Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4382	**April 1, 2002**	**Ministry of Health Processing Office** *(address below)*
Distribution: **Physicians, Hospitals, Clinics, Laboratories**		

Subject **Changes to the Schedule of Benefits and Related Changes Effective April 1, 2002**

1. **Increase to Schedule of Benefits (1%)**
2. **Increase to Threshold Levels**
3. **Other Schedule Changes**
4. **Amendment List**

For your convenience, a complete updated version of the Schedule is available on the ministry's website at **www.health.gov.on.ca**.

1. Increase to Schedule of Benefits

The Physician Services Agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) provides a 2% increase to the Schedule of Benefits effective April 1, 2002. In accordance with this agreement, the Schedule of Benefits will be revised to provide a 1% increase to all professional fees, effective April 1, 2002 and the remaining 1% will be used to fund new and revised services.

This increase does not apply to uninsured services that are listed in Appendix F, and technical, hospital and facility fees for diagnostic services.

2. Increase to Threshold Levels

The threshold levels at which reductions are calculated will increase by $10,000. For general and family practitioners, the starting level will increase from $340,000 to $350,000, and for specialists the increase is from $420,000 to $430,000. The threshold reductions take effect when these higher OHIP earnings amounts are reached. After-hours, non-elective hospital services continue to be exempt from threshold reductions. The threshold levels are increased as follows :

Reduction Rate	**33.3%**	**66.7%**	**75.0%**
Payment amounts for services effective April 1, 2001			
General Practitioners	$340,000	$365,000	$390,000
Specialists	$420,000	$445,000	$470,000
Payment amounts for services effective on or after April 1, 2002			
General Practitioners	$350,000	$375,000	$400,000
Specialist	$430,000	$455,000	$480,000

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After hours non-elective hospital services exempt from threshold calculation

New codes for special visit premiums to an out-patient department (U994, U995, U996, U997) and for evening assessments, Monday to Friday in the Emergency Department (H132, H133, H131, H134), and their associated services, are exempt from threshold calculations when submitted on the same claim record with a valid hospital number.

3. Other Schedule Changes

3.1 Emergency Department Services

Preparation of In-patient Interim Admission Orders - H105

This new fee code, Preparation of In-patient Interim Admission Orders, H105, is payable to an emergency department physician who is on-call or on-duty in the emergency department for writing in-patient interim admission orders pending admission of a non-elective patient by a different "most responsible physician". The General Preamble B.6, Admission to Hospital From the Emergency Department or Out-patient Department, is revised to support this change. For complete information about payment requirements, please refer to the revised General Preamble, B.5.d and B.6, and the Consultation and Visits section of the Schedule.

Emergency and Out-patient Department Special Visit Premiums

The fee codes for special visits to an out-patient department have been separated from those for special visits to an emergency department. New codes for special visits to an out-patient department are payable under the same terms and conditions as they were when included with codes for special visits to an emergency department. For complete information about payment requirements for these codes, refer to the revised General Preamble, B.23, and Special Visit Premiums.

Emergency Department Alternative Funding Agreements

New language is added to the General Preamble, B.32, that disallows fee-for-service payments to any physician for services that are insured under an emergency department alternative funding agreement. For complete information, please refer to the revised Schedule.

3.2 Pediatric Medical Specific Assessment and Medical Specific Re-Assessment

The existing fee code descriptors for pediatric General Assessment and General Re-assessment are revised to Medical Specific Assessment and Medical Specific Re-assessment. This change allows payment to a pediatrician for a medical specific assessment or medical specific reassessment when that service is required rather than a general assessment or general re-assessment. For complete information, refer to the revised General Preamble, Other Assessments, B.4, e, f & r and to the Consultation and Visits section of the Schedule.

3.3 Midwife-Requested Assessment

Midwife-requested Emergency Assessment (C813) and Midwife-requested Special Emergency Assessment (C815) were added to the Schedule of Benefits in April 1999. Effective April 1, 2001, these codes were revised to allow payment for a midwife-requested assessment of a newborn. Effective April 1, 2002, C813/C815 are revised and A813/A815 are added to allow payment for non-emergency requests. Please refer to the Consultation and Visits section of the Schedule for complete information.

3.4 Radiation Oncology

Four new codes are added for radiotherapy treatment planning that will be rendered in a Cancer Care Ontario Centre or Princess Margaret Hospital to account for the complexity and time required for this activity. Each fee code level is tied to specific National Hospital Productivity Improvement Project (NHPIP) Codes.

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4. Amendment List

The following list highlights the amendments that are effective April 1, 2002. For complete information, please refer to the April 2002 edition of the Schedule of Benefits. Fees are shown only for new and revised fees.

