CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
A020	Complex Dermatological assessment	A	49.95		
A050	Special community medicine consultation	A	144.75		
A051	Complex medical specific re-assessment	A	70.90		
A053	Medical specific assessment	A	79.85		
A054	Medical specific re-assessment	A	61.25		
A056	Repeat consultation	A	84.20		
A058	Partial assessment	A	38.05		
A070	Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient	A	185.00		
A120	Colonoscopy assessment, same day as colonoscopy	A	18.85		
A130	Comprehensive internal medicine consultation	A	300.70		
A150	Comprehensive endocrinology consultation	A	300.70		
A160	Comprehensive nephrology consultation	A	300.70		
A191	Consultative interview with caregiver(s) of a patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia	A	212.65		
A192	Consultative interview with patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia	A	212.65		
A400	Comprehensive community medicine consultation	A	240.55		
A460	Comprehensive infectious diseases consultation	A	300.70		
A470	Comprehensive respiratory diseases consultation	A	300.70		
A511	Complex physiatry assessment	A	89.85		
A570	Complex respiratory assessment	A	89.85		
A590	Comprehensive rheumatology consultation	A	300.70		
A600	Comprehensive cardiology consultation	A	300.70		
A760	Complex endocrine neoplastic disease assessment	A	89.85		
A800	Midwife-requested genetic assessment	A	165.00		
A801	Comprehensive midwife genetic assessment	A	300.70		
A802	Extended midwife genetic assessment	A	395.65		
A816	Midwife-Requested Anaesthesia Assessment (MRAA)	A	106.80		
A911	Special consultation - family and general practice	A	144.75		
A912	Comprehensive consultation - family and general practice	A	217.15		
B986	Geriatric home visit special visit premium - Travel Premiums	GP	36.40		
B987	Geriatric home visit special visit premium - First person seen - Nights	GP	110.00		
B988	Geriatric home visit special visit premium - First person seen - weekdays, evenings, holidays	GP	82.50		
C020	Complex Dermatological assessment	A	49.95		
C050	Special community medicine consultation- Non - Emergency Hospital In-Patient Services	A	144.75		
C051	Complex medical specific re-assessment - Non - Emergency Hospital In-Patient Services	A	70.90		
C052	Subsequent visits - first five weeks - Non - Emergency Hospital In-Patient Services	A	31.00		

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
C053	Medical specific assessment - Non - Emergency Hospital In-Patient Services	A	79.85		
C054	Medical specific re-assessment - Non - Emergency Hospital In-Patient Services	A	61.25		
C056	Repeat consultation - Non - Emergency Hospital In-Patient Services	A	84.20		
C057	Subsequent visits - sixth to thirteenth week inclusive - Non - Emergency Hospital In-Patient Services	A	31.00		
C058	Concurrent Care	A	31.00		
C059	Subsequent visits - after thirteenth week - Non - Emergency Hospital In-Patient Services	A	31.00		
C130	Comprehensive internal medicine consultation	A	300.70		
C150	Comprehensive endocrinology consultation	A	300.70		
C160	Comprehensive nephrology consultation	A	300.70		
C222	Genetics - Non-emergency hospital in-patient services - Subsequent visits- first five weeks	A	31.00		
C227	Genetics - Non-emergency hospital in-patient services - Subsequent visits - sixth to thirteenth week inclusive (maximum 3 per patient per week)	A	31.00		
C229	Genetics - Non-emergency hospital in-patient services - Subsequent visits - after thirteenth week (maximum 6 per patient per month)	A	31.00		
C400	Comprehensive community medicine consultation - Non - Emergency Hospital In-Patient Services	A	240.55		
C460	Comprehensive infectious diseases consultation	A	300.70		
C470	Comprehensive respiratory diseases consultation		300.70		
C511	Complex physiatry assessment	A	89.85		
C570	Complex respiratory assessment	A	89.85		
