Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4430	October 1, 2005	Ministry of Health and Long-Term Care Processing Office
Distribution		(address below)
Physicians, Hospitals, Clinics and Laboratories		

Subject: Update to Implementation of 2004 Physician Services Agreement

1. **Revisions to the General Preamble**
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3. **Geriatric age premium**
4. **Anaesthesia base units**
5. **Fee increases**
6. **Introduction of new fee codes**
7. **Revisions to specific fee codes**
8. **Deleted fee codes**
9. **Other Revisions**
10. **Amendment charts**

In accordance with the 2004 Physician Services Agreement, a number of changes are being made to the Schedule of Benefits for Physician Services, **effective October 1, 2005**. These changes are listed in Appendix L of the Agreement.

These changes also include recommendations jointly agreed to by the ministry and the OMA to clarify existing Schedule language regarding billing of specific services, and cost-neutral recommendations by the Ontario Medical Association (OMA) Central Tariff Committee (CTC) from the 2004 CTC Report.

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1. Revisions to the General Preamble

In accordance with Section 13.3 of the 2004 Physician Services Agreement, the General Preamble of the Schedule of Benefits for Physician Services has been revised to improve readability. Some descriptions previously included in the General Preamble have been moved to the Consultations and Visits section of the Schedule. The revisions to the General Preamble **do not** revise any existing policy or legislative requirements associated with the billing of services to OHIP.

2. GP Psychotherapy (K099)

A new fee code, K099, has been created that will pay a 5% premium on psychotherapy services to all physicians identified as GP psychotherapists. GP psychotherapy designation is based on 50% of physician's professional fees being comprised of fee codes K004, K006, K007, K010, K011, K012, K024 and K025 for the interval from October 1, 2003 to September 30, 2004. Eligibility for this premium will be revisited on an annual basis. If you are eligible to bill this fee code you will receive a letter to this effect from the ministry.

Physicians eligible to submit K099 are required at this time to submit K099 and the relevant K-codes (K004, K006, K007, K010, K011, K012, K024, K025 and new fee codes K019 and K020) on the same claim record. A process for automatically applying the 5% premium is under review.

3. Geriatric Age Premium (E070 and E071)

Effective October 1, 2005, all fee-for-service physicians billing family practice intermediate or general assessments on patients 70 years of age and older are eligible to receive a 15% premium on the assessment value.

An automatic system to pay this premium is currently being developed by the ministry but will not be ready until early 2006. Prior to implementation of this automatic system, physicians wishing to receive payment for the age premium may submit the age premium on the same claim record as the assessment:

- E070 should be used for general assessment codes (A003, C003, A903, C903, W903, W102, W109)
- E071 should be used for A007

Alternatively, physicians may choose to delay billing of the age premium and receive payment as part of a retroactive payment adjustment which will be made after implementation of the automatic system has been completed.

Physicians will be notified by OHIP when the automatic application of the premium is implemented.

Physicians in primary care payment models will also be compensated appropriately. Specific details on how these increases will be administered in each of models will be communicated shortly under separate cover.

4. Anaesthesia Base Units

The minimum anaesthesia base units have been increased from 4 to 5 units. This revision refers to procedural base units only and not to premium or add-on fee codes.

5. Fee increases

Effective October 1, 2005, fee increases to specific fee codes are summarized in the attached Chart 1.

6. Introduction of new fee codes

New fee codes, effective October 1, 2005, are summarized in the attached Chart 2.

7. Revisions to specific fee codes

Effective October 1, 2005, changes to the wording/definitions of the fee codes are reflected in the attached Chart 3.

8. Deleted fee codes

Effective October 1, 2005, a number of new fee codes are being introduced to replace existing fee codes that have been deleted as a result of recommendations from the OMA's CTC (Chart 4). The codes being replaced include spinal cord fee codes from Sections N – Musculoskeletal and X- Nervous, which have been replaced with new fee codes identified in a new section of the Schedule, Section Z – Spinal Surgical Procedures.

9. Other Revisions

- Appendix F of the Schedule of Benefits has been updated to correctly reference the *Ministry of Community and Social Services* that now replaces the *Ministry of Community, Family and Children's Services.*

- Clarification is provided to indicate that Appendices A, B, C and F do not form part of the Schedule of Benefits for Physician Services and are provided for reference and information purposes only.

- As identified in Appendix F of the 2004 Physician Services Agreement, a "Hospital Paediatric Stabilization Fund" will be established effective October 2005. This fund has been established in recognition of the need to recruit and retain paediatricians to provide inpatient care in hospitals that offer obstetrical services and have active Departments of Paediatrics. Funding for this program will flow through the eligible hospitals to provide additional funding for paediatricians who provide hospital care. Eligible hospitals will be receiving additional communication on this initiative in the near future.

- As identified in Appendix J of the 2004 Physician Services Agreement, funding improvements for acute care psychiatric services will be initiated effective October 1, 2005. Please refer to Bulletin number 4429 for more information on the Mental Health Sessional Fee Supplements and Psychiatric Stipend programs.

- Information regarding other Agreement items with effective dates of October 2005 will be communicated separately, e.g. HOCC.

10. Amendment charts

Chart 1 – Increases to fee codes
Chart 2 – New fee codes
Chart 3 – Revised fee codes
Chart 4 – Deleted fee codes

This Bulletin is a general summary provided for information purposes only. Physicians, hospitals and other health care providers are directed to review the *Health Insurance Act*, Regulation 552 and the Schedules under that regulation, for the complete text of the provisions. You can access this information on-line at: www.e-laws.gov.on.ca/.

In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulation, the legislation and/or regulation prevails.

Bulletins and the updated version of the Schedule of Benefits are available on the Ministry of Health and Long-Term Care website http://www.health.gov.on.ca/.

CHART 1: Increased Fee Codes: Schedule of Benefits changes effective October 1, 2005

Note: This chart represents fee code increases only

This Bulletin is being provided as a reference guide only to assist in identifying the October 1, 2005 Schedule of Benefits changes. For complete information, service descriptions, and billing information, please refer to the October 2005 edition of the Schedule of Benefits for Physician Services and subsequent amendment pages. Physicians should carefully review these fee code changes in the context of the Schedule of Benefits (including the General Preamble and any other associated Preambles).

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
A003	A1	Family Practice & Practice in General - General assessment	$55.45	**$58.20**
A007	A3, A59	Family Practice & Practice in General - Intermediate assessment	$29.20	**$29.70**
A014	A25	Anaesthesia - Partial Assessment	$21.00	**$29.05**
A025	A31	Dermatology - Consultation	$54.50	**$59.15**
A035	A35	General Surgery - Consultation	$76.50	**$81.60**
A065	A56	Orthopaedic Surgery - Consultation	$57.25	**$66.30**
A074	A40	Geriatrics - Medical specific re-assessment	$41.95	**$45.90**
A078	A40	Geriatrics - Partial assessment	$25.15	**$29.05**
A085	A66	Plastic Surgery - Consultation	$57.05	**$66.30**
A095	A28	Cardiovascular & Thoracic Surgery - Consultation	$60.75	**$66.30**
A134	A44	Internal Medicine - Medical specific re-assessment	$41.95	**$45.90**
A138	A44	Internal Medicine - Partial assessment	$25.15	**$29.05**
A184	A47	Neurology - Medical specific re-assessment	$41.95	**$45.90**
A188	A47	Neurology - Partial Assessment	$25.15	**$29.05**
A194	A67	Psychiatry - Partial Assessment	$25.15	**$29.05**
A195	A67	Psychiatry - Consultation	$127.50	**$153.00**
A197	A67	Psychiatry - Consultative - interview with parents	$127.50	**$163.20**
A198	A67	Psychiatry - Consultative - interview with child	$127.50	**$163.20**
A205	A52	Obstetrics and Gynecology - Consultation	$76.50	**$81.60**
A221	A38	Genetics - Partial Assessment	$18.90	**$29.05**
A225	A38	Genetics - Consultation	$124.45	**$142.80**
A235	A54	Ophthalmology - Consultation	$59.40	**$66.30**
A245	A58	Otolaryngology - Consultation	$57.25	**$66.30**
A263	A59	Paediatrics - Office/Clinic - Medical specific assessment	$54.20	**$58.25**
A264	A59	Paediatrics - Medical specific re-assessment	$35.35	**$45.90**
A265	A59	Paediatrics - Consultation	$137.70	**$142.80**
A284	A46	Laboratory Medicine - Partial Assessment	$21.75	**$29.05**
A310	A63	Physical Medicine and Rehabilitation - Medical specific re-assessment	$41.95	**$45.90**
A318	A63	Physical Medicine - Partial assessment	$25.65	**$29.05**
A340	A73	Radiation Oncology - Medical specific re-assessment	$41.95	**$45.90**
A345	A73	Radiation Oncology - Consultation	$114.60	**$127.50**

This information is provided for reference purposes only. Please refer to the October 1, 2005 Schedule of Benefits for Physician Services for complete information pertaining to the fee code changes.