Page	Fee Code	Description	Fee	N - New R - Revised D - Deleted
ix	GP B.3.d	Anesthetic consultation A/C015		R
xii	GP B.3.m	Special palliative care consultation A/C945		R
xiv	GP B.4.f	Complex medical specific re-assessment		N
xiv, xv	GP B.4.i	Intermediate assessment - pronouncement of death		R
xvi	GP B.4.n	Comprehensive assessment and care		R
xvii	GP B.4.o	Detention - geriatric or geriatric psychiatric consultation, psychiatric or pediatric neurodevelopmental consultation and midwife requested special assessment		R
xvii	K101	Detention in ambulance - Ground ambulance transfer		R
xvii	K112	Detention in ambulance - Return trip without patient	24.55	N
xxii	GP B.5.d	Emergency Department, Emergency Physician on Duty		R
xxiv	GP B.6	Admission to Hospital from ED or OPD		R
xxvii	GP B.7.5(iv)	Other terms and definitions - Counseling		R
xxx	GP B.11	Maximums, minimums and unit-based services		R
xxxi	GP B.12	Defined terms and expressions		R

xxxvi	E101B	Surgical assistant standby premium	1 unit /15 min	N
xli	E008C	Anesthetic premium for patient with incapacitating disease		D
xli	E009C	Anesthetic premium - infant aged 29 days to 1 year	4 units	R
xli	E011C	Anesthesia premium - patient in prone position	4 units	N
xli	E014C	Anesthesia premium - newborn 28 days and younger	5 units	R
xli	E018C	Anesthesia premium - Adult >80 years of age	2 units	N
xli	E022C	Anesthesia premium - Patients ASA 3	2 units	N
xli	E017C	Anesthesia premium - Patients ASA 4	10 units	N
xli	E016C	Anesthesia premium - Patients ASA 5	20 units	N
xli	E019C	Anesthesia premium - infant or child aged 1 to 8 years	2 units	N
xli	E021C	Anesthetic premium - premature newborn < 37 weeks gestation	9 units	N
xlii	GP.B.23	Special visit premiums		R
xliv	K990 to K997	Special visit premiums for visits to emergency department		R (8)
xliv		Special visit premiums for visits to hospital out-patient department		
	U990	Daytime (07:00 - 18:00h) - first patient	17.85	N
	U991	- additional patient - add to consultation or visit fee	30%	N
	U992	Emergency call with sacrifice of office hours - first patient	35.60	N
	U993	- additional patient - add to consultation or visit fee	30%	N
	U994	Evening (18:00 - 24:00h) Monday to Friday or daytime and evenings on Saturday, Sunday or holiday - first patient	50.05	N
	U995	- additional patient - add to consultation or visit fee	45%	N

	U996	Nights (00:00 - 07:00h) -first patient	75.10	N
	U997	- additional patient - add to consultation or visit fee	68.75%	N
lii	General Preamble B.32	Fee-for-service claims for emergency dept. AFA services		N
D4	Appendix D	Surface pathology - removal or treatment of warts on head or neck of patients aged 15 or younger		R
A1, 3, xxiv	A/C933	On-call admission assessment		R (2)
A2, 3, 5, xiv, xv	A/C/W771	Certification of death	17.30	N (3)
A2, 3, xvii	A/C813	Midwife-requested assessment	57.30	N, R
A2, 3, xvii	A/C815	Midwife-requested special assessment	112.35	N, R
A4, xxiv	H105	In-patient Interim Admission Orders	17.30	N
A4		Emergency Dept. - Monday to Friday - evenings (18:00 to 24:00h)		
	H132	Comprehensive assessment and care	35.15	N
	H133	Multiple systems assessment	31.10	N
	H131	Minor assessment	15.45	N
	H134	Re-assessment	15.45	N

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Page	Fee Code	Description	Fee	N-New R-Revised D-Deleted
A11, xii	K023	Palliative care support		R
A12	K028	Sexually transmitted disease (STD) management	50.45	N
A12	K029	Insulin therapy support	50.45	N
A12	K030	Diabetic management assessment	30.00	N
A14	E015	Consultation within 36 hours of an anesthesia		D
A14 - 46, xvi	A/CXXX	Complex medical specific re-assessment - for medical specialty groups with medical specific assessment codes	52.10	N (24)
A32	A230	Orthoptic assessment	14.60	N
A35, 36, 37, xvii	A/C/W667	Neurodevelopmental consultation, pediatric	224.65	N (3)
A36	A/C263, A/C264	Revise general assessment and re-assessment descriptors to pediatric medical specific assessment and medical specific re-assessment		R (4)
A41, 42, xvii	A/C/W795	Geriatric psychiatric consultation	168.40	N (3)

