PEDIATRICS

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

Code	Description	$	Anes. Level

Referred Cases

00510 **Consultation:** To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 204.52

00550 **Extended Consultation –** exceeding 53 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report 269.31

Notes:
- *i) Applicable to patients with chronic and complex medical needs.*
- *ii) Not payable in addition to 00510, 00511, 00512 or 00551.*
- *iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.*

00551 **Extended Consultation** – exceeding 68 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report 333.77

Notes:
- *i) Applicable to patients with chronic and complex medical needs.*
- *ii) Not payable in addition to 00510, 00511, 00512 or 00550.*
- *iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.*

00511 **Consultation** — for complex behavioural, developmental or psychiatric condition in a child**:** To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report 411.87

Notes:
- *i) Not to be billed when no change in condition from previous assessment.*
- *ii) Minimum time requirement for service is 1.5 hours.*
- *iii) Developmental delays include, but are not limited to: non verbal learning disability, developmental reading disability, developmental coordination disability, developmental writing disability, dsycalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.*
- *iv) Includes collection of data from collateral sources and formal screening, as appropriate.*

00512 **Repeat or limited consultation:** Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee 99.19

00514 Prolonged visit for counselling 76.71

Note: *The Plan will pay up to four such visits per year (see Clause D. 3. 3. of the Preamble).*

Group counselling for groups of two or more patients:

00513 - first full hour 120.30

00515 - second hour, per 1/2 hour or major portion thereof 60.15

		$	Anes. Level
	Continuing care by consultant:		
00506	Directive care	69.46	
00507	Subsequent office visit	63.13	
00553	Extended subsequent office visit – exceeding 23 minutes (actual time spent with patient):	114.76	

Notes:
i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00507 or 00554.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

		$	Anes. Level
00554	Extended subsequent office visit – exceeding 38 minutes (actual time spent with patient):	166.51	

Notes:
i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00507 or 00553.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

		$	Anes. Level
00508	Subsequent hospital visit	69.46	
00509	Subsequent home visit	73.16	
00505	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	115.27	

Notes:
i) Claim must state time service rendered.
ii) For premature care or intensive care of a newborn (see Clauses D. 4. 5., D. 4. 6., D. 4. 7., and D. 4. 8. of the Preamble).

Telehealth Service with Direct Interactive Video Link with the Patient

		$	Anes. Level
50510	Telehealth Consultation: To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	204.52	
50511	Telehealth Consultation for complex behavioural, developmental or psychiatric condition in a child: To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	411.87	

Notes:
i) Not to be billed when no change in condition from previous assessment
ii) Minimum time requirement for service is 1.5 hours.
iii) Developmental delays include, but are not limited to: non-verbal learning disability, developmental reading disability, developmental coordination, disability, developmental writing disability, dsycalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.
iv) Includes collection of data from collateral sources and formal screening, as appropriate.

		$	Anes. Level
50512	Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	99.19	

		$	Anes. Level
50514	Telehealth prolonged visit for counselling	76.71	

Note: *The Plan will pay up to four such visits per year.*
(see Clause D. 3. 3. of the Preamble)

50506	Telehealth directive care	69.46	
50507	Telehealth subsequent office visit	63.13	
50508	Telehealth subsequent hospital visit	69.46	

Miscellaneous

00545 Pediatric Case Conference – a formal, scheduled session/meeting to discuss/plan medical management of patients with serious and complex pediatric problems. Payable only when coordination of care and two-way collaborative conference with community agency representative and/or health care provider is required e.g.: psychologists, counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry – per ¼ hour or major portion thereof.............................46.34

Notes:

i) Patient must be 18 years of age or younger.
ii) For services related to:
- *a) psychiatric disorders*
- *b) developmental disorders*
- *c) major chronic disease*
- d) pre-transplant (concerning donor/recipient assessment*)*
- *e) end of life*
- *f) multiple medical handicaps*

iii) Maximum of one hour may be claimed per patient per day.
iv) Not to exceed a maximum of four hours per patient per year.
v) The case conference must last at least 15 minutes to submit a claim.
vi) The results of the case conference must be recorded in the patient's chart along with the start and end times of the conference, as well as the names and job titles of the other participants at the meeting.
vii) This fee is not payable to physicians who are employed or who are under contract to a facility, agency or program (ie: Ministry of Children and Families' FAS, autism and child abuse or neglect assessments, HEAL, health authorities) who otherwise would have attended the conference as a requirement of their employment with the facility, agency or program.
viii) This fee is payable when the care conference occurs in person or by phone
ix) A visit or consult may be payable for the same patient on the same day as a case conference, provided the two items are consecutive, not concurrent, and start and end times are provided for both. A note record must be submitted for consults and patient management conferences occurring on the same day.
x) It may not be claimed unless the pediatrician has a pre-existing relationship with the patient.
xi) Not payable within 3 months of fee item 00511 without a note record explaining the medical necessity.
xii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.
xiii) Start and end times must be included in time fields.