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
A348	A73	Radiation Oncology - Partial Assessment	$25.15	**$29.05**
A355	A76	Urology - Consultation	$57.05	**$66.30**
A414	A34	Gastroenterology - Medical specific re-assessment	$41.95	**$45.90**
A415	A34	Gastroenterology - Consultation	$114.60	**$127.50**
A418	A34	Gastroenterology - Partial assessment	$25.15	**$29.05**
A474	A74	Respiratory Disease - Medical specific re-assessment	$41.95	**$45.90**
A475	A74	Respiratory Disease - Consultation	$114.60	**$127.50**
A478	A74	Respirology - Partial assessment	$25.15	**$29.05**
A484	A75	Rheumatology - Medical specific re-assessment	$41.95	**$45.90**
A488	A75	Rheumatology - Partial assessment	$25.15	**$29.05**
A604	A27	Cardiology - Medical specific re-assessment	$41.95	**$45.90**
A605	A27	Cardiology - Consultation	$114.60	**$127.50**
A608	A27	Cardiology - Partial assessment	$25.15	**$29.05**
A614	A43	Haematology - Medical specific re-assessment	$41.95	**$45.90**
A618	A43	Hematology - Partial assessment	$25.15	**$29.05**
A624	A29	Clinical Immunology - Medical specific re-assessment	$41.95	**$45.90**
A628	A29	Clinical Immunology - Partial assessment	$25.15	**$29.05**
A638	A50	Nuclear Medicine - Partial Assessment	$25.45	**$29.05**
A645	A37	General Thoracic Surgery - Consultation	$76.50	**$81.60**
A667	A59	Paediatrics - Neurodevelopment Consultation	$229.15	**$255.00**
A695	A67	Neurodevelopment - Consultation	$229.15	**$255.00**
A775	A40	Geriatrics - Comprehensive Geriatric Consultation	$158.10	**$183.60**
A777	A3	Family Practice & Practice in General - Pronouncement of death - office	$28.00	**$29.70**
A795	A67	Psychiatry - Geriatric Consultation	$171.75	**$183.60**
A813	A6	Family Practice & Practice in General - Office/Clinic - Midwife Requested Assessment (MRA)	$58.75	**$81.60**
A815	A6	Family Practice & Practice in General - Office/Clinic - Midwife-Requested Special Assessment	$115.15	**$127.50**
A895	A67	Psychiatry - Consultation in association with special visit in hospital or LTC	$136.95	**$178.50**
A903	A2	Family Practice & Practice in General - Pre-operative assessment	$55.45	**$58.20**
A935	A28, A35, A37, A49, A52, A54, A56, A58, A66, A76	Special Surgical Consultation	$114.60	**$127.50**
A945	A1	Family Practice & Practice in General - Special palliative care consultation	$103.70	**$127.50**
CXX2	A7, A25, A27-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76,	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Subsequent visits - up to five weeks - per visit	$23.60	**$29.20**
C003	A7	Family Practice & Practice in General - General assessment, hospital	$55.45	**$58.20**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
CXX7	A7, A25, A27-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76,	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Subsequent Visits - 6th-13th wks incl. (max. of 3/wk)	$23.60	**$29.20**
CXX8	A7, A26-A29, A31, A34-A35, A37, A41, A43-A44, A46-A47, A49, A52, A55-A56, A58, A61 A63, A66, A68, A73-A76	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Concurrent care	$23.60	**$29.20**
CXX9	A7, A25, A27-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Subsequent Visits - after 13th week (max. of 6/mth)	$23.60	**$29.20**
C010	A7	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Supportive care - per visit	$15.30	**$17.75**
C025	A31	Dermatology - Consultation - Non-Emergency Hospital In-Patient Services	$54.50	**$59.15**
C035	A35	General Surgery - Consultation - Non-Emergency Hospital In-Patient Services	$76.50	**$81.60**
C065	A56	Orthopaedic Surgery - Consultation - Hospital In-Patient Service	$62.35	**$66.30**
C074	A40	Geriatrics - Medical specific re-assessment	$41.95	**$45.90**
C075	A40	Geriatrics - Consultation - Non-Emergency Hospital In-Patient Services	$127.50	**$142.80**
C085	A66	Plastic Surgery - Consultation - Non Emergency Hospital In-Patient Services	$57.05	**$66.30**
C095	A28	Cardiovascular and Thoracic Surgery - Consultation - Non-Emergency Hospital In-Patient Services	$76.50	**$81.60**
C121	A7, A26-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76	SUB. VISITS - Visits due to intercurrent illness	$23.60	**$29.20**
C134	A44	Internal Medicine - Medical specific re-assessment	$41.95	**$45.90**
C184	A47	Neurology - Medical specific re-assessment	$41.95	**$45.90**
C194	A68	Psychiatry - Medical specific re-assessment	$41.95	**$45.90**
C205	A52	Obstetrics and Gynecology - Consultation - Non-Emergency Hospital In-Patient Services	$76.50	**$81.60**
C225	A39	Genetics - Consultation - Non Emergency Hospital In-Patient Services	$127.50	**$142.80**
C235	A54	Ophthalmology - Consultation - Non-Emergency Hospital In-Patient Services	$59.40	**$66.30**
C245	A58	Otolaryngology - Consultation - Non-Emergency Hospital In-Patient Services	$57.25	**$66.30**
C263	A61	Paediatrics - Non-Emergency Hospital In-Patient Services - Medical specific assessment	$54.20	**$58.25**
C264	A61	Paediatrics - Medical specific re-assessment	$35.35	**$45.90**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
C265	A61	Paediatrics - Consultation - Non Emergency Hospital In-Patient Services	$137.70	**$142.80**
C314	A63	Physical Medicine and Rehabilitation - Medical specific re-assessment	$41.95	**$45.90**
C344	A73	Radiation Oncology - Medical specific re-assessment	$41.95	**$45.90**
C345	A73	Radiation Oncology - Consultation - Non-Emergency Hospital In-Patient Services	$114.60	**$127.50**
C355	A76	Urology - Consultation - Non-Emergency Hospital In-Patient Services	$62.15	**$66.30**
C414	A34	Gastroenterology - Medical specific re-assessment	$41.95	**$45.90**
C474	A74	Respiratory Disease - Medical specific re-assessment	$41.95	**$45.90**
C484	A75	Rheumatology - Medical specific re-assessment	$41.95	**$45.90**
C604	A27	Cardiology - Medical specific re-assessment	$41.95	**$45.90**
C614	A43	Haematology - Medical specific re-assessment	$41.95	**$45.90**
C624	A29	Clinical Immunology - Medical specific re-assessment	$41.95	**$45.90**
C645	A37	General Thoracic Surgery - Consultation - Non-Emergency Hospital In-Patient Services	$76.50	**$81.60**
C667	A61	Paediatrics - Neurodevelopmental - Consultation - Non-Emergency Hospital In-Patient Services	$229.15	**$255.00**
C695	A68	Neurodevelopment - Consultation - Non-Emergency Hospital In-Patient Services	$229.15	**$255.00**
C775	A40	Geriatrics - Comprehensive Geriatric Consultation - Non-Emergency Hospital In-Patient Services	$158.10	**$183.60**
C777	A7	Family Practice & Practice in General - Pronouncement of death - hospital	$28.00	**$29.70**
C795	A68	Psychiatry - Geriatric Consultation - Non-Emergency Hospital In-Patient Services	$171.75	**$183.60**
C813	A7	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Midwife-requested emergency assessment (<50 mins.)	$58.75	**$81.60**
C815	A7	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Midwife-requested emergency assessment (50-90 mins.)	$115.15	**$127.50**
C882	A7	Family Practice & Practice in General - Subsequent Visits - Palliative Care	$23.60	**$29.20**
C895	A68	Psychiatry - Consultation non-emergency hospital services	$142.80	**$178.50**
C903	A7	Family Practice & Practice in General - Pre-operative assessment, hospital	$55.45	**$58.20**
C935	A28, A35, A37, A49, A52, A54, A56, A58, A66, A76	Special Surgical Consultation - Non Emergency Hospital In-Patient Services	$114.60	**$127.50**
C945	A7	Family Practice & Practice in General - Special palliative care consultation - Non-Emergency Hospital In-Patient Service	$103.70	**$127.50**
C982	A26,-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76	Family Practice and Practice in General - Subsequent Visits - Palliative Care	$23.60	**$29.20**
H055	A33	Emergency Medicine - Consultation	$82.75	**$84.40**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
H065	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Consultation in Emergency Medicine	$55.15	**$56.25**
H101	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Minor assessment	$14.40	**$14.70**
H102	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Comprehensive assessment and care	$35.50	**$36.45**
H103	A10	Family Practice & Practice in General - Multiple systems assessment, daytime	$29.05	**$29.65**
H104	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Re-assessment	$14.40	**$14.70**
H105	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - In-patient Interim Admission Orders	$17.75	**$18.10**
H112	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Nights (00:00h - 08:00h) -Premium per patient visit - When any other service is rendered by the physician on duty (and assessments may not be claimed)	$14.40	**$14.70**
H113	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Daytime and evenings (08:00h - 24:00h) on Saturdays, Sundays or Holidays - Premium per patient visit - When any other service is rendered by the physician on duty (and assessments may not be claimed)	$8.50	**$8.65**
H121	A10	Emergency Department - Physician on Duty - Minor assessment	$25.05	**$25.75**
H122	A10	Emergency Department - Physician on Duty - Comprehensive assessment	$62.10	**$63.80**
H123	A10	Family Practice & Practice in General - Multiple systems assessment, nights	$50.60	**$51.90**
H124	A10	Emergency Department - Physician on Duty - Re-assessment	$25.05	**$25.75**
H131	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Evenings (18:00h - 24:00h) - Minor assessment	$15.85	**$16.15**
H132	A10	Emergency Department - Physician on Duty - Comprehensive assessment	$36.05	**$40.10**
H133	A10	Family Practice & Practice in General - Multiple systems assessment, evenings	$31.90	**$32.65**
H134	A10	Family Practice & Practice in General - Emergency Department - Physician on Duty - Evenings (18:00h - 24:00h) - Re-assessment	$15.85	**$16.15**
H151	A10	Emergency Department - Physician on Duty - Minor assessment	$21.45	**$22.05**
H152	A10	Emergency Department - Physician on Duty - Comprehensive assessment	$53.25	**$54.70**
H153	A10	Family Practice & Practice in General - Multiple systems assessment, weekends	$43.35	**$44.50**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
H154	A10	Emergency Department - Physician on Duty - Re-assessment	$21.45	**$22.05**
H262	A62	Paediatrics - Low birthweight newborn initial visit	$55.45	**$58.20**
H312	A65	Physical Medicine - Team Management, first twelve weeks	$18.60	**$29.20**
H317	A65	Physical Medicine - Team Management - thirteen to twenty six weeks	$18.60	**$29.20**
H319	A65	Physical Medicine - Team Management, twenty seventh week onwards	$18.60	**$29.20**
K030	A21	Family Practice & Practice in General - Diabetic Management Assessment	$30.75	**$34.75**
K033	A13	Family Practice & Practice in General - Counselling, individual - over 3 services	$28.00	**$29.70**
K041	A13	Family Practice & Practice in General - Counselling, group - over 3 services	$28.00	**$29.70**
K190	A70	Psychiatry - Individual -psychotherapy in-patient	$57.55	**$65.25**
K192	A70	Psychiatry - Hypnotherapy - individual	$55.25	**$62.20**
K197	A70	Psychiatry - Individual -psychotherapy out-patient	$59.55	**$62.20**
K198	A70	Psychiatry - Psychiatric Care - out-patient	$59.55	**$62.20**
K199	A70	Psychiatry - Psychiatric Care - in-patient	$63.85	**$65.25**
K200	A70	Psychiatry - Group psychotherapy, 4 people	$14.25	**$15.30**
K201	A70	Psychiatry - Group psychotherapy, 5 people	$11.85	**$12.25**
K202	A70	Psychiatry - Group psychotherapy, 6-12 people	$10.05	**$10.20**
K203	A70	Psychiatry - Group psychotherapy, 4 people	$14.25	**$15.30**
K204	A70	Psychiatry - Group psychotherapy, 5 people	$11.85	**$12.25**
K205	A70	Psychiatry - Group psychotherapy, 6-12 people	$10.05	**$10.20**
K206	A70	Psychiatry - Group psychotherapy, additional	$9.35	**$9.70**
K207	A70	Psychiatry - Group psychotherapy, additional	$9.35	**$9.70**
K269	A59	Paediatrics - Annual Health Examination - adolescent	$55.45	**$58.20**
K313	A65	Physical Medicine - Physiatric Management	$3.42	**$6.10**
K620	A69	Psychiatry - Assessments under the Mental Health Act - Consultation for involuntary psychiatric treatment (as mandated by Section 35a (2) of the Mental Health Act) - per ½ hour or major part thereof	$57.15	**$65.25**
K887	A17	Family Practice & Practice in General - Community Treatment Order (CTO) - CTO initiation - including completion of the CTO form and all preceding CTO services directly related to CTO initiation - per unit	$61.00	**$65.55**
K888	A17	Family Practice & Practice in General - Community Treatment Order (CTO) - CTO supervision - including all associated CTO services except those related to initiation or renewal - per unit	$61.00	**$65.55**
K889	A17	Family Practice & Practice in General - Community Treatment Order (CTO) - CTO renewal - including completion of the CTO form and all preceding CTO services directly related to CTO renewal - per unit	$61.00	**$65.55**
W002	A12	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Subsequent visits - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month	$23.60	**$29.20**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
W022	A32	Dermatology - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W025	A32	Dermatology - Consultation - Non-Emergency Long-Term Care In-Patient Services	$54.50	**$59.15**
W032	A36	General Surgery - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W035	A36	General Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Services	$60.75	**$81.60**
W045	A49	Neurosurgery - Consultation - Non-Emergency Long-Term Care In-Patient Services	$91.50	**$102.00**
W062	A57	Orthopaedics - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W065	A57	Orthopaedic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	$57.25	**$66.30**
W072	A42	Geriatrics - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W075	A41	Geriatrics - Consultation - Non-Emergency Long-Term Care In-Patient Service	$114.60	**$142.80**
W085	A66	Plastic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	$57.05	**$66.30**
W095	A28	Cardiovascular & Thoracic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	$60.75	**$66.30**
W102	A11	Family Practice & Practice in General - Type 1 Admission assessment, Long-term care facility	$55.45	**$58.20**
W109	A11	Family Practice & Practice in General - Annual Physical Examination, Long-term care facility	$55.45	**$58.20**
W132	A45	Internal Medicine - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W182	A48	Neurology - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W185	A48	Neurology - Consultation - Non-Emergency Long-Term Care In-Patient Service	$114.60	**$127.50**
W225	A39	Genetics - Consultation - Non-Emergency Long-Term Care In-Patient Service	$114.60	**$142.80**
W232	A45	Internal Medicine - Type 1 Admission assessment, Long-term care facility	$55.45	**$58.20**
W235	A45	Internal Medicine - Consultation - Non-Emergency Long-Term Care In-Patient Service	$114.60	**$127.50**
W237	A45	Internal Medicine - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	$29.40	**$30.70**
W239	A45	Internal Medicine - Annual Physical Examination, Long-term care facility	$55.45	**$58.20**
W262	A62	Paediatrics - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W265	A62	Paediatrics - Consultation - Non-Emergency Long-Term Care In-Patient Service	$114.60	**$142.80**
W269	A62	Paediatrics - Non-Emergency Long-Term Care In-Patient Services - Annual physical examination	$30.40	**$30.70**
W272	A41	Geriatrics - Type 1 Admission assessment, Long-term care facility	$55.45	**$58.20**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS				
W277	A41	Geriatrics - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	$29.40	**$30.70**
W279	A41	Geriatrics - Annual Physical Examination, Long-term care facility	$55.45	**$58.20**
W305	A53	Obstetrics and Gynecology - Consultation - Non-Emergency Long-Term Care In-Patient Services	$58.45	**$81.60**
W312	A64	Physical Medicine - Chronic care visit, first 4 subsequent visits per month	$23.60	**$29.20**
W345	A58	Otolaryngology - Consultation - Non-Emergency Long-Term Care In-Patient Service	$57.25	**$66.30**
W355	A77	Urology - Consultation - Non-Emergency Long-Term Care In-Patient Service	$57.05	**$66.30**
W419	A64	Physical Medicine and Rehab. - Annual Physical Examination, Long-term care facility	$55.45	**$58.20**
W512	A64	Physical Medicine and Rehab. - Type 1 Admission assessment, Long-term care facility	$55.45	**$58.20**
W515	A64	Physical Medicine and Rehabilitation - Consultation - Non-Emergency Long-Term Care In-Patient Service	$114.60	**$127.50**
W517	A64	Physical Medicine & Rehab - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	$29.40	**$30.70**
W535	A55	Ophthalmology - Consultation - Non-Emergency Long-Term Care In-Patient Service	$59.40	**$66.30**
W562	A62	Paediatrics - Type 1 Admission assessment, Long-term care facility	$55.45	**$58.20**
W567	A62	Paediatrics - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	$29.40	**$30.70**
W645	A37	General Thoracic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	$61.05	**$81.60**
W667	A62	Paediatrics - Neurodevelopmental Consultation - Non-Emergency Long-Term Care In-Patient Service	$229.15	**$255.00**
W695	A68	Neurodevelopment - Consultation - Non-Emergency Long-Term Care In-Patient Service	$229.15	**$255.00**
W775	A41	Geriatrics - Comprehensive Geriatric Consultation - Non-Emergency Long-Term Care In-Patient Services	$158.10	**$183.60**
W777	A11	Family Practice & Practice in General - Pronouncement of death - long-term care facility	$28.00	**$29.70**
W795	A68	Psychiatry - Geriatric Consultation - Non-Emergency Long-Term Care In-Patient Service	$171.75	**$183.60**
W872	A12	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Nursing home or home for the aged - Palliative care	$22.55	**$29.20**
W882	A12	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Chronic care or convalescent hospital - Palliative care	$23.60	**$29.20**
W895	A68	Psychiatry - Consultation non-emergency long-term care in-patient services	$136.95	**$178.50**
W903	A11	Family Practice & Practice in General - Pre-operative assessment, long-term care facility	$55.45	**$58.20**
W972	A32, A36, A42, A45, A48, A57, A64	Specialists - Non-Emergency Long-Term Care In-Patient - Nursing home or home for the aged - Palliative care	$22.55	**$29.20**
W982	A32, A36, A42, A45, A48, A57, A62, A64	Specialists - Non-Emergency Long-Term Care In-Patient - Chronic care or convalescent hospital - Palliative care	$23.60	**$29.20**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
J - DIAGNOSTIC AND THERAPEUTIC PROCEDURES				
G198	J4	Patch Test - industrial or occupational (maximum 90 per patient, per year)	$1.91	**$2.39**
G206	J4	Patch Test (maximum of 60 per patient, per year)	$1.91	**$2.39**
G247	J43	Plus hospital visits for each additional visit rendered, to a maximum fee equivalent to 4 visits per day (see General Preamble P61).	$23.60	**$29.20**
G264	J42	Occipital Nerve Block (initial)	$19.85	**$34.10**
G265	J42	Occipital Nerve Block (additional)	$10.00	**$17.10**
G401	J19	Critical Care - Intensive Care Area - 2nd to 10th day	$105.60	**$132.00**
G418	J46	Electroencephalography (EEG) - Professional fee increase	$29.15	**$37.95**
G478	J59	Diagnostic and Therapeutic Procedures - Psychiatry - Electroconvulsive Therapy (ECT) cerebral - single or multiple - in-patient	$55.25	**$62.20**
G479	J59	Diagnostic and Therapeutic Procedures - Psychiatry - Electroconvulsive Therapy (ECT) cerebral - single or multiple - out-patient	$61.00	**$65.25**
G558	J19	Comprehensive Care - 2nd to 10th day	$154.00	**$192.45**
G611	J20	Neonatal Intensive Care - Level B - 2nd day onwards	$76.85	**$105.55**
G621	J20	Neonatal Intensive Care - Level C - 2nd day onwards	$27.80	**$66.70**
K - OBSTETRICS				
E411	K5	Sole Delivery Premium - increase premium to 100% of appropriate delivery codes; maximum number of premiums per physician per year to remain at 25	add 50%	**add 100%**
E502	K5	Obstetrics - VBAC	$29.05	**$51.00**
P003	K4	Obstetrics - Prenatal general assessment	$55.45	**$58.20**
P004	K4	Obstetrics - Prenatal Care - Minor prenatal assessment	$20.40	**$22.45**
P006	K5	Obstetrics - vaginal delivery	$345.75	**$395.75**
P008	K6	Postnatal assessment	$28.00	**$29.70**
P009	K5	Obstetrics - attendance at labour and delivery when assists, gives anaesthetic or resuscitates newborn	$345.75	**$395.75**
P010	K5	Obstetrics - attendance of obstetrical consultant at delivery	$111.20	**$161.20**
P018	K5	Obstetrics - Cesarean section	$414.85	**$464.85**
P020	K5	Obstetrics - operative delivery, rotation or assisted breech	$377.15	**$427.15**
P038	K5	Obstetrics - attendance at labour when patient transferred	$111.20	**$161.20**
P041	K5	Obstetrics - Cesarean section including tubal interruption	$439.95	**$489.95**
P042	K5	Obstetrics - Cesarean section including hysterectomy	$634.35	**$684.35**
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES				
E555	N3	MUSCULOSKELETAL - GENERAL FEES - Fixation - Rigid external fixation (excluding casts) for closed reduction	add 40%	**add 50%**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES				
E556	N3	MUSCULOSKELETAL - GENERAL FEES - Wound Care - Extensive debridement of compound fractures or dislocations	add 40%	**add 50%**
E569	N3	MUSCULOSKELETAL - GENERAL FEES - Fixation - Percutaneous pinning	add 30%	**add 50%**
E580	N9, N15, 50	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Extensor - each additional	$47.30	**$70.95**
E581	N9, N15, N50	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Flexor - each additional	$85.95	**$128.95**
F007	N10	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Phalanx - open	$191.30	**$248.70**
F010	N10	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Intra-articular - open	$215.25	**$279.85**
F011	N10	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Metacarpal - open	$168.35	**$218.85**
F015	N11	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Bennett's - open	$215.25	**$279.85**
F017	N11	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Carpus - open	$221.80	**$288.45**
F019	N11	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Scaphoid - open	$242.25	**$314.95**
F021	N16, N42	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Osteochondral - open	$251.55	**$327.00**
F030	N16, N42	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Radius - Distal - open	$216.30	**$281.15**
R208	N40	Arthroscopic meniscal repair	$240.45	**$336.65**
R486	N12	Complete arthroplasty replacement (equal to R441)	$617.70	**$619.90**
R534	N7	Musculoskeletal - Hand & Wrist - Incision and Drainage - Tendon sheath	$147.60	**$191.85**
R548	N8, N15, N50	Musculoskeletal - Hand & Wrist - Reconstruction - Ligaments - Extensive/multiple repair - wrist	$393.40	**$511.45**
R549	N8, N49	Excision of Ganglion simple or complex	$120.70	**$177.80**
R578	N9, N15, N50	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Extensor - single	$126.25	**$164.10**
R585	N9, N15, N50	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Flexor - single	$236.60	**$307.60**
R597	N8, N15, N50	Musculoskeletal - Hand & Wrist - Reconstruction - Ligaments - Simple/singe repair - wrist	$232.00	**$301.60**
R601	N8	Musculoskeletal - Hand & Wrist - Reconstruction - Ligaments - Metacarpal phalangeal repair	$243.70	**$316.75**
R629	N5	Musculoskeletal - Hand & Wrist - Amputation - Revision of amputated finger tip	$185.80	**$241.55**
P - RESPIRATORY SURGICAL PROCEDURES				
M138	P11	Respiratory - Lungs and Pleura - Excision - Hilar lymph node or lung biopsy - with limited thoracotomy	$410.85	**$534.10**
M142	P11	Respiratory - Lungs and Pleura - Excision - Pneumonectomy with or without radical mediastinal node dissection or pericardial resection	$951.10	**$1,236.45**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
P - RESPIRATORY SURGICAL PROCEDURES				
M143	P11	Respiratory - Lungs and Pleura - Excision - Lobectomy with or without radical mediastinal node dissection	$951.10	**$1,236.45**
M144	P11	Respiratory - Lungs and Pleura - Excision - Segmental resection, including segmental bronchus and artery	$951.10	**$1,236.45**
M145	P11	Respiratory - Lungs and Pleura - Excision - Wedge resection of lung	$430.35	**$559.40**
S - DIGESTIVE SYSTEM SURGICAL PROCEDURES				
S063	S2	Tonsillectomy	$148.60	**$178.35**
S065	S2	Adenoidectomy	$84.35	**$101.25**
S162	S14	Digestive System - Intestines - Excision - Local excision of lesion of intestine	$406.85	**$528.85**
S164	S14	Digestive System - Intestines - Excision - Small intestine - duodenum	$573.90	**$746.10**
S165	S14	Digestive System - Intestines - Excision - Small intestine - Resection with anastomosis - other	$528.85	**$687.55**
S166	S14	Digestive System - Intestines - Excision - Small and large intestine terminal ileum, cecum and ascending colon (right hemicolectomy)	$615.00	**$799.55**
S167	S14	Digestive System - Intestines - Excision - Large intestine - any portion	$615.00	**$799.55**
S168	S14	Digestive System - Intestines - Excision - Ileostomy, subtotal colectomy	$813.60	**$1,057.70**
S169	S14	Digestive System - Intestines - Excision - Total colectomy with ileo-rectal anastomosis	$956.10	**$1,242.90**
S170	S14	Digestive System - Intestines - Excision - Ileostomy, subtotal colectomy	$1,147.80	**$1,492.15**
S171	S14	Digestive System - Intestines - Excision - Left hemicolectomy with anterior resection or proctosigmoidectomy)anastomosis below peritoneal reflection & mobilization of splenic flexure)	$833.05	**$1,082.95**
S172	S14	Digestive System - Intestines - Excision - Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy	$1,729.00	**$2,247.70**
T - UROGENITAL AND URINARY SURGICAL PROCEDURES				
S411	T3	Urogenital and Urinary System - Kidney and Perinephrum - Excision - Partial or heminephrectomy	$536.90	**$697.95**
S416	T3	Urogenital and Urinary System - Kidney and Perinephrum - Excision - Nephrectomy - thoraco - abdominal or radical nephrectomy	$673.10	**$875.00**
S423	T3	Urogenital and Urinary System - Kidney and Perinephrum - Excision - Partial or heminephrectomy with total ureterectomy	$583.00	**$757.85**
U - MALE GENITAL SURGICAL PROCEDURES				
S645	U7	Male Genital - Prostate - Excision - Prostatectomy (not to include investigate cystoscopy) and may include vasectomy Perineal	$442.00	**$574.60**
S646	U7	Male Genital - Prostate - Excision - Prostatectomy (not to include investigate cystoscopy) and may include vasectomy - Perineal with vesiculectomy	$673.10	**$875.00**
S647	U7	Male Genital - Prostate - Excision - Suprapubic - with or without removal of bladder stones - one stage	$462.10	**$600.75**