C590	Comprehensive rheumatology consultation	A	300.70		
C600	Comprehensive cardiology consultation	A	300.70		
C760	Complex endocrine neoplastic disease assessment	A	89.85		
C800	Midwife-requested genetic assessment	A	165.00		
C801	Comprehensive midwife genetic assessment	A	300.70		
C802	Extended midwife genetic assessment	A	395.65		
C816	Midwife-Requested Anaesthesia Assessment (MRAA)	A	106.80		
C911	Special consultation - family and general practice	A	144.75		
C912	Comprehensive consultation - family and general practice	A	217.15		
D026	Tarso-metatarsal - closed reduction, one or more joints	N	147.60		6
D028	Tarso-metatarsal - open reduction, one joint	N	300.00	6	6
E025C	Unianticipated massive transfusion - transfusion of at least one blood volume of red blood cells	GP			10
E412	After Hours Procedure Premiums - Emergency Department Physician - Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by	GP	20%		
E413	After Hours Procedure Premiums - Emergency Department Physician - Nights (00:00h – 07:00h) - increase the procedural fee(s) by	GP	40%		

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
E423	Manual Cycloplegic Refraction, to A233, A234	A	25.00		
E440	with injection of contrast using fluoroscopy, to G246, G117, G119 or G918	J	30.00		
E441	when performed at same level of previous spinal surgery, to G246, G117, G119 or G918	J	16.60		
E442	when performed using a transforaminal technique, to G246, G117, G119 or G918	J	20.00		
E443	with catheter for continuous infusion, to G246, G117, G119 or G918	J	80.00		
E444	with radiofrequency ablation, to G233	J	50%		
E445	when alcohol or other sclerosing solutions are used, to G920, G234, G236, G233, G217 or G232	J	50%		
E446	peripheral joint injection using image guidance following a failed blind attempt, to G370 or G371	J	30.00		
E497	Carpal bone, other than scaphoid - pedicled vascularized bone graft, to R322, R345	N	350.00		
E508	Tarso-metatarsal - each additional joint, to D028	N	85.00		
E509	conduit to aorta or common iliac artery, to R875	Q	805.65		
E511	Arthrodesis - additional midtarsal(s), to R695	N	100.00		
E512	Arthrodesis - additional mid tarsal(s), to R696	N	100.00		
E513	Breast mound creation by soft tissue, includes flap insetting and shaping for autogenous reconstruction, to R118, R125, R064, R008 or R155	M	297.50		
E514	Immediate breast reconstruction following mastectomy, to R125, R064, R156, R008, or R155	M	200.00		
E808	Neo-rectal pouch formation, to S169, S171, or S213	S	150.00		
E809	Panniculectomy – excision of pannus that extends beyond the mid thigh, to S318	S	250.00		
E815	angioplasty remote from subintimal dissection site, to R878 and R879	Q	398.15		
E837	additional biopsy(s) performed by EBUS, to a maximum of 3, to G050	P	50.75		
E838	Bronchoscopy - bronchoscopy in a high risk patient with respiratory failure	P	79.40		
E839	with flexible endoscopy	P	19.20		
E894	Intracranial Aneurysm Repair - Endovascular approaches - aneurysm greater than 2.5 cm, to N122 or N125	X	229.55		
F140	Mandible - removal of intermaxillary fixation device(s)	N	100.00		
G042	Target drug testing, urine, qualitative or quantitative, sixth to ninth service (inclusive) per month	J	2.50		
G043	Drugs of abuse screen, urine, must include at least four drugs of abuse, sixth to ninth service (inclusive) per month	J	15.00		
G050	Endobronchial ultrasound (EBUS), for guided biopsy of hilar and/or mediastinal lymph nodes	P	203.05		
G285	Dye dilution densitometry when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438	J	32.90		
G286	Thermal dilution studies when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438	J	32.90		
G388	Management of special oral chemotherapy, for malignant disease	J	20.50		

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
G471	Schedule C Electromyography - Technical component	J	28.10		
G473	Schedule C Electromyography - Professional component	J	191.00		