A41, 42, xvii	A/C/W695	Neurodevelopmental consultation, psychiatric			224.65	N (3)
B3	J811/J611 J813/J613	Myocardial wall motion studies (Note)				R (4)
C1	Preamble	Radiation Oncology				R
C2	X301	Major treatment planning				D
C2	X310	Treatment planning - Level 1			219.00	N
C2	X311	Treatment planning - Level 2			381.00	N
C2	X312	Treatment planning - Level 3			692.00	N
C3	X313	Treatment planning - Level 4			825.00	N
C4	X333	Metastatic disease with radioactive lymphogram				D
E4	#J016	Percutaneous vertebroplasty			148.10	N
E4	#J054	Percutaneous vertebroplasty - each additional - max 3 per patient per day			74.05	N
G4	J165	Transvaginal sonohysterography	H 101.50	P1 74.20	P2 00.00	N
G5	J193/J493, J194/J494, J195/J495, J202/J502	Peripheral vessel assessment				R (8)

G7	J149	Note: Diagnostic ultrasound J138/438 and J161/461 rendered same visit as ultrasound guidance J149 is an insured service payable at nil.		R
J10	G316, G335	Cardiovascular stress testing - vector analysis T & P components		D (2)
J11		Continuous ECG monitoring		
	G650	Level 1: 12 - 47 hr recording - P fee	46.95	R
	G658	Level 1: 48 - 71 hr recording - P fee	70.45	N
	G659	Level 1: 72 hr or more recording - P fee	93.95	N
	G653	Level 2: 12 - 47 hr recording - P fee	33.45	R
	G656	Level 2: 48 - 71 hr recording - P fee	50.15	N
	G657	Level 2: 72 hr or more recording - P fee	66.85	N
J13	Preamble	Critical Care - Life threatening emergency situation		R
J13	Critical Care	Critical Care - Other resuscitation		R
J14 - J16	Critical Care	Critical Care - Per Diem listings Preambles - Intensive Care Area, Comprehensive Care, Neonatal Intensive Care		R
J16	#G603	Neonatal low volume intensive care premium	452.50	N
J16	#G604	Neonatal low birth weight intensive care premium	452.50	N
J24	#G322	Nasogastric intubation under general anesthetic	9.40	N

J35, M4, xlii	Preamble	Brachial plexus block added to that payable as G224 with anesthetic service		R
J36	G216	Lumbar epidural block		R
J36	G245	Lumbar epidural or intrathecal injection of sclerosing solution		R
J37	#G246 #G125	Introduction of lumbar epidural catheter for analgesia - concurrent with anesthesia time units for operative procedure		R R
	#G255	- with insertion of subcutaneous port		D
	#E833	- with insertion of subcutaneous port	113.80	N

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Page	Fee Code	Description	Fee	N-New R-Revised D-Deleted
J37	#G117	Introduction of thoracic epidural catheter for analgesia	94.75	N
	#G118	- concurrent with anesthesia time units for operative procedure	56.05	N
J37	#G119	Introduction of cervical epidural catheter for analgesia	113.70	N
J38	#G273	Lumbar epidural injection of adrenal steroid or autologous blood		R
J43	Diagnostic Hearing Tests	Clarify commentary. See Bulletin 4378, November 21, 2001.		R
J45	Preamble	Electromyography and nerve conduction studies preamble		R
J47	#Z458	Electroconvulsive therapy - single or multiple		D
J47	#G478	Electroconvulsive therapy - single or multiple - inpatient	54.15	N
J47	#G479	Electroconvulsive therapy - single or multiple - outpatient	59.80	N
J48	J890/J690	Level 1 - overnight sleep study - diagnostic study		R (2)

J48	J889/J689	Level 1 - overnight sleep study - therapeutic study for CPAP titration	H 376.50	P1 180.50	P2 67.50	N (2)
J48	J894	Sleep Studies - maintenance of wakefulness test - separated from J893 MSLT	H 70.00	P1 51.45	P2 00.00	N
K4	P005	Antenatal preventative health assessment			40.65	N
K4	P009	Attendance at labour and delivery by physician other than obstetric consultant			338.95	R
K4	E411	Sole Delivery Premium payable in addition to E414				R
K4	P011	Attendance at labour when same physician assists or gives anesthesia at C-section or operative delivery and claims separately as assistant or anesthetist				D
K5	E414	High risk obstetrical premium			60.85	N
K6	P030	Cervical ripening			57.45	N
K6	P025	Non-stress test for high-risk pregnancy			9.45	N
M4	Preamble	Surgical Procedures				R
M5	#E673	Lysis of extensive intra-abdominal adhesions and/or scarring			60.85	N
M9	R010	Malignant melanoma - wide excision			121.65	N
M13	Preamble	Skin Flaps and Grafts				N