Fee Code	Page #	Description	Existing Fee April 1, 2004	Increased Fee Oct 1, 2005
U - MALE GENITAL SURGICAL PROCEDURES				
S648	U7	Male Genital - Prostate - Excision - Suprapubic - with or without removal of bladder stones - two stage, 1st stage	$215.80	**$280.50**
S649	U7	Male Genital - Prostate - Excision -Suprapubic - with or without removal of bladder stones - two stages - 2nd stage	$260.85	**$339.15**
S650	U7	Male Genital - Prostate - Excision - Retropubic - with or without removal of bladder stones - radical	$462.10	**$600.75**
S651	U7	Male Genital - Prostate - Excision - Retropubic - with or without removal of bladder stones - simple	$775.65	**$1,008.35**
S652	U7	Male Genital - Prostate - Excision - Staging pelvic lymphadenectomy for prostatic cancer	$331.70	**$431.20**
S653	U7	Male Genital - Prostate - Excision - Laproscopic radical prostatectomy	$1,085.90	**$1,411.70**
S654	U7	Male Genital - Prostate - Endoscopy - Transurethral resection of prostate for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon	$316.30	**$411.20**
V - MALE GENITAL SURGICAL PROCEDURES				
S776	V9	Female Genital - Corpus Uteri - Incision or Excision - Staging pelvic node lymphadenectomy for carcinoma	$331.55	**$431.20**
S781	V9	Female Genital - Corpus Uteri - Incision or Excision - Para-aortic lymph node dissection	$331.55	**$431.20**
X - NEUROLOGICAL SURGICAL PROCEDURES				
E919	X1	Intracranial duroplasty (greater than 2 cm diameter) to any intracranial procedure . . add	$241.00	**$244.80**
Y - ORGANS OF SPECIAL SENSES				
E158	Y6	Strabismus repair - two muscles, one or both eyes	$370.20	**$444.25**
E159	Y6	Strabismus repair - one muscle, one or both eyes	$262.70	**$315.25**
E162	Y6	Strabismus repair - three or more muscles, one or both eyes	$411.20	**$514.05**

