

SPECIALIST SERVICES COMMITTEE INITIATED LISTINGS

The following Specialist Services Committee (SSC) fee items are available to BC specialist physicians who are a certificant or fellow of the Royal College of Physicians and Surgeons of Canada.

The objective of the SSC fees is to facilitate improved care for patients by avoiding unnecessary face to face encounters, being seen by the most appropriate physician, and receiving faster access to specialist advice.

Fees will be monitored to ensure that the overall expenditures do not exceed the funds available. Changes may be made to the fees to ensure financial accountability and effectiveness.

Telephone Fees

		Total Fee \$
G10001	Specialist Telephone Advice - Initiated by a Specialist or General Practitioner, Response within 2 hours	60.00
	Notes:	
	<ul style="list-style-type: none"> i) Payable to Specialist Physicians for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient. ii) Conversation must take place within two hours of the initiating physician's request. Not payable for written communication (i.e. fax, letter, e-mail). iii) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated. iv) A chart entry, including advice given and to whom, is required. v) Not payable for situations where the purpose of the call is to: <ul style="list-style-type: none"> a) book an appointment b) arrange for transfer of care that occurs within 24 hours c) arrange for an expedited consultation or procedure within 24 hours d) arrange for laboratory or diagnostic investigations e) inform the referring physician of results of diagnostic investigations f) arrange a hospital bed for the patient vi) Limited to one claim per patient per physician per day. vii) Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition. viii) Not payable to physician initiating call. ix) Not payable in addition to another service on the same day for the same patient by same practitioner. x) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant). xi) Cannot be billed simultaneously with salary, sessional, or service contract arrangements. 	
G10002	Specialist Telephone Patient Management - Initiated by a Specialist, General Practitioner, or Allied Care Provider, Response in one week – per 15 minutes or portion thereof	40.00
	Notes:	
	<ul style="list-style-type: none"> i) Payable to Specialist Physicians for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient. ii) Conversation must take place within 7 days of initiating physician or allied care provider's request. Initiation may be by phone or referral letter. 	

- iii) *If conversation is with an allied care provider, include a note record specifying the type of provider.*
- iv) *Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
- v) *A chart entry, including advice given and to whom, is required.*
- vi) *Include start and end times in the patient's chart and time fields when submitting claim.*
- vii) *Not payable for situations where the purpose of the call is to:*
 - a) *book an appointment*
 - b) *arrange for transfer of care that occurs within 24 hours*
 - c) *arrange for an expedited consultation or procedure within 24 hours*
 - d) *arrange for laboratory or diagnostic investigations*
 - e) *inform the referring physician of results of diagnostic investigations*
 - f) *arrange a hospital bed for the patient*
- viii) *Limited to two services per patient per physician per week.*
- ix) *Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition.*
- x) *Not payable to physician initiating call.*
- xi) *Not payable in addition to another service on the same day, for the same patient by same practitioner.*
- xii) *No claim may be made where communication is with a proxy for the consultant physician (e.g.: nurse or assistant).*
- xiii) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

G10003 Specialist Telephone Patient Management / Follow-Up – per 15 minutes or portion thereof20.00

Notes:

- i) *This fee applies to two-way direct telephone communication (including other forms of electronic verbal communication) between the specialist physician and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, e-mail).*
- ii) *This fee is only payable for scheduled telephone appointments with the patient.*
- iii) *Access to this fee is restricted to patients having received a prior consultation, office visit, hospital visit, diagnostic procedure or surgical procedure from the same physician, within the 18 months preceding this service.*
- iv) *Not payable in addition to another service on the same day, for the same patient by the same practitioner.*
- v) *Telephone management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.*
- vi) *No claim may be made where communication is with a proxy for the physician (e.g.: nurse or assistant).*
- vii) *This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.*
- viii) *Include start and end times in the patient's chart and time fields when submitting claim.*
- ix) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*
- x) *Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition.*

Specialist Group Medical Visits

Referred Cases

	Total Fee \$
Fee per patient, per 1/2 hour	
G78763 Three patients.....	31.44
G78764 Four patients.....	25.41
G78765 Five patients	21.83
G78766 Six patients	19.42
G78767 Seven patients.....	17.72
G78768 Eight patients	16.44
G78769 Nine patients	15.43
G78770 Ten patients	14.60
G78771 Eleven patients.....	12.79
G78772 Twelve patients.....	12.03
G78773 Thirteen patients.....	11.14
G78774 Fourteen patients.....	10.94
G78775 Fifteen patients	10.50
G78776 Sixteen patients	10.18
G78777 Seventeen patients.....	9.76
G78778 Eighteen patients.....	9.54
G78779 Nineteen patients.....	9.20
G78780 Twenty patients	8.98
G78781 Greater than 20 patients (per patient)	8.67

