

GENERAL INTERNAL MEDICINE

These listings cannot be correctly interpreted without reference to the Preamble.

		\$	Anes. Level
Referred Cases			
00310	Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....	164.37	
00312	Repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	79.41	
00311	Complex Consultation - 3 medical conditions	243.07	
	Notes:		
	i) Payable only for General Internal Medicine specialists who do not hold a sub specialty.		
	ii) For hospital in-patients, paid once per patient per hospital admission.		
	iii) Written consultation report includes advice or recommendations for treatment regarding 3 or more of the conditions listed in note iv), below.		
	iv) Payable for patients that have 3 or more of the following listed chronic diseases. Exceptions to this rule could be made if the patient has two diagnoses from this list and one alternative diagnosis not on the list can be submitted with correspondence/note record, outlining the medical necessity. Each case will be reviewed on an independent consideration basis.		
	<i>(Diagnostic codes in brackets):</i>		
	Septicemia (038)		
	Other HIV infection (044)		
	DM including complications (250)		
	Disorders of Lipid Metabolism (272)		
	Thyroid disorders (246)		
	Purpura, thrombocytopenia and hemorrhagic conditions (287)		
	Anemia, unspecified (285.9)		
	Senile dementia, presenile dementia (290)		
	Acute confusional state (293)		
	Congestive Heart Failure (428)		
	Diseases of the aortic and mitral valve (396)		
	Essential hypertension (401)		
	Coronary atherosclerosis (414)		
	Neoplasm of uncertain behaviour of other and unspecified sites. "Not for minor or superficial skin malignancies." (238)		
	Cardiac dysarrhythmias (427)		
	Cerebral atherosclerosis (437)		
	Asthma allergic bronchitis (493)		
	Emphysema (492)		
	Other bacterial pneumonia (482)		
	Non infective enteritis and colitis (557.1)		
	GI hemorrhage (578)		
	Chronic liver diseases and cirrhosis of the liver (571)		
	CRF (585)		
	ARF (584)		
	Disorders of fluid, electrolyte and acid base balance (276)		
	Syncope (780.2)		
	Venous thrombosis and embolism (453)		
	Pulmonary fibrosis (515)		
	Rheumatoid Arthritis (714)		
	Systemic Lupus Erythematosus (710)		

		\$	Anes. Level
00314	Prolonged visit for counselling (maximum, four per year)	54.06	
	<i>Note: See Preamble, Clause D. 3. 3.</i>		
	<u>Group counselling for groups of two or more patients:</u>		
00313	- first full hour	110.71	
00315	- second hour, per 1/2 hour or major portion thereof.....	55.32	
	<u>Continuing care by consultant:</u>		
00306	Directive care	46.09	
00307	Subsequent office visit.....	49.12	
00308	Subsequent hospital visit.....	28.37	
00309	Subsequent home visit	50.65	
00305	Emergency visit when specially called	112.24	
	(not paid in addition to out-of-office-hours premiums)		
	<i>Note: Claim must state time service rendered.</i>		
	<u>Telehealth Service with Direct Interactive Video Link with the Patient</u>		
32270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....	164.37	
32272	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	79.41	
32271	Telehealth Complex Consultation.....	243.07	
	Notes:		
	i) Payable only for General Internal Medicine specialists who do not hold a sub specialty.		
	ii) Limited to one per patient in a 6 month period.		
	iii) Written consultation report includes advice or recommendations for treatment regarding 3 or more of the conditions listed in note iv), below.		
	iv) Payable for patients that have 3 or more of the following listed chronic diseases. Exceptions to this rule could be made if the patient has two diagnoses from this list and one alternative diagnosis not on the list can be submitted with correspondence/note record, outlining the medical necessity. Each case will be reviewed on an independent consideration basis.		
	(Diagnostic codes in brackets):		
	Septicemia (038)		
	Other HIV infection (044)		
	DM including complications (250)		
	Disorders of Lipid Metabolism (272)		
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- Cardiac dysarrhythmias (427)
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32276	Telehealth directive care	46.09
32277	Telehealth subsequent office visit	49.12
32278	Telehealth subsequent hospital visit	28.37

Examinations by Certified Internist

00322	Internists' part in cardioangiogram, per hour or fraction thereof	45.64	
33037	Replacement transfusion - hepatic failure to include two weeks' care after transfusion	282.31	
	<i>Note: Consultation and necessary hospital visits prior to initial transfusion extra</i>		
00343	Cardiac screening (maximum, three a month within manufacturer's guarantee and one a week beyond manufacturer's guarantee).....	4.56	
00344	- professional fee	2.28	
00345	- technical fee	2.28	
33032	Pacemaker standby and/or placement of the endocardial catheter (operation only).....	79.10	4
33033	Generator placement and venous cutdown.....	258.25	4

Adult Critical Care

Please refer to the Critical Care Section of the Payment Schedule for Preamble rules and billing guidelines applicable to appropriate billing of the critical care fees.