CHART 2: New Fee Codes: Schedule of Benefits changes effective October 1, 2005

Note: This chart represents new fee codes only

The Bulletin is being provided as a reference guide only to assist in identifying the October 1, 2005 Schedule of Benefits changes. For complete information, service descriptions, and billing information, please refer to the October 2005 edition of the Schedule of Benefits for Physician Services and subsequent amendment pages. Physicians should carefully review these fee code changes in the context of the Schedule of Benefits (including the General Preamble and any other associated Preambles).

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
GENERAL PREAMBLE					
E078	**A27, A29, A34, A40, A43-A44, A46-A47, A59, A63, A73-A75**	Medical Specific Assessment, Medical Specific Re-Assessment, Complex Medical Specific Re-Assessment and Partial Assessment (Restricted to Specialty 07, 13, 18, 26, 28, 31, 34, 41, 47, 48, 60, 61, 62 and restricted to specified Diagnostic Codes 402, 428, 714, 720, 710, 250, 585, 491, 492, 493, 286, 287, 555, 556, 571, 345, 332, 340, 290, 042, 043, 044, 343, 515, 758 and new code for other seronegative spondyloarthropathies)	add 30%		
E676B	**GP57**	Morbidly obese patient - surgical assistant	$62.55		
E020C	**SP6**	Anaesthesia ASA Emergency patient premium (applicable to ASA III, IV and V patients)	4 units		$48.04
A - CONSULTATIONS AND VISITS					
A215	**A25**	Limited consultation for pain management	$46.20		
A835	**A50**	Special Nuclear Medicine Consultation	$127.50		
A920	**K4**	Medical Management of Early Pregnancy, initial visit	$95.65		
A921	**K4**	Medical Management of Early Pregnancy, subsequent visit	$29.70		
B998	**GP48**	Family Practice and Practice in General - Special Visit to Home of Palliative Care Patient	$63.80		
C122	**A7, A26-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76**	Most Responsible Physician - Day 2	$46.15		
C123	**A7, A26-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76**	Most Responsible Physician - Day 3	$46.15		

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
A - CONSULTATIONS AND VISITS					
C124	**A7, A26-A29, A31, A34-A35, A37, A41, A43-A44, A47, A49, A52, A55-A56, A58, A61, A63, A66, A68, A73-A76**	Most Responsible Physician - Day of Discharge	$46.15		
C835	**A51**	Special Nuclear Medicine Consultation	$127.50		
E070	**A1-A1, A7, A11**	Family Practice & Practice in General - 15% premium for A003, C003, W102, W109, A903, C903, W903 for patients aged 70 or older	add 15%		
E071	**A3**	Family Practice & Practice in General - 15% premium for A007 for patients aged 70 or older	add 15%		
K019	**A14**	GP Psychotherapy Premium - 2 people	$25.85		
K020	**A14**	GP Psychotherapy Premium - 3 people	$17.25		
K099		GP Psychotherapy Premium	add 5%		
K120	**A60**	Paediatric Adolescent Psychotherapy	$62.20		
K121	**A18**	Patient Case Conference	$51.70		
K208	**A70**	Group psychotherapy - out-patient - 2 people	$31.10		
K209	**A70**	Group psychotherapy - out-patient - 3 people	$20.70		
K210		Group psychotherapy - in-patient - 2 people	$31.10		
K211	**A70**	Group psychotherapy - in-patient - 3 people	$20.70		
B - NUCLEAR MEDICINE - IN VIVO					
J476	**G7**	Transvaginal Sonohysterography - add on code for use of Echovist contrast media for demonstration of tubal patency	H-$238.85 P1-$75.70		
J619	**B9**	SPECT - permit up to three claims with Gallium scans	H-$44.60 P2-$13.40		
J663B	**B12**	Implement technical fee for scintimammography	H-$102.50		
J819		SPECT - permit up to three claims with Gallium scans	H-$44.60 P1-$26.70		
J863B	**B12**	Implement technical fee for scintimammography	H-$102.50		
D - DIAGNOSTIC RADIOLOGY					
X417C	**D17**	Three dimensional CT acquisition sequencing	$64.00		$64.00
J - DIAGNOSTIC AND THERAPEUTIC PROCEDURES					
G500	**J28**	Insulin Supervision - for patients on >= 3 multiple daily injections or insulin pump	$10.60		
G900	**J60**	Residual Urine Measurement	$12.70		

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
SURGICAL PREAMBLE					
E420	**GP62**	Trauma Premium - Within 24 hours of admission (includes consults, surgery, anaesthesia, assistant fees) diagnostic and lab service excluded.	add 50%		
M - INTEGUMENTORY SYSTEM SURGICAL PROCEDURES					
R690	**M7**	Skin Allograft Procurement	$17.25	$72.80	$84.07
Z143	**M17**	Large core breast biopsy	$107.05		
P - RESPIRATORY SURGICAL PROCDURES					
E642	**P2**	External approach to septoplasty , septorhinoplasty or partial septorhinoplasty (applicable to M012, M013 and M014)	$119.20		
E644	**P11**	Radical mediastinal node dissection, following preoperative chemotherapy and/or radiotherapy	$207.45		
M156	**P11**	Repeat lung transplant	$2,670.55	24	33
Z313	**P3**	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis, unilateral	$123.70		
Q - CARDIOVASCULAR SURGICAL PROCEDURES					
E682	**Q2**	Axillary artery graft for cardiopulmonary bypass	$423.85		
R709	**Q4**	Atrial ablative procedure for surgical treatment of atrial arrhythmia	$741.55	18	20
R773	**Q7**	Mitral Valve Reconstruction - Complex	$2,021.05	18	28
R774	**Q7**	Mitral Valve Reconstruction - Simple	$1,618.50	18	28
R875	**Q10**	Endovascular aortic stent (all-inclusive code)	$1,330.40	10	17
R876	**Q7**	Valve sparing aortic root replacement or remodeling	$2,021.05	18	28
Z465	**Q5**	Percutaneous transluminal catheter assisted closure - single defect	$198.55		
Z466	**Q5**	Percutaneous transluminal catheter assisted closure - multiple defect	$347.45		
S - DIGESTIVE SYSTEM SURGICAL PROCEDURES					
E793	**R1, S7, S14, W2**	Laparoscopic or laparoscopic assisted procedures (S166, S167, S169, S171, R905, S798, S799, S800, S091, S092)	add 25%		
E794	**S22**	Intra-operative cholangiogram (applicable to S287)	$35.85		
E796	**S14**	Mobilization of splenic flexure during bowel resection applicable to S167)	$102.40		
Z532	**S9**	Percutaneous endoscopic gastrostomy - revise to a Z-code and increase fee relative to 1/2 of S118	$172.95		
T- UROGENITAL AND URINARY SURGICAL PROCEDURES					
E792	**T3-T4**	Laparoscopic to S411, S413, S416, and S436 Nephrectomies	add 25%		
E819	**T5**	Diagnostic ureteroscopy of second ureter	$54.65		
E822	**T5**	Removal of calculus, upper 1/3 of ureter or renal pelvis	$37.70		
E823	**T5**	Resection and fulguriz ation of ureteral or renal pelvic turmors (applicable to Z628) may be billed in combination with E760 and E761	$233.65		
Z608	**T9**	Manual catheter declotting and irrigation of bladder	$58.65		

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
X - NEUROLOGICAL SURGICAL PROCEDURES					
E979	**X1**	Clinoidal drilling for complex aneurysm (applies to N105 and N154)	$215.50		
Y - OCULAR AND AURAL SURGICAL PROCEDURES					
E318	**Y12**	Incision and drainage of extensive haematoma or pinna ***with packing of ear and external compression dressing*** under local anaesthesia	$92.40		
E982	**Y12**	Eye examination under general anaes <16 yrs old. (Add 30% to Z850 only)	add 30%		
E983	**Y3**	Following previous glaucoma filtering procedure	add 25%		
Z - SPINAL					
E360	**Z3-Z4**	Each additional level decompressed, to N500 or N501 add	$306.00		
E361	**Z7, Z17**	Each additional level decompressed including disc excision - unilateral or bilateral, to N509 or N510 add	$255.00		
E362	**Z3-Z4, Z6, Z11**	Combined thoracotomy/laparotomy, to N502 or N503 add	$153.00		
E363	**Z5**	One disc level, to N500 or N501 add	$357.00		
E364	**Z5, Z8, Z10**	Each additional disc level fused, to E365 add	$102.00		
E365	**Z5**	One disc level, to N502, N503, N504, N505, N506, N507, N508 or N579 add	$765.00		
E366	**Z5-Z6, Z8-Z10**	Each additional disc level fused, to E365 add	$153.00		
E367	**Z5**	One disc level, to N502, N503, N504, N505, N506, N507, N508, or N579 add	$255.00		
E368	**Z7, Z17**	First disc excision, to N509, N510 or N520 add	$306.00		
E369	**Z8**	One disc level, to N509, N510, N520, N511 or N512 add	$255.00		
E370	**Z8-Z9**	One disc level – below C2, to N509, N510, N572, N574, N575 or N576 add	$867.00		
E371	**Z8, Z10**	Fusion to occiput, to E384 add	$816.00		
E372	**Z9**	One disc level, to N511, N512 or N513 add	$510.00		
E373	**Z14**	For repeat decompression add	Add 30%		
E374	**Z7, Z17**	Foramen magnum decompression <3cm as part of cervical decompression, to N510 add	$357.00		
E375	**Z14**	For repeat fusion add	Add 30%		
E376	**Z9**	Each additional disc level stabilized, to E372 add	$255.00		
E377	**Z8, Z10**	Cervico-thoracic junction, to N509, N510, E370, N572 or N574 add	$255.00		
E378	**Z8, Z10-Z11, Z13**	3D stereotactic spinal procedure, add	$1,020.00		
E379	**Z8, Z10-Z11, Z13**	2D stereotactic spinal procedure, add	$510.00		
E380	**Z7, Z17**	Each additional level – laminoplasty (includes fixation of lamina), to N520 add	$357.00		
E381	**X1, X3, X5, Z3, Z5, Z7, Z10-Z13, Z16-Z18**	Intra-operative, diagnostic or physiological neuro monitoring, add	$179.30		
E382	**Z3, Z7, Z12, Z17-18**	Spinal duroplasty using autologous/allogenic/synthetic tissue add	$244.80		

