Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4367	**April 1, 2001**	**Ministry of Health Processing Office** *(address below)*
Distribution: **Physicians, Hospitals, Clinics, Laboratories**		

Subject:

1. **Changes to the Schedule of Benefits Physician Services and Related Changes Effective April 1, 2001**
   - **1.1. Increase to Schedule of Benefits fees of 2%**
   - **1.2. Increase to Threshold Levels**
   - **1.3. Discontinue Combined Billing Submission for Diagnostic Professional and Technical Fees**
   - **1.4. Increase to After-Hours and Special Visit Premiums**
   - **1.5. Updates to Schedule of Benefits**
2. **Community Medicine Specialty Codes**

Changes to the Schedule of Benefits Physician Services and Related Changes Effective April 1, 2001

Amended pages of the Schedule are not distributed with this Bulletin. A complete new edition of the official Schedule will be distributed following this Bulletin. For your convenience, a complete updated unofficial version of the Schedule will be available on the Ministry's web site www.health.gov.on.ca.

1.1 Increase to Schedule of Benefits Fees of 2%

Effective April 1, 2001, under the current agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association, the Schedule of Benefits will be revised to provide a 2.0% increase to all fees except uninsured services that are listed in Appendix F and technical, hospital and facility fees for diagnostic services. As per the agreement, the Committee on Technical Fees will make recommendations regarding technical, hospital and facility fees.

The 2.0% increase will be applied automatically to all claim submissions for services provided on or after April 1, 2001.

1.2 Increase to Threshold Levels

Effective April 1, 2001, for fiscal year 2001/2002, the threshold levels at which reductions are calculated will increase by $10,000. For General/Family Practitioners, the starting level will increase from $330,000 to $340,000 and for specialists from $410,000 to $420,000. The threshold reductions only take effect as these higher OHIP earnings amounts are reached. After-hours non-elective hospital services continue to be exempt from threshold reductions.

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30 Poyntz St.
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Hamilton
119 King St. W
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Kenora
220-808 Robertson St.
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Kingston
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201 City Centre Dr.
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K9J 8J8

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N7T 5W4

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P3E 5R1

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Reduction Rate	**33.3%**	**66.7%**	**75%**
Payment amounts for services provided prior to April 1, 2001			
GPs	$330,000	$355,000	$380,000
Specialists	$410,000	$435,000	$460,000
Revised payment amounts for services provided on or after April 1, 2001			
GPs	$340,000	$365,000	$390,000
Specialists	$420,000	$445,000	$470,000

Calculation of Threshold Reduction

The method of calculation is unaffected except that each threshold level has increased by $10,000. The reductions are calculated at the percentages above as physicians reach the level of payments noted. However, to reach those payment amounts, the actual billings are higher since payments are reduced once the threshold is reached. The calculations take these reduction amounts into account prior to determining the level and percentage deduction to apply. The new total billing amounts that correspond to each revised payment level above are shown below.

Reduction Rate	**33.3%**	**66.7%**	**75%**
Billed amounts for services provided on or after April 1, 2001			
GPs	$340,000	$377,500	$452,500
Specialists	$420,000	$457,500	$532,500

1.3 Discontinue Combined Billing Submission for Diagnostic Professional and Technical Fees

The "A" suffix billing option for diagnostic services is discontinued on or after April 1, 2001. Claims for H, T and F fees and P-fees must be submitted as separate claim items, i.e., H, T and F fees must be claimed using the "B" suffix, and P-fees must be claimed using the "C" suffix. Claims for diagnostic services listed in the table below, with a service date on or after April 1, 2001 and submitted as a combined fee using the "A" suffix option, will be paid at nil. See Bulletin #4364 "Claims Submission for E450, E451, X, J and Y Prefixed Diagnostic Services".

Note: In all other sections of the Schedule, the "A" suffix continues to indicate a professional fee submitted by the attending physician who renders the procedure. Use of "A" suffix in this context is not subject to this change.