G524	Multi-focal electro-retinography - professional component	J	75.00		
G541	Sleep-deprived/induced EEG - Technical component	J	40.00		
G543	Sleep-deprived/induced EEG - Professional component	J	60.00		
G556	ICU/NICU assessment fee when initial visit rendered during night time (00:00-0:700), to G400, G405, G557, G600, G603, G604, G610, G620	J	136.40		
G582	Echocardiography - Stress study - technical component	J	92.90		
G583	Echocardiography - Stress study - professional component (P1)	J	91.55		
G584	Echocardiography - Stress study - professional component (P2)	J	72.85		
G790	Acquired Acute Brain Injury Management - 1st Day	J	223.10		
G791	Acquired Acute Brain Injury Management - 2nd to 30th day, inclusive	J	146.45		
G792	Acquired Acute Brain Injury Management - 31st day onwards	J	58.60		
G840	DTaP–IPV-Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus – paediatric	J	4.50		
G841	DTaP–IPV–Hib—Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b paediatric	J	4.50		
G842	HB—Hepatitis B	J	4.50		
G843	HPV—Human Papillomavirus type 6, 11, 16, 18	J	4.50		
G844	Men–C–C—Meningococcal C Conjugate	J	4.50		
G845	MMR—Measles, Mumps, Rubella	J	4.50		
G846	Pneu - Pneumococcal Conjugate	J	4.50		
G847	TdaP—Tetanus, Diphtheria, acellular Pertussis–adult	J	4.50		
G848	Var—Varicella	J	4.50		
G910	Percutaneous facet medial branch block, facet joint injection or sacral lateral branch block with fluoroscopic guidance - Cervical, first site	J	80.00		
G911	Percutaneous facet medial branch block, facet joint injection or sacral lateral branch block with fluoroscopic guidance - Thoracic, first site	J	80.00		
G912	Percutaneous facet medial branch block, facet joint injection or sacral lateral branch block with fluoroscopic guidance - Lumbar/Sacral, first site	J	80.00		
G913	Percutaneous facet medial branch block, facet joint injection or sacral lateral branch block with fluoroscopic guidance - each additional site, to G910, G911 or G912	J	20.00		
G914	Percutaneous lumbar facet medial branch block with ultrasound guidance - first site	J	56.00		
G915	Percutaneous lumbar facet medial branch block with ultrasound guidance - each additional site, to G914	J	14.00		
G916	Percutaneous diagnostic and/or corticosteroid sacroiliac joint injection with fluoroscopic guidance, unilateral	J	75.00		
G917	Percutaneous diagnostic selective nerve root block with fluoroscopic guidance, with or without contrast – any number of sites	J	160.00		
G918	Percutaneous epidural injection - Caudal	J	74.20		

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
G919	Percutaneous epidural adhesiolysis by infusion with fluoroscopic guidance	J	400.00		
G920	Percutaneous cervical sympathetic nerve block or Stellate ganglion block - with ultrasound or fluoroscopic guidance, unilateral	J	80.00		
G921	Spheno-palatine ganglion block, transnasal topical, uni or bilateral	J	12.50		
J186	Transcranial Doppler assessment of intracranial circulation - assessment with power mode doppler (P1)	G	42.80		
J187	Transcranial Doppler assessment of intracranial circulation - prolonged study requiring at least 50 minutes (P1)	G	42.80		
J188	Transcranial Doppler assessment of intracranial circulation - follow-up within 4 weeks of J186/J486/J187 or J487 requiring at least 50 minute (P1)	G	30.15		
J336	Oxygen Saturation - with single blind assessment of exercise on room air and with supplemental oxygen	P	T - 31.35 P - 16.05		
J486	Transcranial Doppler assessment of intracranial circulation - assessment with power mode doppler (P2)	G	32.10		
J487	Transcranial Doppler assessment of intracranial circulation - prolonged study requiring at least 50 minutes (P2)	G	32.10		
J488	Transcranial Doppler assessment of intracranial circulation - follow-up within 4 weeks of J186/J486/J187 or J487 requiring at least 50 minute (P2)	G	22.60		