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
Z - SPINAL					
E383	**Z3, Z7, Z11-Z13, Z16-Z17**	Acute spinal cord injury premium, add	$255.00		
E384	**Z8**	C1/C2 screw fixation (transarticular, pedicle, lateral mass), to N509 or N510 add	$1,020.00		
E385	**Z7, Z17**	Each additional level of percutaneous discotomy, to N571 add	$71.40		
E386	**Z12**	Extradural decompression – spinal cord or cauda equina - tumour or infection	Add 40%		
E387	**Z9-Z10, Z13**	Fusion to sacrum, to N511, N512, N575, N576 add	$153.00		
E388	**Z11**	Vertebroplasty combined with any other procedure, first level, add	$204.00		
E389	**Z13**	Each additional level of scoliosis correction over six levels, to N540 add	$102.00		
E390	**Z13**	Halo fixation/traction – pre or perioperative, to N539 or N540 add	$255.00		
E391	**Z11**	Vertebroplasty, each additional level, to N580 or E388 add	$204.00		
E392	**Z11**	Kyphoplasty combined with any other procedure, first level add	$510.00		
E393	**Z11**	Kyphoplasty, each additional level, to N583 or E392 add	$510.00		
E394	**Z5**	Each additional level replaced, to N526 or N525 add	$765.00		
E395	**Z11**	Open reduction, additional level, spine fracture dislocation, anterior/posterior	$306.00		
E396	**Z16**	Each additional level (uni/bilateral), to N556 add	$71.40		
F200	**Z11**	No reduction, brace (includes Halo orthosis), total care by operating surgeon	$178.50		
F201	**Z11**	Closed reduction, fracture/dislocation (Halo or caliper traction)	$280.50	5	5
N500	**Z3**	Disc excision (one level)	$918.00	9	10
N501	**Z3**	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	$1,020.00	9	11
N502	**Z3**	Disc excision (one level)	$1,530.00	11	15
N503	**Z3**	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	$1,836.00	12	17
N504	**Z3**	Disc excision (one level)	$1,122.00	11	15
N505	**Z3**	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	$1,428.00	12	17
N506	**Z4**	Disc excision (one level)	$1,224.00	9	13
N507	**Z4**	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	$1,734.00	10	15
N508	**Z4**	Disc excision (one level)	$918.00	9	13
N509	**Z7**	One level - unilateral	$1,004.70	9	12
N510	**Z7**	One level – bilateral	$1,208.70	9	12

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
Z - SPINAL					
N511	**Z7**	One level - unilateral	$800.70	8	9
N512	**Z7**	One level – bilateral	$1,004.70	8	9
N513	**Z8-Z9**	One disc level – below C2	$867.00		
N514	**Z10**	One disc level – below C2	$408.00	7	10
N515	**Z10**	One disc level - below C2	$1,020.00	9	11
N516	**Z6**	One disc level	$510.00	7	10
N517	**Z6**	One disc level	$1,224.00	9	13
N518	**Z6**	One disc level	$765.00	9	13
N519	**Z10**	C1/C2 fusion using graft/posterior wires	$612.00	8	10
N520	**Z7**	One level - laminoplasty (includes fixation of lamina)	$1,514.70	9	14
N521	**Z7**	Re-opening of laminectomy for post-op haematoma/infection	$357.00	7	8
N522	**Z7**	Re-opening of laminectomy for repair of CSF leak	$535.50	7	8
N523	**Z16**	AV malformation of cord – excision/obliteration	$1,530.00	10	13
N524	**Z7**	One level – bilateral canal enlargement – unilateral approach	$1,208.70	9	12
N525	**Z5**	Artificial disc insertion (approach by separate surgeon)	$1,734.00	10	15
N526	**Z5**	Artificial disc insertion (includes approach)	$2,040.00	11	17
N527	**Z16**	Percutaneous cordotomy or tractotomy	$469.20	6	8
N528	**Z8**	C1/C2 screw fixation (transarticular, pedicle, lateral mass)	$1,020.00		
N529	**Z16**	Medullary spinal trigeminal tractotomy	$1,020.00	10	15
N530	**Z16**	Implantation of spinal cord stimulating electrode by laminectomy	$816.00	8	10
N531	**Z16**	Removal of any stimulation pack or electrode	$306.00	6	6
N532	**Z10**	C1/C2 screw fixation (transarticular, pedicle, lateral mass)	$1,224.00	9	11
N533	**Z10**	Pars reconstruction for spondylolysis	$1,020.00	9	11
N534	**Z16**	Percutaneous radio frequency posterior rhizotomy – any number of levels	$306.00		8
N535	**Z18**	Repair of meningocoele	$510.00	7	9
N536	**Z18**	Repair of myelomeningocoele (one surgeon)	$765.00	7	9
N537	**Z18**	Repair of myelomeningocoele (two surgeons) neurosurgeon	$510.00		9
N538	**Z18**	Repair of myelomeningocoele (two surgeons) reconstructive surgeon	$510.00		
N539	**Z13**	Anterior scoliosis correction – any number of levels (includes approach, disc excision and instrumentation)	$3,060.00	12	18
N540	**Z13**	Posterior scoliosis correction – up to six levels (includes approach, disc excision and instrumentation)	$2,805.00	11	17
N541	**Z14**	Removal of posterior instrumentation	$255.00	8	8
N542	**Z17**	Sympathectomy – unilateral, cervical	$357.00	6	6
N543	**Z17**	Sympathectomy – unilateral, cervico-dorsal	$586.50	10	10

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
Z - SPINAL					
N544	**Z17**	Sympathectomy – unilateral, thoracic approach	$433.50	9	13
N545	**Z17**	Sympathectomy – unilateral, lumbar	$295.80	6	6
N546	**Z15**	Open vertebral biopsy – posterior approach – sole procedure	$244.80	4	7
N547	**Z15**	Open vertebral biopsy – anterior approach – sole procedure	$306.00	6	8
N548	**Z12**	Spinal osteomyelitis – incision and drainage only, posterior approach	$102.00	4	5
N549	**Z12**	Spinal osteomyelitis – incision and drainage including sequestrectomy anterior approach	$632.40	7	10
N550	**Z12**	Spinal osteomyelitis – sequestrectomy posterior approach	$357.00	4	5
N551	**Z15**	Excision spinous process – sole procedure	$229.50	4	5
N552	**Z15**	Excision transverse process – sole procedure	$382.50	6	8
N553	**Z12**	Simple soft tissue tumour excision <5cm	$204.00	6	8
N554	**Z12**	Radical soft tissue tumour excision >5cm	$484.50	9	13
N555	**Z16**	Insertion / revision of implantable infusion pump	$510.00		8
N556	**Z16**	Percutaneous vertebral facet denervation – one level (uni/bilateral)	$142.80		5
N557	**Z17**	Syringo-subarachnoid shunt	$1,224.00	8	12
N558	**Z17**	Syringopleural/syringoperitoneal shunt	$1,428.00	9	13
N559	**Z6**	One disc level	$1,122.00	7	10
N560	**Z12**	Intradural extramedullary spinal tumour – partial or total removal	$1,530.00	8	10
N561	**Z12**	Intradural intramedullary spinal tumour – partial or total removal	$1,734.00	9	12
N562	**Z17**	Intradural neurolysis of unusual lesions e.g. diastematomyelia, tethered conus, intramedullary haematoma, etc. including laminectomy	$1,224.00	8	12
N563	**Z16**	Implantation of permanent subcutaneous reservoir including laminectomy	$510.00	11	11
N564	**Z16**	Open myelotomy for lesion – unilateral or bilateral	$1,020.00	8	10
N565	**Z18**	Repair of lipomeningocoele including release of tethered cord	$1,020.00	8	10
N566	**Z18**	Repair of anterior sacral meningocoele including release of tethered cord	$1,020.00	8	10
N567	**Z18**	Repair of intraspinal meningocoele	$1,020.00	8	10
N568	**Z14**	Removal of anterior instrumentation	$306.00	8	8
N569	**Z3**	Anterior cervical decompression by intra-oral approach	$1,442.95	15	15
N570	**Z11**	Vertebroplasty (injection of bone cement) as sole procedure, first level	$459.00	7	9
N571	**Z7**	Percutaneous discotomy	$255.00	6	8
N572	**Z11**	Open reduction, any single level, spine fracture/dislocation, anterior/posterior	$1,020.00	8	11

Fee Code	Page #	Description	New Fee Oct 1, 2005	Assist Fee Oct 1, 2005	Anae Fee Oct 1, 2005
Z - SPINAL					
N573	**Z11**	Anterior odontoid screw fixation	$1,020.00	8	11
N574	**Z7**	Above cord and conus (includes partial rib resection) – each level	$1,020.00	9	13
N575	**Z7**	Below conus – each level	$765.00	9	9
N576	**Z7**	Smith Peterson Osteotomy – each level	$255.00	9	9
N577	**Z17**	Intradural rhizotomy anterior/posterior (uni/bilateral) - any number of roots	$714.00	8	10
N578	**Z17**	Dorsal root entry zone lesions for pain relief – any number of levels	$1,020.00	8	10
N579	**Z4**	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	$1,428.00	10	15
N580	**Z6**	One disc level	$765.00	7	10
N581	**Z10**	One disc level	$408.00	7	10
N582	**Z10**	One disc level	$1,020.00	9	11
N583	**Z11**	Kyphoplasty (balloon tamp and injection of bone cement) as sole procedure, first level	$969.00	8	11
Z940	**Z15**	Vertebral needle biopsy (IOP)	$142.80	4	
Z941	**Z15**	Percutaneous diagnostic stimulation of spinal cord, trigeminal nerve root and / or ganglion (IOP)	$331.50	6	8
Z942	**Z16**	Implantation or revision of stimulation pack or leads (IOP)	$306.00	6	8
Z943	**Z16**	Programming infusion pump or dorsal column stimulator (IOP)	$102.00		
Z944	**Z16**	Lumbar sub-arachnoid drainage of CSF (chronic) (IOP)	$81.60		

CHART 3: Revised Fee Codes: Schedule of Benefits changes effective October 1, 2005

Note: This chart represents revised fee codes only

The Bulletin is being provided as a reference guide only to assist in identifying the October 1, 2005 Schedule of Benefits changes. For complete information, service descriptions, and billing information, please refer to the October 2005 edition of the Schedule of Benefits for Physician Services and subsequent amendment pages. Physicians should carefully review these fee code changes in the context of the Schedule of Benefits (including the General Preamble and any other associated Preambles).

Fee Code	Page #	Previous Description	Revised Description/Wording
GENERAL PREAMBLE			
Partial Assessment	GP21	Requires a history of the presenting complaint and an appropriate physical examination. It is also the service rendered for the purpose of subsequent visits for assessing the response to treatment and/or advice provided in a previous service.	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
Medical Specific re-assessment	GP20	Is a service rendered by a specialist and:	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A074	GP20	Geriatrics - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A078	GP21	Geriatrics - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A084	GP21	Plastic Surgery - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A094	GP21	Cardiovascular and Thoracic Surgery - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A134	GP20	Internal Medicine - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A138	GP21	Internal Medicine - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A184	GP20	Neurology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A188	GP21	Neurology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A194	GP21	Psychiatry - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A204	GP21	Obstetrics & Gynecology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.

Fee Code	Page #	Previous Description	Revised Description/Wording
GENERAL PREAMBLE			
A234	GP21	Ophthalmology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A244	GP21	Otolaryngology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A264	GP20	Paediatrics - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A284	GP21	Laboratory Medicine - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A310	GP20	Physical Medicine - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A318	GP21	Physical Medicine & Rehab - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A340	GP20	Radiation Oncology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A348	GP21	Radiation Oncology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A354	GP21	Urology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A414	GP20	Gastroenterology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A418	GP21	Gastroenterology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A474	GP20	Respiratory Disease - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A478	GP21	Respiratory Disease - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A484	GP20	Rheumatology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A488	GP21	Rheumatology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A604	GP20	Cardiology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.