Fee Code	Description
X001 to X230	Diagnostic radiology in hospitals
J102 to J893*	Diagnostic ultrasound, nuclear medicine, sleep studies and pulmonary function studies in hospitals
Y602 to Y888	Nuclear medicine studies with data manipulation in hospitals
J301, J304, J324, J327	Spirometry and flow volume loop testing in both hospitals and private offices or clinics
E450, E451	Add-on codes to graded exercise pulmonary function studies in hospitals
* Does not include J001 to J068 clinical radiology procedures for which the clinical fee is not assigned.	

1.4 Increase to After Hours and Special Visit Premiums

After hours and special visit premiums are increased as follows. This increase includes the 2% increase to the Schedule of Benefits fees.

Surgical Assistants' Services

General Preamble, Section 20 (d), after-hours premiums payable when a case commences

E400B	Evenings (18:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays. Premium increased from 45% to 47.5%.
E401B	Nights (00:00h - 07:00h). Premium increased from 62.5% to 68.75%.

General Preamble, Section 20 (e), special visit premiums payable when a physician is required to make a special visit to assist at non-elective surgery with sacrifice of office hours for a case commences

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C998B	Evenings (18:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays. Premium increased from $43.70 to $49.55.
C999B	Nights (00:00h - 07:00h). Premium increased from $65.60 to $74.35.

Anesthetists' Services

General Preamble, Section 22 (e), after-hours premiums payable when a case commences

E400C	Evenings (18:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays. Premium increased from 45% to 47.5%.
E401C	Nights (00:00h – 07:00h). Premium increased from 62.5% to 68.75%.

General Preamble, Section 22 (f), special visit premiums payable for a case that commences

C998C	Evenings (18:00h – 24:00h), Saturdays, Sundays, Holidays or non-elective surgery with sacrifice of office hours. Premium increased from $43.70 to $49.55.
C999C	Nights (00:00h – 07:00h). Premium increased from $65.60 to $74.35.

Special Visit Premiums

General Preamble, Sections 23 (g), The maximum number of special visit premiums including "additional patient(s)" is one per patient to a maximum of 10 during a single visit to a patient(s) in an emergency or out-patient department, and a maximum of 3 during a single visit to hospital inpatient(s).

General Preamble, Sections 23 (j and k), payable for special visits to emergency department or outpatient department (prefix "K") or hospital inpatient (prefix "C")

C/K991	Daytime Special Visit (07:00h - 18:00h) Monday to Friday, for additional patients requiring a special visit and seen during the same special visit. New maximum premium of $17.65 per patient.
C/K993	Emergency call with sacrifice of office hours, for additional patients requiring a special visit and seen during the same special visit. New maximum premium of $35.25 per patient.
C/K994	Evenings (18:00h - 24:00h), Saturdays, Sundays, Holidays - first patient seen. Premium increased from $43.70 to $49.55.
C/K995	For additional patients requiring a special visit and seen during the same special visit. Premium increased from 40% to 45%. Minimum increased from $20.60 to $24.15. New maximum premium of $49.55 per patient.
C/K996	Nights (00:00h - 07:00h) - first patient seen. Premium increased from $65.60 to $74.35.
C/K997	For additional patients requiring a special visit and seen during the same special visit. Premium increased from 62.5% to 68.75%. Minimum increased from $31.20 to $36.35. New maximum premium of $74.35 per patient.

General Preamble, Section 23 (l), special visit to patient's home or a multiple resident dwelling. Payable only for first patient seen regardless of number of patients seen during one visit to a home or to one or more living units in a multiple resident dwelling

B994	Evenings (18:00h - 24:00h), Saturdays, Sundays, Holidays. Premium increased from $50.70 to $57.90.
B996	Nights (00:00h - 07:00h). Premium increased from $76.20 to $87.00.

General Preamble, Sections 23 (m) and (n), special visit to long-term care institutions (prefix "W") and office or other similar facility (prefix "A") regardless of how many patients seen at the same location. No “additional patient” premium payable.

A/W994	Evenings (18:00 - 24:00h), Saturdays, Sundays, Holidays. Premium increased from $43.70 to $49.55.
A/W996	Nights (00:00 - 07:00). Premium increased from $65.60 to $74.35.

After-hours Premiums

General Preamble, Section (25)

E409	Evenings (18:00h - 24:00h), Saturdays, Sundays or Holidays. Premium increased from 40% to 45%.
E410	Nights (00:00h - 07:00h). Premium increased from 62.5% to 68.75%.