K046	Diabetes Team Management	A	115.00		
K077	Geriatric Telephone Support	A	35.45		
K119	Paediatric Developmental Assessment Incentive	C	100.00		
K187	Acute post-discharge community psychiatric care, to K198, K197, K196 or K195	A	15%		
K188	High risk community psychiatric care, to K198, K197, K196, K195, A695, A795, A195, A190, A195, A197, A198, A191 or A192	A	15%		
K189	Urgent community psychiatric follow-up, to A695, A795, A190 or A195	A	200.00		
K224	Clinical interpretation requested by a midwife	A	37.65		
K480	Physician to allied professional telephone consultation	A	31.35		
K481	Rheumatoid arthritis management by a specialist	A	75.00		
K630	Psychiatric Consultation Extension	A	105.10		
K682	Opioid Agonist Maintenance Program monthly management fee – intensive	A	45.00		
K683	Opioid Agonist Maintenance Program monthly management fee – maintenance	A	38.00		
K684	Opioid Agonist Maintenance Program monthly management fee – team maintenance	A	6.00		
K705	Long-term care – high risk patient conference	A	31.35		
K706	Convalescent Care Program case conference	A	31.35		
K707	Chronic pain out-patient case conference	A	31.35		
K710	MCC Radiologist Participant, per patient	A	31.35		
N122	Intracranial Aneurysm Repair - Endovascular approaches - Carotid circulation - per vessel	X	2,140.15	15	20

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
N125	Intracranial Aneurysm Repair - Endovascular approaches - Vertebrobasilar circulation, including aneurysm of vein of Galen	X	2,140.15	15	20
P045	Repair of third degree tear or episiotomy extension, must include repair of perianal sphincter and perineum	K	82.15		6
P046	Repair of fourth degree tear or episiotomy extension, must include repair of rectal mucosa, perianal sphincter and perineum	K	200.00		6
R155	Latissimus dorsi or unilateral rectus abdominus	M	734.95	6	6
R156	Breast mound creation by insertion of tissue expander, includes creation of submuscular pocket	M	425.00	6	6
R345	Carpal bone, other than scaphoid	N	260.75	6	6
R347	Skull and Mandible - Bicoronal flaps	N	200.00		
R694	Arthroplasty - Ankle - Liner replacement	N	353.25	8	10
R695	Arthrodesis - Subtalar	N	450.00	6	6
R696	Arthrodesis - Midtarsal, single joint	N	500.00	6	6
R697	Arthrodesis - Metatarsal-tarsal (fusion of one or more joints)	N	300.00	6	6
R698	Debridement excision and flap and/or graft closure for necrotizing fasciitis - in Operating Room	M	100.00	6	10
R706	Right atrial ablative procedure for treatment of atrial arrhythmia - surgical procedure or performed with an energy source) to R709	Q	1,245.85	18	20
R878	Subintimal dissection for recanalization of femoral/popiteal/tibial arterial occlusive disease	Q	759.60	10	10
R879	Subintimal dissection for recanalization of iliac/aorta arterial occlusive disease	Q	759.60	10	10
R941	Thrombectomy, by open technique	J	350.00	7	10
R942	Ligation, removal or obliteration of AV fistula or graft for haemodialysis	J	250.00	6	6
R943	Revision and/or repair of AV fistula or graft by plication, imbrication, and/or resection, with or without thrombectomy	J	400.00	6	6
R944	Revision and/or repair of AV fistula or graft by angioplasty by patch or graft, and/or segment replacement , with or without thrombectomy	J	650.00	6	6
R945	Resection or repair of an AV fistula aneurysm(s), includes any necessary repair, with or without thrombectomy	J	975.50	6	6
R946	Brachio-basilic vein AV fistula transposition for haemodialysis	J	975.50	10	17
S086	Cricopharyngeal myotomy	S	300.00		
S243	Sphincterotomy(ies) under general anaesthesia	S	200.00	6	6
UVC	Mandible - no reduction	N	Visit Fee		
W050	Special community medicine consultation - Non - Emergency Long-Term Care In-Patient Services	A	144.75		
W051	Subsequent visits - Chronic care or convalescent hospital - additional subsequent visits	A	21.20		
W052	Subsequent visits - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month	A	32.20		