Fee Code	Page #	Previous Description	Revised Description/Wording
GENERAL PREAMBLE			
A608	GP21	Cardiology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A614	GP20	Hematology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A618	GP21	Haemotology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A624	GP20	Clinical Immunology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
A628	GP21	Clinical Immunology - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A638	GP21	Nuclear Medicine - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A644	GP21	General Thoracic Surgery - Partial Assessment redefinition	A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and an appropriate record.
A990	GP48	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
A994	GP48	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
B990	GP48	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
B994	GP48	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
C014	GP20	Anaesthesia - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C024	GP20	Dermatology - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C034	GP20	General Surgery - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C044	GP20	Neurosurgery - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C064	GP20	Orthopaedic Surgery - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C074	GP20	Geriatrics - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.

Fee Code	Page #	Previous Description	Revised Description/Wording
GENERAL PREAMBLE			
C084	GP20	Plastic Surgery - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C094	A28	Cardiovascular & Thoracic - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C109	GP60	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
C134	GP20	Internal Medicine - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C184	GP20	Neurology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C194	GP20	Psychiatry - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C204	GP20	Obstetrics & Gynecology - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C234	GP20	Ophthalmology - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C244	GP20	Otolaryngology - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C264	GP20	Paediatrics - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C314	GP20	Physical Medicine - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C344	GP20	Radiation Oncology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C354	GP20	Urology - Specific re-assessment (remove comprehensivie)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C414	GP20	Gastroenterology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.

Fee Code	Page #	Previous Description	Revised Description/Wording
GENERAL PREAMBLE			
C474	GP20	Respiratory Disease - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C484	GP20	Rheumatology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C604	GP20	Cardiology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C614	GP20	Hematology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C624	GP20	Clinical Immunology - Medical Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C644	GP20	General Thoracic Surgery - Specific re-assessment (remove comprehensive)	Specific Re-Assessment and Medical Specific Re-Assessment are services rendered by *specialists* and require a full, relevant history and physical examination of one or more systems.
C990	GP47	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
C991	GP47	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
C994	GP47	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
C995	GP47	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
C998B	GP53	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
C998C	GP55	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
E402	GP61	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
G117	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G118	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G119	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G262	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G263	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G297	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G298	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
G509	GP60	Add to Major Invasive Procedures list	Added to After Hours Procedure Premium
K990	GP46	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
K991	GP46	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
K994	GP46	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
K995	GP46	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h

Fee Code	Page #	Previous Description	Revised Description/Wording
GENERAL PREAMBLE			
Q990	GP48	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
Q994	GP48	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
U990	GP48	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
U991	GP47	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
U994	GP47	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
U995	GP47	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
W990	GP48	Special Visits Premium - change weekday end time to 5:00pm	Weekday end time changed to 17:00h
W994	GP48	Special Visits Premium - change weekday start time to 5:00pm	Weekday start time changed to 17:00h
A - CONSULTATIONS AND VISITS			
A003	GP18	General Assessment	General Assessment - exclude breast, *genital* or rectal as constituent elements of exam
A775	A40	Comprehensive geriatric care - Every 2 years	Payment rules: Consultation must be scheduled at least one day before service is rendered. Comprehensive geriatric consultation is only eligible for payment if this service has not been rendered on the same patient by the same consultant within the previous 2 years.
A945	A1	Family Practice & Practice in General - Special palliative care consultation Revision - Allow K023 after 50 minutes.	Start and stop time to be recorded in patient's file. Allow K023 after 50 minutes.
C775	A40	Comprehensive geriatric care -	Subject to the same conditions as A775 - every 2 years.
C882/C982	GP35	Palliative Care Assessment -	Redefine Palliative Care - see General Preamble
C945	A1	Family Practice & Practice in General - Special palliative care consultation	Allow K023 after 50 minutes
H001	A8	Newborn Hospital Care -	1) to require only 1 visit for payment purposes; and 2) revise definition of special visit premiums to allow with "routine care" under specific circumstances i.e. facilitating discharge of newborn from hospital outside of physician
H101	A10	Emergency Department - Physician on Duty - Minor assessment - weekday end time 18:00h	Weekday end time changed to 17:00h
H102	A10	Emergency Department - Physician on Duty - Comprehensive assessment - weekday end time 18:00h	Weekday end time changed to 17:00h
H103	A10	Emergency Department - Physician on Duty - Multiple systems assessment - weekday end time 18:00h	Weekday end time changed to 17:00h
H104	A10	Emergency Department - Physician on Duty - Re-assessment - weekday end time 18:00h	Weekday end time changed to 17:00h
H131	A10	Emergency Department - Physician on Duty - Minor assessment - weekday start time 17:00h	Weekday start time changed to 17:00h
H132	A10	Emergency Department - Physician on Duty - Comprehensive assessment - change weekday start time to 17:00h	Weekday start time changed to 17:00h
H133	A10	Emergency Department - Physician on Duty - Multiple systems assessment - weekday start time to 18:00h	Weekday start time changed to 17:00h
H134	A10	Emergency Department - Physician on Duty - Re-assessment - weekday start time 18:00h	Weekday start time changed to 17:00h

Fee Code	Page #	Previous Description	Revised Description/Wording
A - CONSULTATIONS AND VISITS			
K028	A20	Sexually Transmitted Disease (STD) - Maximum one unit per patient per day up to two units per patient per physician per year	Definition to include blood borne disease and increase limit to 2 per patient per physician per day with a maximum of 4 per patient per physician per year
K032	A20	Family Practice & Practice in General - Specific Neurocognitive Assessment - Diagnosis of Dementia	
K032	A22	Specific Neurocognitive Assessment -	A Specific Neurocognitive Assessment is an assessment of neurocognitive function rendered personally by the physician where all of the following requirements are met: a. Tests of memory, attention, language, visuospatial function and executive function. b. A minimum of 20 minutes (consecutive or non consecutive) must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and c. The start and stop time(s) of the assessment must be recorded in the patient's medical record.
W775	A41	Comprehensive geriatric care -	permitted every 2 years
B - NUCLEAR MEDICINE - IN VIVO			
J866/J666	B4, B11	Revision to J866/J666 to incorporate change below	Application of Tomography (SPECT), other than to J808/J608 or J852/J652
H - PULMONARY FUNCTION STUDIES			
J315	H4	Stage I - Graded exercise to maximum tolerance (exercisemust include continuous heart rate, oximetry and ventilation at rest and at each workload)	Not eligible for payment when rendered with J323, J332
J316	H4	Oximetry included	Not eligible for payment when rendered with J323, J332
J323	H4	Oximetry - not claimed with J332, J315, J316 or overnight sleep studies	Oximetry - not claimed with J332, J315, J316 or overnight sleep studies
J - DIAGNOSTIC AND THERAPEUTIC PROCEDURES			
G185	J4	Drug(s) desensitisation - hospital sector	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 dirct and ongoing physician attendance.
G208	J4	Serial oral and parental provocation testing -	limit one baseline pulmonary function tests
G216	J42	Lumbar epidural block	Lumbar epidural or caudal epidural block
G369	J31	Multiple B.C.G. innoculations used for treatment of carcinoma are considered experimental	Note: G370, G371 is not eligible for payment in addition to surgical benefits w hen performed at time of surgery
G424	J48	Contact lens fitting	children < 4yrs old not subject to 3 month wait on visits
G460/G461	J51	Ocular Photodynamic Therapy -	additional criteria Presumed Ocular Histoplasmosis Syndrome
G601	J20	Neonatal Intensive Care - Level A - 2nd to 10th days (inclusive)	Neonatal Intensive Care - Level A - 2nd to 30th day
G602	J20	Neonatal Intensive Care - Level A - 11th day onwards	Neonatal Intensive Care - Level A - 31st day onwards
G60x	J20	Neonatal Intensive Care - Revise description invasive or non-invasive	Full life support including monitoring **(either invasive or non-invasive)** ventilatory support and parenteral alimentation (all modalities)
G61x	J20	Neonatal Intensive Care - Revise description invasive or non-invasive	Intensive Care **including monitoring (invasive or non-invasive)**, oxygen administration and intravenous therapy, but without ventilatory support.
G62x	J20	Neonatal Intensive Care - Revise description invasive or non-invasive	Intermediate care i**ncluding one or more** of oxygen, administration, non-invasive monitoring **or** gavage feeding
G650	J13	Continuous ECG Monitoring - Holter Level 1 12-47 hours	Continuous ECG Monitoring - Holter Level 1 redefinition 12-35 hours
G651	J13	Continuous ECG Monitoring - Holter Level 1 12-47 hours (technical)	Continuous ECG Monitoring - Holter Level 1 redefinition 12-35 hours (technical)

Fee Code	Page #	Previous Description	Revised Description/Wording
J - DIAGNOSTIC AND THERAPEUTIC PROCEDURES			
G652	J13	Continuous ECG Monitoring - Holter Level 1 12-47 hours (technical)	Continuous ECG Monitoring - Holter Level 1 redefinition 12-35 hours (technical)
G653	J13	Continuous ECG Monitoring - Holter Level 2 12-47 hours	Continuous ECG Monitoring - Holter Level 2 redefinition 12-35 hours
G654	J13	Continuous ECG Monitoring - Holter Level 2 12-47 hours (technical)	Continuous ECG Monitoring - Holter Level 2 redefinition 12-35 hours (technical)
G655	J13	Continuous ECG Monitoring - Holter Level 2 12-47 hours (technical)	Continuous ECG Monitoring - Holter Level 2 redefinition 12-35 hours (technical)
G656	J13	Continuous ECG Monitoring - Holter Level 2 48-71 hours	Continuous ECG Monitoring - Holter Level 2 redefinition 36-59 hours
G657	J13	Continuous ECG Monitoring - Holter Level 2 72 hours to 13 days	Continuous ECG Monitoring - Holter Level 2 redefinition 60 hours to 13 days
G658	J13	Continuous ECG Monitoring - Holter Level 1 48-71 hours	Continuous ECG Monitoring - Holter Level 1 redefinition 36-59 hours
G659	J13	Continuous ECG Monitoring - Holter Level 1 72 or more hours	Continuous ECG Monitoring - Holter Level 1 redefinition 60 or more hours
G682	J13	Continuous ECG Monitoring - Holter Level 1 48-71 hours (technical)	Continuous ECG Monitoring - Holter Level 1 redefinition 36-59 hours (technical)
G683	J13	Continuous ECG Monitoring - Holter Level 1 48-71 hours (technical)	Continuous ECG Monitoring - Holter Level 1 redefinition 36-59 hours (technical)
G684	J13	Continuous ECG Monitoring - Holter Level 1 72 or more hours (technical)	Continuous ECG Monitoring - Holter Level 1 redefinition 60 or more hours (technical)
G685	J13	Continuous ECG Monitoring - Holter Level 1 72 or more hours (technical)	Continuous ECG Monitoring - Holter Level 1 redefinition 60 or more hours (technical)
G686	J13	Continuous ECG Monitoring - Holter Level 2 48 to 71 hours (technical)	Continuous ECG Monitoring - Holter Level 2 redefinition 36-59 hours (technical)
G687	J13	Continuous ECG Monitoring - Holter Level 2 48 to 71 hours (technical)	Continuous ECG Monitoring - Holter Level 2 redefinition 36-59 hours (technical)
G688	J13	Continuous ECG Monitoring - Holter Level 2 72 hours to 13 days (technical)	Continuous ECG Monitoring - Holter Level 2 redefinition 60 hours to 13 days (technical)
G689	J13	Continuous ECG Monitoring - Holter Level 2 72 hours to 13 days (technical)	Continuous ECG Monitoring - Holter Level 2 redefinition 60 hours to 13 days (technical)
ICU	J19	Step down from comprehensive care to critical or ventilatory care starts as second day	Step down from comprehensive care to critical or ventilatory care starts as second day
R codes	J1	All R and Z codes in section J are subject to rules found in surgical preamble	All R and Z codes in section J are subject to rules found in surgical preamble
Z403	J38, R1	Bone marrow aspiration	Amend wording - payable with Z408 if multiple sites
Z457	J7	Surgical removal of Hickman or Broviac catheter	Surgical removal of Hickman or Broviac catheter revised to read ***Surgical removal or repair of implanted central venous catheter***
K - OBSTETRICS			
Obst.	K1	Surgical procedures rules apply to Obstetrical procedures	
P020	K5	Operative delivery - extraction ***by any method***	Operative delivery - extraction ***by any method***
SURGICAL PREAMBLE			
Surgical Preamble	SP3	Trauma Second Surgeon - Revision to Surgical Preamble to allow second surgeon to bill as first surgeon.	Trauma Second Surgeon - Revision to Surgical Preamble to allow second surgeon to bill as first surgeon.
Surgical Preamble	SP4	Surgical Preamble revision - to incorporate claims for post-operative visits	Surgical Preamble revision - to incorporate claims for post-operative visits