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How to Submit Claims for After-Hours Non-Elective In-Hospital Services

Effective April 1, 2000, after-hours non-elective hospital services provided during evenings, nights, weekends and holidays, as defined in the General Preamble B.11, have been exempt from threshold reductions. In order to process your after-hours non-elective in-hospital claims and calculate your threshold amounts accurately.

i. Enter all in-hospital after-hours non-elective services and associated services that are rendered to the same patient on the same claim record. Otherwise, the associated service will not be exempted from the physician's threshold income calculation.

ii. Do not include any other service on this claim record.

iii. Enter the hospital number on the claim record. Claims submitted without a valid hospital number will not be exempted from the physician's threshold income calculation.

If you failed to submit an associated service on the same claim record and, as a result, did not receive a threshold exemption on that service, contact your District Office to have the matter corrected.

1.5 Update to Schedule of Benefits

The following fee codes have been revised, added or deleted from the Schedule of Benefits to reflect changes in medical practice and currently accepted standards of practice and to enhance patient care. A fee code is deleted when the service is replaced by a newly insured service, is no longer medically necessary or is obsolete.

Fee Code	**Descriptor** Newly added text that modifies conditions of payment is underlined. Deleted text is indicated by ~~strike-though.~~		**New (N) Revised (R) Deleted (D)**
After-Hours Premium (General Preamble B.25)			
E409/E410	Applicable in addition to the fees listed for Non Elective Surgical Procedures… Air-Ambulance Transfer (K111); and Transport of Donor Organs (K102)		R
Allergy (Diagnostic and Therapeutic Procedures)			
G208	Serial oral (not sublingual) and parenteral provocation testing for food colours… test administration (maximum 5 sessions per year). Unit means 1 hour or major part thereof. See General Preamble for definitions and time-keeping requirements per test, per unit.		R
Anesthesia (General Preamble B.22 and Diagnostic and Therapeutic Procedures)			
E014C	- newborn patient up to and including 28 days, add	2 units	N
E009C	- 29 days to 1 year, add		R
E010C	- patient with body mass index (BMI) > 45, add	2 units	N

Z432	Specific Elements for Examination Under Anesthesia (EUA) 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. EAU 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. EUA with or without intubation and may include removal of vaginal foreign body.		R
Cardiovascular (Diagnostic and Therapeutic Procedures)			
#G298	Coronary angioplasty stent. Note: J058 claimed same patient same day as G298 is payable at nil.	$70.75	N
G502	Carotid phonoangiography – professional component		D
G503	Oculoplethymography – professional component		D
G504/G505 /G506	Phonocardiogram – multiple channel with pharmacological intervention		D
G507/G508	Apex cardiogram		D
Cardiovascular (Surgical Procedures)			
#E652	Use of internal mammary, epigastric or radial artery for construction of bypass graft		R
#R940	Pulmonary thromboendarterectomy (PTE) – includes circulatory arrest with hypothermia (18 assistant / 28 anesthetic base units)	$1961.80	N

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Consultations and Visits – Miscellaneous			
A008	Mini assessment	$9.90	R
C935	Non-Emergency Hospital In-Patient Services, Special surgical consultation (see General Preamble B3(k))	$111.25	N-
Gastrointestinal			
#E795	Endoscopy: with brushing of esophagus, stomach, duodenum	$44.95	N
	Esophagus, Endoscopy:		
#E703	- with snare polypectomy (>1 cm)		R
#E799	- each additional polyp (>1 cm) (to a maximum of 2)		R
#E797	Esophagus: management of uncomplicated bleeding by any technique, (e.g., laser, injection, diathermy, banding etc.) add	$44.95	N
#E798	Esophagus: management of complicated upper gastrointestinal bleeding by any technique in hemodynamically unstable patients with active bleeding during endoscopy, add	$67.65	N
	Esophagus, Endoscopy		
#E691	- with injection of esophageal varices		D
#E689	- with injection of bleeding ulcer		D
#E701	- with or without duodenoscopy - with diathermy or laser		D
#E674	Stomach - Endoscopies: - with snare polypectomy - 1st polyp >1cm (maximum 1), add	$138.20	N
#E675	Stomach - Endoscopies: - One or more additional polyps >1cm by snare polypectomy (maximum 2), add. Note: E674 and E675 are payable with Z527, Z547 or Z528.	$71.35	N
#Z584	Intestines, Endoscopy: Small bowel push enteroscopy	$179.70	N
#E685	Intestines, Endoscopy: Total excision of very large sessile polyp (>3cm) through colonoscopy, each, and may include fulguration, add. Note: Z570 payable at nil if claimed with Z685 or Z571 for same polyp.	$221.00	N
#Z561	Biliary Tract: Endoscopic retrograde cholangiopancreatography (ERCP) with cannulation of the common bile duct and/or pancreatic duct		R
#Z558	Biliary Tract: ERCP including sphincterotomy and may include removal of 1 or more bile duct stones		R
#Z760	Biliary Tract: ERCP through gastrojejunostomy following previous Billiroth II		R
#E680	- with insertion of first endobiliary prosthesis and/or pancreatic stent (maximum 1), add	$79.95	N
#E681	- with insertion of each additional endobiliary prosthesis and/or pancreatic stent (maximum of 3), add	$42.35	N