1. **CRITICAL CARE** - includes provision in an Intensive Care Area of all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, family counselling, emergency resuscitation, intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, pressure infusion set and pharmacological agents, insertion of arterial C.V.P., Swan-Ganz or urinary catheters and nasogastric tubes, defibrillation, cardio version and usual resuscitative measures, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 1 hour of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in ICU's for example, routine post-op monitoring, or patients admitted for ECG monitoring or observation alone.

Physician-in-charge is the Physician(s) daily providing the above.

01411	1st day	331.77
01421	2nd to 7th day (inclusive) per diem	169.21
01431	8th to 30th day	86.08
01441	31st day onward	27.72

2. VENTILATORY SUPPORT - includes provision of ventilatory care including initial consultation and assessment of the patient, family counselling, cut-down, pressure infusion, insertion arterial & CVP, Swan-Ganz, tracheal toilet, endotracheal intubation, intravenous lines, artificial ventilation and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, end tidal CO₂, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1 hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to postoperative care by the surgeon.

Physician-in-charge is the physician(s) daily providing the above.

01412	1st day	289.27
01422	2nd to 7th day (inclusive) per diem	147.04
01432	8th to 30th day	99.79
01442	31st day onward	36.16

3. COMPREHENSIVE CARE -These fees apply to intensive care physicians who provide complete care, both Critical Care and Ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment and subsequent examinations of the patient, family counselling, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, arterial and/or venous catheters, insertion of a Swan-Ganz catheter, pressure infusion sets and pharmacological agents, insertion of C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric tubes, securing and interpretation of blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 2 hours of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in the ICU's or patients admitted for ECG monitoring and observations.

Physician-in-charge is the physician(s) daily providing the above.

01413	1st day	549.61
01423	2nd to 7th day (inclusive) per diem	251.68
01433	8th to 30th day	127.85
01443	31st day onwards	63.28

If ventilatory support only is provided, claims should then be made under Ventilatory Support. Comprehensive Care fees do not apply. Other physicians should then charge Critical Care fees, if applicable, or the appropriate consultation, visit or procedure fees.

Injections

00017	Insertion of central venous pressure catheter	23.32
00018	Autologous ascitic infusion	46.93

Blood Transfusions

00021	Administered in hospital	36.38
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Dialysis Fees

Acute renal failure

Peritoneal dialysis:

33756	Reinsertion of peritoneal catheter after 10 days from initial insertion	51.21
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Note: Item 00081 not to be charged in addition to item 33723.
Where an initial peritoneal dialysis is performed and for various reasons, haemodialysis initiated within next 48 hours, the subsequent service should be charged under item 33758 plus item 33756 for the insertion of catheter.

Chemotherapy

- a) Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.
- b) Hospital visits are not payable on the same day.
- c) Visit fees are payable on subsequent days, when rendered.
- d) A consultation, when rendered, is payable in addition to fee item 33581, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.
- e) The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

33581	High intensity cancer chemotherapy: To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis.....	199.36
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Note: This service is not payable more frequently than once every 28 days.
The following treatments fall into this category:

- a) chemotherapy for acute leukemia;
- b) chemotherapy utilizing cisplatin given in a dose exceeding 50 mg/m² per treatment;
- c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;
- d) chemotherapy using DTIC in a dose exceeding 100 mg/m²;

- e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m² (and combined with the folinic acid rescue regimen);
- f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).

33582 **Major Cancer Chemotherapy:**
 To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents116.91
Note: This service is not payable more than once every 7 days.

33583 **Limited Cancer Chemotherapy:**
 To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line66.80
Note: This item is not payable more than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.

Diagnostic Procedures

Cardio-vascular Diagnostic Procedures – procedural fee

S00839 Direct intracoronary streptokinase thrombolysis353.16 4
Note: When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).

Pulmonary Investigative and Function Studies

S00930 Peak expiratory flow rate5.44
Note: Fee item 00930 payable when performed in physicians' office (not restricted to an accredited facility).

Laboratory Procedures:

S00928 Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus without bronchodilators.....12.52
 S00929 Simple screening spirometry as above but before and after bronchodilators18.54

Exercise Studies:

Note: No more than one exercise study item may be billed for a single patient on any one day without written explanation.

Testing for exercise-induced asthma by serial flow measurements:
 S00958 - professional fee21.91
 S00959 - technical fee32.31

		\$	Anes. Level
	Precipitin tests-one or more antigens:		
S00970	- professional fee	10.90	
S00971	- technical fee	26.40	

Puncture Procedures for Obtaining Body Fluids
(when performed for diagnostic purposes)

S00753	Marrow aspiration - procedural fee	42.93	2
S00755	Artery puncture - procedural fee.....	6.25	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	21.67	2

Miscellaneous

00319	Insertion of central catheter for total parenteral nutrition (operation only)	55.46	2
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