Fee Code	Page #	Previous Description	Revised Description/Wording
P - RESPIRATORY SURGICAL PROCEDURES			
M142	P11	Pneumonectomy - with or without radical mediastinal node dissection or pericardial resection requiring repair	Pneumonectomy, may include radical mediastinal node dissection, sampling or pericardial resection requiring repair
M143	P11	Lobectomy with or without radical mediastinal node dissection	Lobectomy, may include radical mediastinal node or sampling
Z299	P1	Fiberoptic endoscopy of upper airway with rigid endoscope	Fiberoptic endoscopy with rigid endoscope for diagnostic evaluation or to facilitate biopsy or surgical treatment of pathology in the posterior nasal cavity, hypopharynx or larynx
R - HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES			
Z408	R1	Bone marrow core biopsy (with biopsy needle)	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.
S - DIGESTIVE SYSTEM SURGICAL PROCEDURES			
S066	S2	Adenoidectomy Secondary suture or cauterization 24 hours following T and A .	Secondary suture or cauterization following T and A
EUS	S5	Move codes and re-title section	new heading Esophagus Ultra Sound move and
T - UROGENITAL AND URINARY SURGICAL PROCEDURES			
E761	T5	If disintegrated by any method	If disintegrated by ultrasound - change to ***intracorporeal lithotripsy by any method***
Z615	T12	Filiform and Follower Urethral Dilation under general anaesthetic, and may include bladder catheterization	Filiform and Follower Urethral Dilation - remove wording *under general anaesthetic, and may include bladder catheterization*
U - MALE GENITAL SURGICAL PROCEDURES			
S577	U1	Circumcision - for infants less than one year of age. Prior approval required	For infants less than one year of age Note: 1. Circumcision is an insured service only when medically necessary. As such, circumcision performed for ritual, cultural, religious or cosmetic reasons at any age is not an insured service. 2. Circumcision for neonatal phimosis is not an insured service.
V- FEMALE GENITAL SURGICAL PROCEDURES			
S772	V8	Endometrial Ablation ***by any method***	Endometrial Ablation ***by any method***
S772/S773	V8	Revision ***Note: Hysteroscopy codes Z582 or Z583 are not to be claimed in conj unction with S772 and S773.***	Revision ***Note: Hysteroscopy codes Z582 or Z583 are not to be claimed in conjunction with S772 and S773.***
S773	V8	Endometrial Ablation within one year of previous ablation by same surgeon	Endometrial Ablation ***by any method*** within one year of previous ablation by same surgeon
X - NEUROLOGICAL SURGICAL PROCEDURES			
Heading	X1	Heading above N105 and N154 Intracranial Aneurysm Repair	Revise heading Intracranial Aneurysm Repair ***- Craniotomy or Endovascular Approaches*** above N105 and N154
Y - OCULAR AND AURAL SURGICAL PROCEDURES			
E136	Y3	With intraocular implant of seton	Revise fee to percentage add-on of 15%
E317	Y12	Incision and drainage of extensive hematoma of pinna under general anaesthetic	Incision and drainage of extensive hematoma of pinna **with packing of ear and external compression dressing** under general anaesthetic
E540	M4, M9	If excision is performed in hospital for tumour free margin with frozen section, add 25% to excision or repair fees	Permit to be claimed with E300
APPENDIX A			
Appendix A	3A	Redefine act referred to in section 24(1.1)3	Reference updated to reflect new legislation *Ontario Disability Support Plan Act*
APPENDIX F			
MCSS	1F-2F	Ministry of Community, Family and Children's Services (MCFCS)	Ministry of Community and Social Services (MCSS

CHART 4: Deleted Fee Codes: Schedule of Benefits changes effective October 1, 2005

Note: This chart represents deleted fee codes only

The Bulletin is being provided as a reference guide only to assist in identifying the October 1, 2005 Schedule of Benefits changes. For complete information, service descriptions, and billing information, please refer to the October 2005 edition of the Schedule of Benefits for Physician Services and subsequent amendment pages. Physicians should carefully review these fee code changes in the context of the Schedule of Benefits (including the General Preamble and any other associated Preambles).

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
A - CONSULTATIONS AND VISITS					
A145	**A31**	Consultation if physician's practice is predominantly cardiology, respirology or gastroenterology	$114.60		
E075	**A1, A4, A6, A7**	Family Practice & Practice in General - 20% premium for A003, C003, W102, W109, A903, C903, W903 for patients aged 75 or older	Add 20%		
E076	**A16, A23, A31, A56**	Internal Medicine - add-on for consultation with special visit to hospital	$12.90		
E - CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS					
J016	**E4**	Percutaneous vertebroplasty - first level per patient per day	$148.10		
J054	**E4**	Percutaneous vertebroplasty - first level per patient per day - each additional vertebral level (maximum of 3 per patient per day)	$74.05		
J - DIAGNOSTIC AND THERAPEUTIC PROCEDURES					
G491	**J58**	Infrared mammography - technical	$13.95		
G492	**J58**	Infrared mammography - professional	$7.40		
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES					
E522	**N30**	Arthrodesis - Fusion with other procedure(s), and/or by different surgeon - each additional level of fixation	$65.05		
E533	**N33**	Instrumentation - Deformities - Readjustment of instrumentation - Harrington instrumentation to sacrum or pelvis	$76.40		
E534	**N33**	Instrumentation - Deformities - Readjustment of instrumentation - Harrington instrumentation	$18.25		
E535	**N33**	Instrumentation - Deformities - Segmental procedure - with fusion - segmental instrumentation to pelvis	$151.00		
E536	**N33**	Instrumentation - Deformities - Segmental procedure - with fusion - segmental instrumentation	$30.05		
E549	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Posterior - with rib or transverse release	$121.05		
E554	**N33**	Instrumentation - Deformities - Readjustment of instrumentation - - with posterior osteotomy	$144.70		
E570	**N31**	Decompression - Posterior - Percutaneous discectomy - with multiple levels	$61.40		

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES					
E573	**N30**	Arthrodesis - Anterior or posterior fusion, or fusion of C1-2 - each additional level	$83.65		
R234	**N32**	Incision and Drainage (Osteomyelitis) - Sequestrectomy - anterior	$616.85	7	10
R251	**N32**	Incision and Drainage (Osteomyelitis) - Bone - incision and drainage only	$295.70	4	4
R252	**N32**	Incision and Drainage (Osteomyelitis) - Saucerization with bone grafting - posterior	$429.40	4	5
R254	**N32**	Incision and Drainage (Osteomyelitis) - Sequestrectomy - posterior	$352.15	4	4
R264	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Cervical	$998.15	10	12
R270	**N32**	Incision and Drainage (Osteomyelitis) - Saucerization with bone grafting - anterior	$759.70	6	10
R271	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Anterior - via chest and abdomen	$855.25	9	13
R274	**N30**	Biopsy - Bone - open - posterior approach	$237.50	4	7
R275	**N30**	Biopsy - Bone - open - anterior approach	$303.90	6	8
R296	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Posterior	$672.35	9	9
R303	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Anterior - via chest	$710.60	9	13
R310	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Circumferential	$1,139.05	9	9
R336	**N33**	Instrumentation - Deformities - Revision of entire instrumentation - without fusion	$948.90	8	12
R346	**N33**	Instrumentation - Deformities - Revision of entire instrumentation - with fusion	$1,186.50	8	12
R348	**N33**	Instrumentation - Deformities - Removal of posterior instrumentation	$256.60	8	8
R350	**N33**	Instrumentation - Deformities - Anterior (Dwyer etc. includes fusion/discectomy) - via chest or abdomen	$1,246.45	9	17
R356	**N33**	Instrumentation - Deformities - Localizer cast	$130.10		4
R357	**N33**	Instrumentation - Deformities - Anterior release including Halo traction - via chest and abdomen	$664.20	9	13
R358	**N33**	Instrumentation - Deformities - Anterior release including Halo traction - via chest or abdomen	$535.05	9	13
R359	**N33**	Instrumentation - Deformities - Anterior (Dwyer etc. includes fusion/discectomy) - via chest and abdomen	$1,372.05	9	17
R361	**N33**	Instrumentation - Deformities - Halo traction prior to surgery (complete care)	$285.70	4	4
R362	**N33**	Instrumentation - Deformities - Posterior (Harrington) - with or without fusion	$756.15	8	12
R368	**N33**	Instrumentation - Deformities - Removal of electrodes	$250.20	8	8
R369	**N33**	Instrumentation - Deformities - Readjustment of instrumentation	$141.95		4
R370	**N31**	Decompression - Posterior - Percutaneous discectomy	$203.80	6	8
R371	**N33**	Instrumentation - Deformities - Segmental procedure - with fusion	$1,145.45	8	12

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES					
R373	**N32**	Excision - Bone - Spinous process	$237.50	4	4
R374	**N32**	Excision - Bone - Lamina or transverse process	$379.40	6	8
R397	**N31**	Decompression - Anterior, Anterolateral or Posterolateral - Anterior decompression with instrumentation	$1,418.45	9	13
R450	**N32**	Excision - Bone - Part of body or pedicle	$569.50	6	8
R455	**N32**	Excision - Bone - Total body (includes replacement)	$948.90	9	13
R459	**N30**	Arthrodesis - Anterior or posterior fusion of one level	$385.70	7	10
R461	**N33**	Instrumentation - Deformities - Removal of - anterior instrumentation	$283.80	8	8
R464	**N33**	Instrumentation - Deformities - Muscle stripping spine prior to surgery	$189.20	6	8
R634	**N32**	Excision - Muscle/Soft Tissue - Tumours - simple	$189.20	6	8
R635	**N32**	Excision - Muscle/Soft Tissue - Tumours - radical resection	$474.85	9	13
R636	**N32**	Reconstruction - Osteotomy (includes fixation/fusion) - Anterior - via abdomen	$759.70	9	9
Z868	**N30**	Biopsy - Bone - needle	$141.95	4	
E548	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s), and/or by different surgeon - with instrumentation	$135.55		
E562	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Reapplication of Halo traction (IOP) - counter traction pins or vest	$105.60		
E565	**N31, X8**	Decompression - Posterior - Cervical/Lumbar hemilaminectomy for disc disease, with or without foraminotomy	$70.95		
E566	**N31, X8**	Decompression - Posterior - Cervical/Lumbar hemilaminectomy for disc disease, with or without foraminotomy	$76.40		
E567	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s) - by same surgeon - one level	$238.40		
E568	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s) - by same surgeon - two or more levels	$304.60		
E574	**N30, X9**	Arthrodesis - Fusion by different surgeon - repeat fusion, to any fusion	$200.10		
E897	**N31, X8-X9**	Posterior Spinal Decompressive Procedures - Use of operating microscope in assoc. with ant./anterolateral/posterolateral spinal decompressive procedures - add to N182, R451, R457	$40.90		
E913	**N31, N34, X8-X10**	Posterior, Anterior, Anterolateral or Posterolateral Spinal Decompressive Procedures - With spinal cord injury	$152.85		
E914	**N31, Z8, X10-X11**	For various procedures that encompass 3 or more segments	$156.75		
E915	**N31, X8**	Posterior Spinal Decompressive Procedures - Foraminotomy in association with posterior spinal decompressive procedures - add to N185, R457	$79.20		