#E669	- with esophagoscopy-gastroscopy may include duodenoscopy, add Note: E662, E666, E668, E702, E680, E681, E669, are payable with Z561, Z558 or Z760.	$99.75	N
#Z556	Insertion of endobiliary prosthesis, or pancreatic stent - first one		D
#Z557	Insertion of endobiliary prosthesis, or pancreatic stent - each additional (to a maximum of 3)		D
Genetics			
A225	A genetic consultation is payable at nil if a genetic assessment (K016) or Genetic Care (K222) has previously been performed by the same physician.	$120.80	R
K016	General Preamble: Genetic Assessment: is a detailed…to make a diagnosis, construct/ revise a pedigree, and assess the risks to persons seeking advice. …The assessment and counselling must be rendered personally by the attending physician. This code may be used as a first or follow-up assessment as long as a complete assessment is performed.		R
K222	General Preamble: Genetic Care: is a Genetic Assessment, patient or family direct contact, per half-hour (maximum 2 hours). ~~When claimed in respect of the same patient for whom K016 has been or is claimed, the amount payable for K222 is reduced to zero.~~		R
K223	General Preamble: Clinical Interpretation: is a clinical interpretation by a geneticist of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports, and must be requested in writing…		R

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A221	Genetic minor assessment	$18.35	N
K044	Genetic Counselling with relatives, guardian or person authorized to make treatment decision for genetic patient – per 1/2 hour	$49.95	N
Hematic and Lymphatic			
#R913	Axillary or inguinal node – radical resection – unilateral		R
Laboratory			
A283/C283	Laboratory Medicine: Medical specific assessment	$49.00	N
A284	Laboratory Medicine: Partial assessment	$21.10	N
G590/G591	Influenza Vaccination: Delete Note: 1.		R
Musculoskeletal			
#R953/R954	Elbow and Forearm, Reconstruction - Bone - Deformity, Bone transport		R
#R959/R960	Shoulder/Arm/Chest, Reconstruction - Pseudoarthrosis – Clavicle & Deformity: Bone transport		R
#R629	Revision of amputated finger tip (3 assistant / 4 anesthetic base units)	$180.35	N
#E041	Pseudoarthrosis tibia: Intramedullary nail with distal and proximal locking screws		R
#E048	Pseudoarthrosis femur: Intramedullary nail with distal and proximal locking screws		R
#R965 #R966 #R973 #R974	Reconstruction – Deformity: Bone transport - femur (<6 cm) - femur (>6 cm) - tibia & fibula (<6 cm) - tibia & fibula (>6 cm)		R
#E926	Spinal duroplasty – delete anesthesia units		R
#F028 #F046	Radius-Distal, Colles', Smith's, Bartons, etc: - closed reduction, under local or regional anesthetic ~~(3 assistant / 4 anesthetic base units)~~ - closed reduction, under general anesthetic (3 assistant / 4 anesthetic base units)	$144.95	R N
#F072	Foot and Ankle, Reduction – Fractures: Os calcis - open reduction - with repair of both the subtalar and calcaneocuboid joints	$382.55	R
#E522	Arthrodesis, Fusion - with instrumentation (maximum of 2 additional levels), add	$64.40	N
Neurology			
#G267	Intra-operative evaluation of movement disorders during functional neurosurgery - not payable with assistant units. Not to be billed with G413.	$262.15	N

