P_2).		5.40
+ G476	Prostatic massage	5.40	

SPECIFIC ELEMENTS

Sleep Studies are divided into a professional component listed in the columns headed with a "P_1" or "P_2", and a technical component listed in the column headed with an "H". The technical component of the procedure subject to the conditions stated under the "Diagnostic Services Rendered at a Hospital" on page GP11, is eligible for payment only if the service is:

a. rendered at a hospital;

or

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

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

OTHER TERMS AND DEFINITION

1. Professional and technical components are claimed separately. Claims for the technical component H are submitted using listed fee code with suffix B. Claims for professional component P1 are submitted using first listed fee code with suffix C (e.g. J890C), while claims for professional component P_2 are submitted using second listed fee code with suffix C (e.g. J690C).

2. For services rendered outside a hospital setting, the only fees payable under the *Health Insurance Act* are for the professional component listed under the P_1 or P_2 columns (use suffix C). Fees for the technical component of these services are only payable under the *Independent Health Facilities Ac*t and are listed in the Schedule of Facility Fees.

3. Overnight sleep studies are limited to a maximum of two per 12-month period (any combination of study levels) unless written prior authorization is obtained from the Ministry of Health and Long-Term Care Medical Consultant. For services rendered on or after October 1, 1999, the 12-month period is determined from October 1, 1998 onwards.

OVERNIGHT SLEEP STUDIES

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

Level 1

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

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

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

Level 2

J891	- overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by plethysmography	237.80	93.40	
J691	- overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by plethysmography	237.80		51.00
J893	Multiple Sleep Latency Test	70.70	52.50	00.00
J894	Maintenance of Wakefulness Test	70.70	52.50	00.00

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