Special Procedures

Code	Description	$	Anes. Level
00525	Insertion of intra-arterial infusion line in infants - extra to consultation	91.79	
00523	Exchange transfusion - procedural fee	439.96	

Notes:

i) *Charge full fee for all repeat transfusions.*
ii) *Normally an assistant for exchange transfusion is not required. However, in those exceptional cases when an assistant is required, an explanation of need must accompany the account to the payment agency.*
iii) *Paid at 50% when billed in conjunction with critical care codes.*
iv) *Not applicable to replacement of blood with saline for hyperviscosity syndrome.*

Code	Description	$	Anes. Level
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	54.90	
	Electrocardiogram and interpretation:		
00527	- office (each)	33.51	
00528	- home (each)	46.36	
	Electrocardiogram:		
00529	- professional fee	11.73	
93120	E.C.G. tracing, without interpretation, (technical fee)	16.26	
	Graded exercise test:		
00530	- technical fee	41.37	
00535	- professional fee	60.36	
00531	- total fee	101.73	

Note: *The notes following fee items 33034/35-36 in the Internal Medicine section of this Schedule apply to items 00530, 00531, and 00535.*

Code	Description	$	Anes. Level
00532	Electrocardiogram and interpretation for children under 2 years of age	54.90	
00533	- interpretation	12.88	
00534	- technical fee	42.03	
00539	Rectal suction biopsy in children	102.02	
00540	24 hour intraoesophageal pH study in children (to include probe and monitoring)	235.55	
SY00541	Pediatric urethral catheterization in child under 5 years – isolated procedure	19.09	

Notes:

i) *Procedure not payable if delegated to a non-physician.*
ii) *Not payable with critical care listings or diagnostic urological procedures (e.g.: voiding cystourethrogram.)*
iii) *Restricted to Pediatricians.*

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 00578, 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.*

		$	Anes. Level
00578	High Intensity Cancer Chemotherapy for patients 16 years of age and under: 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	233.36	

Notes: *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 cisplatinum 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.)*

		$	Anes. Level
00579	Major Intensity Cancer Chemotherapy for patients 16 years of age and under: 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 agents	180.32	

Note*: This service is not payable more frequently than once every 7 days.*

		$	Anes. Level
00580	Limited Intensity Cancer Chemotherapy for patients 16 years of age and under: 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 line	106.06	

Note: *This service is not payable more frequently 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

Puncture procedures for obtaining body fluids (when performed for diagnostic purposes):

		$	Anes. Level
SY00750	Lumbar puncture in a patient 13 years of age and over ***Note:*** *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*	53.02	2
SY00570	Lumbar puncture in a patient 12 years of age and younger ***Note:*** *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*	79.55	2
S00755	Artery puncture - procedural fee	6.25	2
S00571	Pediatric Oesophagogastroduodenoscopy in a patient 16 years of age and under ***Note:*** *Restricted to Pediatricians.*	190.92	3

		$	Anes. Level
S00572	Pediatric colonoscopy with flexible colonoscope – patients 16 years of age and under	350.03	2
	Notes: *i) Includes biopsies, removal of polyps, collection of specimens by brushing or washing, control of bleeding, removal or foreign body, if required.* *ii) Restricted to Pediatricians.*		
S50520	Pediatric right heart catheterization – patients 0 – 6 years of age	344.22	4
	Note: *Restricted to BC Children's Hospital.*		
S50521	Pediatric right heart catheterization – patients 7 – 16 years of age	258.16	4
	Note: *Restricted to BC Children's Hospital.*		
S50527	Pediatric retrograde left heart catheterization, extra – patients 0 – 6 years of age	275.31	4
	Note: *Restricted to BC Children's Hospital.*		
S50528	Pediatric retrograde left heart catheterization, extra – patients 7 – 16 years of age	206.48	4
	Note: *Restricted to BC Children's Hospital.*		
S50530	Pediatric trans-septal left heart catheterization – patients 0 – 6 years of age	371.00	4
	Note: *Restricted to BC Children's Hospital.*		
S50531	Pediatric trans-septal left heart catheterization – patients 7 – 16 years of age	278.25	4
	Note: *Restricted to BC Children's Hospital.*		
S50539	Pediatric percutaneous transluminal coronary angioplasty – patients 0- 6 years of age	783.62	4
	Note: *Restricted to BC Children's Hospital.*		
S50540	Pediatric percutaneous transluminal coronary angioplasty – patients 7- 16 years of age	587.72	4
	Note: *Restricted to BC Children's Hospital.*		
S50541	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0 – 6 years of age	413.11	4
	Note: *Restricted to BC Children's Hospital.*		
S50542	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7– 16 years of age	309.83	4
	Note: *Restricted to BC Children's Hospital.*		
S50545	Pediatric therapeutic radiological embolization – patients 0 – 6 years of age	718.55	3
	Note: *Restricted to BC Children's Hospital.*		
S50546	Pediatric therapeutic radiological embolization – patients 7 – 16 years of age	538.93	3
	Note: *Restricted to BC Children's Hospital.*		