M13	#E540	Excision of tumour free margin with frozen section - add to first flap or graft	25%	R
		Male mastectomy for adolescent male gynaecomastia, secondary to endocrine or genetic disorders or chemotherapy		
M20	#R146	- simple	174.00	N
M20	#R147	- subcutaneous with nipple preservation	268.60	N
		Male mastectomy for treatment of male breast cancer		
M20	#R148	- simple	268.60	N
M20	#R149	- subcutaneous with nipple preservation	268.60	N
N5	#R209	Arthroplasty - basal thumb - first carpo-metacarpal joint	355.95	N
N7	#R322	Reconstruction - bone - pseudoarthrosis - scaphoid	356.65	R
N11	#N189	Ulnar nerve transposition at elbow	273.75	N
N17	#R298	Simple excision - clavicle or acromion - R416 paid at 85% with R298		R
N17	#R416	Rotator cuff exploration - excludes simple excision of clavicle R928 - paid at 85% with R298		R
N17	#R490	Excision - joint - acromio/sterno-clavicular meniscectomy		D
N19	#F120	Reduction - fractures - scapula - closed reduction with anesthetic		D

N19	#F122	Reduction - fractures - sternum - no reduction		D
N27, X7	#E926	Spinal duraplasty utilizing autologous tissue		R
N28	Z215	Spine-Examination under general anesthetic		D
N32, X13	 #N188 #N285 #N177	Pelvis & Hip - Exploration, decompression, division, excision, biopsy, neurolysis, transposition - minor nerve - major nerve - sciatic nerve in buttock		 R R R
N42	#R552	Revision ankle arthrodesis	496.70	N
Q1	Preamble	Operations on cardiovascular system		N
Q3	#E646	Vein patch angioplasty of coronary artery	184.10	N
Q4	#R741	Coronary artery endarterectomy and/or gas endarterectomy		R
Q7	Preamble	Operations on the Cardiovascular Systems - Arteries - Excision & Repair		R
Q7	#E679	Vein graft harvest remote from bypass site when saphenous vein unavailable	121.65	N
Q8	#R873	Thrombin injection of femoral artery pseudoaneurysm	53.90	N

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Page	Fee Code	Description	Fee	N-New R-Revised D-Deleted
S4	#Z567	Esophagoscopy - subsequent procedure within 3 months after initial Z515 endoscopic procedure		D
S4	#Z568	Esophagoscopy-gastroscopy, subsequent procedure within 3 months after Z399 or Z400		D
S9	E785	Endoscopy of sigmoid to descending colon - multiple screening biopsies >34 sites for malignant changes in ulcerative colitis, add	53.20	N
T4	#E820	Cystoscopy and diagnostic ureteroscopy with biopsy of one or more sites in ureter and/or renal, pelvis using ureteroscope, and	48.75	N
T4	#Z640	Resection and fulgurization of ureteral or renal tumours with or without cystoscopy	266.00	N
T6	Bladder Preamble	Bladder operations - E codes payable with S codes or Z codes under the "Bladder" subheading"		R
U3	S626	Vasectomy - uni or bilateral by any technique		R
U4	#S653	Laparoscopic radical prostatectomy	1064.60	N
V1	#E854	Ureterolysis	106.45	N
V3	#S812	Repeat post-hysterectomy vault prolapse - vaginal approach	444.80	N
V3	#S813	Repeat abdominal approach to vaginal vault prolapse - vaginal sacropexy	444.80	N

V6	#E861	Paracervical block - add-on for unilateral or bilateral payable in addition to endometrial sampling in office	8.80	N
V7	#S762	Hysterectomy, radical trachelectomy - add "excluding node dissection"		R
V8	#S743	Fallopian tube - repair of extensive unilateral or bilateral & peritubal disease - laparotomy		R
V8	#S746	Fallopian tube - repair of extensive unilateral or bilateral & peritubal disease - laproscopic technique	755.65	N
V9	#S750	Radical resection of pelvic & para-aortic nodes for cancer		R
X1	#E921	Repeat cranial procedure applies to N111		R
X3	#N124	Functional stereotaxy	1520.80	N
X7	#N316	Stereotactic spinal operative procedure	1055.55	N
X7	#E900	Spinal - Tumors - repeat total or partial removal	211.15	N
Y2	Z871, #Z853	Cornea ulcer cautery		R (2)
Y8	#Z917	Lacrimal tract incision - three snip punctum procedure - increase maximum # of services to 4		R

Payment

The April 1 changes to the Schedule of Benefits will be applied automatically to all claim submissions for services provided on or after April 1, 2002.

To assist with updating OHIP billing software, Ministry District Offices will send a copy of the new Fee Schedule Master to physicians with the May Remittance Advice. Note: there are new fee codes that have a "U" prefix. Please update your billing software to accept "U" prefix fee codes.

Communication

Bulletins and the updated version of the Schedule are available on the Ministry of Health and Long-Term Care web site : **www.health.gov.on.ca**.

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