#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	$180.25	N
#G549	- additional implantation sites - maximum 1 per patient	$153.20	N
#G266	Electrophysiological assessment 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.	$270.70	N
#G548	Electrophysiological assessment of deep brain stimulators (DBS) - 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.	$270.70	N
	Prolonged EEG Monitoring: Videotape recording of clinical signs in association with spontaneous EEG. Unit means 1/4 hour or major part thereof. See general preamble for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG.		R
G540	- technical component (maximum of 12 units), per unit		R
G545	- professional component (maximum of 12 units), per unit		R
Nerve Blocks			
#G260	Nerve Blocks: Combined 3 in 1 block of the femoral, obturator, and lateral femoral cutaneous nerves – unilateral	$96.75	N

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G264	Occipital nerve blocks (initial) – maximum 1 per patient per day regardless of number of occipital nerve blocks rendered		R
G265	Occipital nerve blocks (additional) – maximum 3 per day		R
Obstetrics and Gynecology			
P003	General assessment (major prenatal visit)	$53.55	R
E411	Sole Delivery Premium – payable in addition to labour and delivery fees P011A … or P041A		R
#G397	Medical management of ectopic pregnancy - includes administration of cyto-toxic medications and routine follow-up visits for supervision within a period of seven days	$65.75	N
#P050	Therapeutic amnio-reduction (6 assistant / 6 anesthetic base units)	$241.55	N
#P051	Percutaneous fetal blood transfusion - into fetal hepatic vein (8 assistant/ 8 anesthetic base units)	$338.15	N
#P052	Percutaneous fetal blood sample – from umbilical cord or fetal hepatic vein (6 assistant / 6 anesthetic base units)	$193.25	N
	Fetal management, selective fetal reduction of one or more fetuses		
#P053	- by bipolar or unipolar cautery of umbilical cord (6 assistant / 6 anesthetic base units)	$241.55	N
#P054	- by intracardiac potassium chloride injection (6 assistant / 6 anesthetic base units)	$241.55	N
#P055	Insertion of fetal shunt – bladder to amniotic cavity (8 assistant / 8 anesthetic base units)	$386.45	N
#P056	Insertion of fetal shunt - chest to amniotic cavity (8 assistant / 8 anesthetic base units)	$386.45	N
#P057	Fine needle fetal body cavity aspiration from fetal abdomen, chest, heart, bladder and/or renal tract (6 assistant / 6 anesthetic base units)	$193.25	N
#P058	In-utero ligation of umbilical cord vessels (8 assistant / 8 anesthetic base units)	$450.85	N
#P059	In-utero placental vessel ablation by YAG laser (8 assistant / 8 anesthetic base units)	$450.85	N
	Note: Procedures listed under Maternal-Fetal Procedures (P050 to P059) are payable in addition to J149, Ultrasonic Guidance and/or Z552, Diagnostic Laparoscopy where applicable.		
#S701	Repair of infibulation – resulting from female genital mutilation (4 anesthetic base units)	$79.75	N
#S805	Laparoscopic retropubic urethropexy (6 assistant / 6 anesthetic base units)	$365.60	N
#S807	Laparoscopic repeat retropubic urethropexy (8 assistant / 8 anesthetic base units)	$429.35	N
#S806	Laparoscopic combined abdominal/vaginal approach for vaginal vault prolapse (6 assistant / 6 anesthetic base units)	$523.50	N
#S808	Laparoscopic vaginal sacropexy (6 assistant / 6 anesthetic base units)	$423.45	N
#S811	Rectus abdominus myocutaneous neovaginostomy – includes harvest of longitudinal, vertical or transverse rectus abdominus flap(s), formation vaginal pouch and insertion of vaginal mould (8 assistant / 8 anesthetic units)	$805.10	N
#S810	Laparoscopic vaginal hysterectomy (LAVH) (8 assistant / 8 anesthetic base units)	$520.70	N
#S727	Ovarian debulking, for ovarian carcinoma of stage 2C, 3B, 3C or 4 including hysterectomy, omentectomy and bowel resection and may include one or more biopsies and/or resection of pelvic peritoneum. (8 assistant / 8 anesthetic base units)	$660.70	N