W053	Subsequent visits - Nursing home or home for the aged - first 2 subsequent visits per patient per month	A	32.20		
W054	General re-assessment of patient in nursing home	A	20.60		

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
W056	Repeat consultation - Non - Emergency Long-Term Care In-Patient Services	A	84.20		
W058	Subsequent visits - Nursing home or home for the aged - subsequent visits per month	A	21.20		
W130	Comprehensive internal medicine consultation	A	300.70		
W150	Comprehensive endocrinology consultation	A	300.70		
W160	Comprehensive nephrology consultation	A	300.70		
W221	Non-Emergency Long-Term Care In-Patient Services - Chronic care or convalescent hospital - additional subsequent visits (maximum of 6 per patient per month)	A	21.20		
W222	Non-Emergency Long-Term Care In-Patient Services - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month	A	32.20		
W224	Non-Emergency Long-Term Care In-Patient Services - Nursing home or home for the aged - first 2 subsequent visits per patient per month	A	32.20		
W228	Non-Emergency Long-Term Care In-Patient Services - Nursing home or home for the aged - subsequent visits per month (maximum of 3 per patient per month	A	21.20		
W400	Comprehensive community medicine consultation -Non - Emergency Long-Term Care In-Patient Services	A	240.55		
W402	Admission assessment - Type 1	A	69.35		
W404	Admission assessment - Type 2	A	20.60		
W407	Admission assessment - Type 3	A	30.70		
W409	Annual physical examination	A	65.05		
W460	Comprehensive infectious diseases consultation	A	300.70		
W511	Complex physiatry assessment	A	89.85		
W760	Complex endocrine neoplastic disease assessment	A	89.85		
W911	Special consultation - family and general practice	A	144.75		
W912	Comprehensive consultation - family and general practice	A	217.15		
X480	MRI guidance of biopsy or ablation of the breast, unilateral	F	300.00		
X481	MRI guidance of biopsy or ablation of other medically indicated organ	F	300.00		
Z080	Debridement of wound(s) and/or ulcer(s) extending into subcutaneous tissue - one	M	20.00		
Z081	Debridement of wound(s) and/or ulcer(s) extending into subcutaneous tissue - two	M	30.00		
Z082	Debridement of wound(s) and/or ulcer(s) extending into subcutaneous tissue - three	M	45.00		
Z083	Debridement of wound(s) and/or ulcer(s) extending into subcutaneous tissue - four or more	M	60.00		
Z084	Debridement of wound(s) and/or ulcer(s) extending into any of the following structures: tendon, ligament, bursa and/or bone - one	M	60.00		
Z085	Debridement of wound(s) and/or ulcer(s) extending into any of the following structures: tendon, ligament, bursa and/or bone - two or more	M	90.00		

CHART 4 – NEW FEE CODES – EFFECTIVE SEPTEMBER 1, 2011

Fee Code	Description	Schedule Section	September 1, 2011 Fee	Assistant Units	Anaesthetist Units
Z119	Cryotherapy treatment of multiple pre-malignant actinic keratosis skin lesions (5 or more lesions), not to include freeze-thaw cycles	M	29.00		
Z187	Complex laceration repair, face	M	92.30		
Z188	Complex laceration repair, anatomical area other than face, (except finger, zone 1 repair)	M	92.30		
Z189	Complex laceration repair, anatomical area other than face, (except finger, zone 1 repair)	M	92.30		
Z360	Emergency rigid bronchoscopy for obstructed airway	P	474.65		
Z361	Insertion of indwelling catheter	P	200.00		
Z362	Removal of indwelling catheter	P	200.00		
Z464	Declotting by cannula, any method	J	150.00	nil	nil
Z496	Presence of signs or symptoms - sigmoid to descending colon	S	57.70	nil	4
Z497	Confirmatory colonoscopy - sigmoid to descending colon	S	57.70	nil	4
Z498	Surveillance colonoscopy - sigmoid to descending colon	S	57.70	nil	4
Z499	Colonoscopy - Absence of signs or symptoms, family history of colon cancer in a first degree relative – sigmoid to descending colon	S	57.70	nil	4