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES					
E924	**N30, X10**	Arthrodesis - Fusion by different surgeon - anterior cervical interbody fusion, per level - add to R493, R494	$118.25		
E926	**N31, X7**	Decompression - Posterior - Spinal duraplasty (payable with any spinal procedure)	$237.20		
E928	**N31, X3, X9**	Each additional disc level decompressed	$257.55		
E929	**N30, X9-X10**	Arthrodesis, Fusions - Anterior spinal cervical interbody fusion - per level	$80.05		
F103	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Closed reduction	$198.30	5	5
F105	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Open reduction - posterior approach	$304.70	5	10
F107	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Open reduction - anterior approach	$358.45	7	10
N182	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body	$596.60	8	10
N185	**N31, X8**	Decompression - Posterior - Posterior laminectomy one or two levels, cervical, thoracic, lumbar	$682.50	6	9
N186	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level	$1,144.95	9	13
N337	**N31, X8**	Decompression - Posterior - Repeat posterior exploration or reopening of posterior exploration, more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	$805.10	8	10
R419	**N30, X10**	Arthrodesis - Fusion of C1-2	$549.70	8	10
R447	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Simple anterior cervical discectomy	$390.30	8	10
R451	**N31, X8**	Decompression - Posterior - Cervical hemilaminectomy for disc disease, with or without foraminotomy	$560.50	6	10
R452	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Simple anterior lumbar discectomy	$480.35	6	10
R457	**N31, X8**	Decompression - Posterior - Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	$499.10	6	8
R493	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s) by different surgeon - one level	$304.70		
R494	**N30, N34, X9-X10**	Arthrodesis - Fusion by different surgeon - two or more levels	$358.45		
Z236	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Skull calipers	$49.10		
Z241	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Halo traction	$79.20		

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
N - MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES					
Z246	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Reapplication of Halo traction	$49.10		
S - DIGESTIVE SYSTEM SURGICAL PROCEDURES					
S119	**S9**	Percutaneous endoscopic gastrostomy - revise to a Z-code and increase fee relative to 1/2 of S118	$160.60	6	7
T - UROGENITAL AND URINARY SURGICAL PROCEDURES					
Z640	**T5**	Resection and fulgurization of ureteral or renal pelvic turmors (applicable to Z628, billed in combination with E760 and E761	$271.30		4
U – MALE GENITAL SURGICAL PROCEDURES					
S641	**U9**	Replace transpubic total prostatovesiculectomy with newer procedures	$949.20	8	11
X - NERVOUS					
E548	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s), and/or by different surgeon - with instrumentation	$163.40		
E562	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Reapplication of Halo traction (IOP) - counter traction pins or vest	$211.15		
E565	**N31, X8**	Decompression - Posterior - Cervical/Lumbar hemilaminectomy for disc disease, with or without foraminotomy	$135.75		
E566	**N31, X8**	Decompression - Posterior - Cervical/Lumbar hemilaminectomy for disc disease, w ith or without foraminotomy	$80.05		
E567	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s) - by same surgeon - one level	$238.40		
E568	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s) - by same surgeon - two or more levels	$304.60		
E574	**N30, X9**	Arthrodesis - Fusion by different surgeon - repeat fusion, to any fusion	$200.10		
E897	**N31, X8-X9**	Posterior Spinal Decompressive Procedures - Use of operating microscope in assoc. with ant./anterolateral/posterolateral spinal decompressive procedures - add to N182, R451, R457	$40.90		
E900	**X7**	Tumours - Removal of spinal tumour by anterior or anterolateral cervical or anterior, anterolateral or posterolateral thoracic or lumbar approach - repeat	$211.15		
E909	**X11**	Ablative & Stimulation Procedures - Percutaneous vertebral facet denervation or intercostal neurectomy	$69.80		
E910	**X11**	Ablative & Stimulation Procedures - Percutaneous radio frequency posterior rhizotomy for pain or spasticity - three or more roots, each additional	$69.80		

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
X - NERVOUS					
E913	**N31, N34, X8-X10**	Posterior, Anterior, Anterolateral or Posterolateral Spinal Decompressive Procedures - With spinal cord injury	$152.85		
E914	**N31, X8, X10-X11**	For various procedures that encompass 3 or more segments	$156.75		
E915	**N31, X8**	Posterior Spinal Decompressive Procedures - Foraminotomy in association with posterior spinal decompressive procedures - add to N185, R457	$79.20		
E920	**X1, X3, X7, X9, X13**	Intraoperative, diagnostic or physiological monitoring for intracranial, spinal or peripheral nerve procedures, (e.g. stimulation with recording, evoked potentials, ultrasound or impedance monitoring)	$179.30		
E923	**X5**	Intraoperative diagnostic or physiological monitoring (e.g. stimulation and recording, evoked potentials, cerebral blood flow determinations) to N220, Z808	$179.30		
E924	**N30, X10**	Arthrodesis - Fusion by different surgeon - anterior cervical interbody fusion, per level - add to R493, R494	$118.25		
E926	**N31, X7**	Decompression - Posterior - Spinal duraplasty (payable with any spinal procedure)	$237.20		
E928	**N31, X3, X9**	Each additional disc level decompressed	$257.55		
E929	**N30, X9-X10**	Arthrodesis, Fusions - Anterior spinal cervical interbody fusion - per level	$80.05		
E978	**X7**	Tumours - A.V. malformation of cord - Excision or operative obliteration; with or without evacuation of haematoma - per segment after three segments	$156.75		
F103	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Closed reduction	$198.30	5	5
F105	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Open reduction - posterior approach	$304.70	5	10
F107	**N30, X10**	Reduction - Fractures or Fracture Dislocations - Open reduction - anterior approach	$358.45	7	10
N182	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body	$596.60	8	10
N185	**N31, X8**	Decompression - Posterior - Posterior laminectomy one or two levels, cervical, thoracic, lumbar	$682.50	6	9
N186	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level	$1,144.95	9	13
N192	**X10**	Other Laminectomies (uni- or bilateral) - Re-opening of laminectomy for repair of CSF leak	$522.75	7	8
N194	**X10**	Other Laminectomies (uni- or bilateral) - Syringo subarachnoid shunt	$783.15	8	10
N195	**X10**	Other Laminectomies (uni- or bilateral) - Terminal ventriculostomy	$783.15	8	10
N196	**X10**	Other Laminectomies (uni- or bilateral) - Syringopleural/syringoperitoneal shunt	$914.35	9	12

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
X - NERVOUS					
N197	**X12**	Meningocele and Meningomyelocele - Repair of lipomeningocele (to include release of tethered spinal cord)	$813.85	7	9
N198	**X12**	Meningocele and Meningomyelocele - Repair of anterior sacral meningocele - posterior approach	$839.00	7	9
N199	**X12**	Meningocele and Meningomyelocele - Repair of intraspinal meningocele (extradural cyst)	$839.00	7	9
N248	**X10**	Other Laminectomies (uni- or bilateral) - Implantation of permanent subcutaneous reservoir for the chronic delivery of epidural or intrathecal medications to include laminectomy	$412.05	11	11
N313	**X7**	Tumours - Removal of spinal tumour by anterior or anterolateral cervical or anterior, anterolateral or posterolateral thoracic or lumbar approach	$1,292.55	9	13
N314	**X7**	Tumours - Removal of spinal tumour by anterior or anterolateral cervical or anterior, anterolateral or posterolateral thoracic or lumbar approach	$1,501.85	9	14
N316	**X7**	Stereotactic spinal procedure	$1,055.55	8	6
N317	**X7**	Tumours - Extradural partial or total removal by laminectomy (including posterolateral cervical approach)	$1,123.20	8	10
N318	**X7**	Tumours - Intradural (extramedullary) partial or total removal of spinal tumour	$1,423.10	8	10
N319	**X7**	Tumours - Intramedullary - biopsy and/or decompression	$1,209.05	9	9
N320	**X7**	Tumours - Intramedullary - removal	$1,632.35	9	12
N321	**X7**	Tumours - A.V. malformation of cord - Excision or operative obliteration; with or without evacuation of haematoma	$1,255.65	9	12
N323	**X10**	Other Laminectomies (uni- or bilateral) - Re-opening of laminectomy for post-operative haematoma or infection	$366.45	7	8
N324	**X11**	Ablative & Stimulation Procedures - Implantation of spinal cord stimulating electrode by laminectomy	$567.35	8	10
N329	**X11**	Ablative & Stimulation Procedures - Percutaneous cordotomy or tractotomy	$462.25	6	8
N330	**X11**	Ablative & Stimulation Procedures - Open myelotomy for lesion (e.g. tractotomy, midline commissurotomy, Bischoff's longitudinal myelotomy, etc.) uni - or bilateral	$944.10	8	10
N331	**X11**	Ablative & Stimulation Procedures - Spinal intradural anterior and/or posterior rhizotomy, unilateral or bilateral, any number of roots	$632.50	8	10
N332	**X11**	Ablative & Stimulation Procedures - Removal of any stimulation pack or electrode from peripheral nerve, brain or spinal cord	$221.35	6	6
N333	**X11**	Ablative & Stimulation Procedures - Dorsal root entry zone lesions for pain relief (any number of levels) - includes use of operating microscope	$1,004.50	8	10

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
X - NERVOUS					
N334	**X12**	Meningocele and Meningomyelocele - Repair of meningocele	$422.30	7	9
N335	**X12**	Meningocele and Meningomyelocele - Repair of meningomyelocele - one surgeon	$572.90	7	9
N336	**X10**	Other Laminectomies (uni- or bilateral) - Laminectomy for intradural neurolysis or unusual lesions e.g. diastematomyelia, tethered conus, intramedullary haematoma, etc.	$784.05	7	8
N338	**X12**	Meningocele and Meningomyelocele - Repair of meningomyelocele - two surgeons - neurosurgeon	$422.30		9
N339	**X12**	Meningocele and Meningomyelocele - Repair of meningomyelocele - two surgeons - reconstructive surgeon	$341.45		
N340	**X11**	Ablative & Stimulation Procedures - Percutaneous radio frequency posterior rhizotomy for pain or spasticity - one or two roots	$266.05		8
N341	**X11**	Ablative & Stimulation Procedures - Medullary spinal trigeminal tractotomy	$994.25	10	15
N337	**N31, X8**	Decompression - Posterior - Repeat posterior exploration or reopening of posterior exploration, more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	$805.10	8	10
R419	**N30, X10**	Arthrodesis - Fusion of C1-2	$549.70	8	10
R447	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Simple anterior cervical discectomy	$390.30	8	10
R451	**N31, X9**	Decompression - Posterior - Cervical hemilaminectomy for disc disease, with or without foraminotomy	$560.50	6	10
R452	**N31, X9**	Decompression - Anterior, Anterolateral or Posterolateral - Simple anterior lumbar discectomy	$480.35	6	10
R457	**N31, X8**	Decompression - Posterior - Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	$499.10	6	8
R493	**N30, N34, X9-X10**	Arthrodesis - Fusion with other procedure(s) by different surgeon - one level	$304.70		
R494	**N30, N34, X9-X10**	Arthrodesis - Fusion by different surgeon - two or more levels	$358.45		
Z236	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Skull calipers	$49.10		
Z241	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Halo traction	$79.20		
Z244	**X11**	Ablative & Stimulation Procedures - Percutaneous diagnostic stimulation of brain or spinal cord or trigeminal nerve root and/or ganglion	$321.80	6	8
Z246	**N34, X10**	Reduction - Fractures or Fracture Dislocations - Reapplication of Halo traction	$49.10		
Z662	**X11**	Ablative & Stimulation Procedures - Insertion revision of implantable infusion pump	$163.40		5
Z800	**X7**	Tumours - Myeloscopy	$211.15		

Fee Code	Page #	Description	Fee April 1, 2005	Assist Units April 1, 2005	Anae Units April 1, 2005
X - NERVOUS					
Z810	**X11**	Ablative & Stimulation Procedures - Percutaneous vertebral facet denervation or intercostal neurectomy	$135.75		4
Z817	**X11**	Ablative & Stimulation Procedures - Lumbar subarachnoid drainage of CSF (chronic)	$80.05		