#S750	Radical resection pelvic and para-aortic nodes for cancer (6 assistant / 8 anesthetic base units) Note: S758, S776 or S781 claimed for same patient same day as S750 is payable at nil.	$595.45	N
Psychiatry			
	General Preamble, B7.5 – Family Psychotherapy: Is defined as psychotherapy provided to the patient in the presence of one or more members of the patient's household.		R
C195/W195	Non-Emergency hospital and long-term care in-patient consultation		D
C895/W895	Non-Emergency hospital and long-term care in-patient consultation (replaces C195/W195 to mirror A895)	$132.90	N
A895	Consultation in association with special visit to hospital or long-term care in-patient	$132.90	N-
K623	Note: 1. A completed Form 1 - *Application by Physician for Psychiatric Assessment* retained on the patient's medical record is sufficient documentation to indicate that a consultation for involuntary psychiatric treatment has been requested by the referring physician.		R
	Psychotherapy, Family Psychotherapy…Note: 4. Psychotherapy or Hypnotherapy claimed in conjunction with obstetric delivery are payable at nil.		R

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K193	Family psychotherapy - out-patients (2 or more family members)		R
K195	Family psychotherapy - in-patients (2 or more family members)		R
Respiratory Procedures			
#E677	Transbronchial needle aspiration (TBNA) of mediastinal and/or hilar lymph nodes, add to bronchoscopy	$91.55	N
#E678	Transbronchial needle aspiration (TBNA) of lung mass, add to bronchoscopy.	$91.55	N
#Z317	Nose, Endoscopy: Examination under anesthesia (EUA) of nose including suction cautery for posterior epistaxis, unilateral or bilateral (6 anesthetic base units)	$108.75	N
#Z306	Nose, Endoscopy: Excision of middle turbinate concha bullosa – unilateral (4 anesthetic base units)	$53.95	N
Special Sense / Eyelids			
#E977	If excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees, add. Note: E977 is payable only in addition to codes E222, E223, E225, E226, E227, E228 and E229.	25%	N
Surgical – miscellaneous			
#E676	Morbidly Obese Patient. Body mass index (BMI) > 45 - applies to open procedures through incision into body cavity or major neck surgery, under general anesthesia. Add to major procedure. BMI must be recorded in patient record.	$60.70	N
#Z915	External Ear: Endoscopy: Removal of foreign body - simple. Note: Claimed solely for removal of cerumen is payable at nil.	$10.25	N
#Z866	- complicated - general anesthetic		R
Urology			
#E791	Bladder, Endoscopy – Cystoscopy: With periurethral injection of collagen or polytetrafluoroethylene (PTFE), add	$25.25	N
#Z480	Cystotomy with trochar and cannula and insertion of tube (5 anesthetic base units)	$82.80	N
#S480	Cystotomy with trochar and cannula and insertion of tube		D
#Z615	Filiform & follower urethral dilation under general anesthetic, and may include bladder catheterization (4 anesthetic base units). Note: Z619, Z620, Z621, Z622 payable at nil if claimed with Z615.	$58.00	N
#S640	Stereotactic prostate brachytherapy (5 assistant / 6 anesthetic base units)	$608.75	N

2. Community Medicine Specialty Codes

Effective April 1, 2000, the Ministry introduced a new specialty billing code (05) for specialists certified in community medicine, and added community medicine fee codes to the Schedule of Benefits. See Bulletin 4357, July 19, 2000. At that time, Community Medicine specialists were advised that they could continue to submit claims using fee codes for Internal Medicine (13) during a transition period ending December 31, 2000. The Ministry has extended the transition period during which community medicine specialists submit claims using either the Community Medicine code (05) or the Internal Medicine code (13) until further notice pending agreement between the OMA and MOHLTC on payment for community medicine specialists.

Communications

Bulletins and the updated version of the Schedule may be seen on the Ministry of Health and Long-Term Care web site www.health.gov.on.ca.

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