		$	Anes. Level
50550	Percutaneous cardiac stenting in pediatric patients (0 – 18 years of age) - composite fee (operation only)	1,007.65	7

Notes:
- i) *Applicable to placement of stents in vena cava, pulmonary or coronary arteries and veins and aorta.*
- ii) *Includes all necessary diagnostic imaging, right and left heart catheterization,all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implantation to include any declotting or treatment of underlying cause of access failure.*
- iii) *Not payable with fee items 00898 and 00871. This composite also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance.*
- iv) *Payable to Pediatricians only.*
- v) *Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.*

		$	Anes. Level
50551	- Additional stents – extra	212.15	

Notes:
- i) *Must be inserted into a differently named, non-contiguous vessel (provide information in note record).*
- ii) *Maximum payable is 2 additional stents.*

		$	Anes. Level
50555	Percutaneous transcatheter cardiac occluder device closure of ASD in pediatric patients (0 – 18 years of age) – composite fee (operation only)	1,007.65	7

Notes:
- I) *Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implementation to include any declotting or treatment of underlying cause of access failure.*
- ii) *Not payable with fee item 00871. This composite fee also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance.*
- iii) *Payable to Pediatricians only.*
- iv) *Medically necessary assistance payable under cardiac assist fee items 0845 and 00846.*

Neonatal Intensive 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.

These listings may be used for patients receiving neonatal intensive care and are intended for use by the Neonatologist or Pediatrician (or Team) in charge of the patient. These listings may be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, haemodynamic support including vasoactive medications or prolonged resuscitation. They are to be billed only on sick or preterm infants requiring intensive care. They are also for infants who are more than 28 days old, who have neonatal problems related to prematurity, etc. These listings do not apply to non-ventilated stable patients admitted to a special care unit for routine post-op care. These fees are not for the infant who is stable and only requiring a period of observation. Neither are they for the infant who needs a short course of prophylactic antibiotics. It would be unusual to bill these fees on an infant whose period of care in the NICU lasted less than 48 hours Consultation and visit fees would be appropriate.

These neonatal intensive care fees only apply to physicians who are directly involved in the bedside care of patients in the Critical Care Areas. “Preamble to the Payment Schedule” applies:

"C. 18. Guidelines for payment for services by residents and/or interns.

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the medical practitioner responsible shall be personally identified to the patient at the earliest possible moment. No fees may be charged in the name of the responsible staff physician for services rendered by an intern or resident prior to the identification taking place. Moreover, the responsible staff physician must be in the clinical teaching unit and/or immediately available to intervene (immediately available means on-site).

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of residents, interns or other members of the team, total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other team members."

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family counselling, emergency resuscitation, insertion of arterial, venous, Swan-Ganz, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support. Exchange transfusion is not included in these fees and not all infants requiring an exchange transfusion are critically ill.

Out-Of-Office Hours Call-out Charges may still apply for special calls back to the hospital and may be billed in conjunction with a no charge visit. If a patient is discharged from the unit for more than 48 hours and is readmitted, second day rates again apply. If the patient is re-admitted within 48 hours of discharge, billing continues under fee code billed at discharge, unless acuity level changes. If a patient changes acuity level up or down then the appropriate second day rate applies. A note record is required indicating the change in acuity level. Fee item 00505 (Emergency Visit) may not be billed by the person claiming these fees.

Call-out charges are billable with the neonatal critical care fee items. Historically, these have not been included in the neonatal fees and may be billed separately.

Members of the team billing the Neonatal Guide can not be receiving other payments (e.g.: fees, alternative or sessional payments) for the clinical care of the patient.

		$	Anes. Level
	LEVEL A - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all necessary procedures.		
01511	Day 1	610.86	
01521	Day 2 - 10	244.32	
01531	Day 11	162.91	
	LEVEL B - Infants in a Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive and requiring IV therapy or parenteral alimentation but without ventilator support.		
01512	Day 1	448.00	
01522	Day 2 - 10	162.91	
01532	Day 11	121.05	
	LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513	Day 1	386.87	
01523	Day 2 - 10	119.56	
01533	Day 11	69.46	