Notes:

- i) *A separate claim must be submitted for each patient.*
- ii) *An active referral is required by a medical practitioner or a health care practitioner for each patient.*
- iii) *Claim must state start and end times for the service.*
- iv) *Service is not payable with other services, for the same patient, on the same day.*
- v) *The SSC reserves the right to reduce, suspend or cancel these fee items.*
- vi) *Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have provided the service as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangement.*
- vii) *Where two physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate per patient for the reduced group size. Each claim should indicate "group medical visit" and also identify the other physician*

Care Planning

G78717 Specialist Discharge Care Plan for Complex Patients – extra	75.00
This fee is intended to support clinical coordination leading to effective discharge and community based management of complicated patients. It is to be billed for patients who require community support upon discharge and are otherwise at risk of readmission.	

Notes:

- For the purpose of creating and ensuring complex patients have a detailed care plan following discharge.*
- i) *Payable to the Specialist Physician who is the MRP for the majority of the patient's in-hospital care and writes the care plan.*
 - ii) *Payable for the communication and clinical oversight of a patient care plan for complex patients.*

- iii) *Primary care provider must be notified of admission by phone, fax, or electronic means within 24 hours for patients with an estimated length of stay greater than 4 days.*
- iv) *Patient must be an admitted in-patient with length of stay greater than 4 days.*
- v) *Not applicable for patients admitted for elective procedures.*
- vi) *The written Discharge Care Plan must be completed and shared with:*
 - a) *the patient at time of discharge, and*
 - b) *the patient's primary health care provider within 24 hours of discharge.*
- vii) *Care plan must:*
 - a) *be developed in consultation with the providers identified in the plan, as necessary;*
 - b) *include record of appropriate clinical information, interventions, co-morbidities and safety risks;*
 - c) *include re-referral triggers and description of arranged follow-up care;*
 - d) *include expectation of symptom progression / remission and patient progress;*
 - e) *be included in the patient's medical record.*
- viii) *Payable once per patient per discharge from hospital.*
- ix) *Claim on the day of discharge.*
- x) *Out-of-Office Hours Premiums may not be claimed in addition.*
- xi) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

Advance Care Planning

Advance Care Planning is when a capable adult thinks about and discusses their beliefs, values and wishes for future health care, in the event the adult becomes incapable of making such decisions in the future. The adult may have advance care planning discussions with close family or trusted friends and health care providers. When an adult's wishes or instructions for advance care planning are written down, they become an Advance Care Plan.

This fee premium is to facilitate a Specialist Physician to have a discussion with the patient about advance care planning based on the patient's beliefs, values and wishes for future health care.

G78720 Specialist Advance Care Planning Discussion – extra.....40.00

Notes:

- i) *Paid only to the Specialist Physician for Advance Care Planning discussions and plan development for patients presenting with:*
 - a) *a chronic medical illness or complex co-morbidities, and*
 - b) *a deteriorating quality of life or end-stage disease state.*
- ii) *The advance care planning discussion should include sharing information and resources on how a patient can create an advance care plan, including Advance Directives.*
- iii) *A care plan form is required to be completed and added to the patient's chart and the discussion summarized in the consultation report including any decisions about the patient's future health care wishes. (The care plan form template is available at: www.sscbc.ca).*
- iv) *The care plan template form must be completed and shared with:*
 - *the patient, and*
 - *the patient's primary health care provider.*
- v) *Payable at 100% in addition to other services rendered on the same day.*
- vi) *Not paid with adult and pediatric critical care (01400 series), or neonatal intensive care (01500 series) per hospital admission.*
- vii) *The message to the patient and the plan must be consistent with the Practice Support Program's End of Life Module resources. (<http://www.practicesupport.bc.ca/psp/specialist-learning/clinical-management>)*
- viii) *Not paid for physicians on salary, sessional, or service contract arrangements.*

Labour Market Adjustment Fee Items

The 2009 Physician Master Agreement included provisions for the Specialist Services Committee (SSC) to allocate funding specifically for making labour market adjustments where required to recruit and retain specialists and to support the delivery of high quality specialty care in British Columbia. The SSC allocated \$10 million to specifically address labour market adjustments linked to recruitment and retention pressures. In so doing, the SSC ensured funds would be made available only in relation to proposed initiatives that met the overall objectives of the 2009 Agreement, that met the necessary thresholds regarding demonstrable recruitment and retention pressures and, further, that provided for new fees or initiatives that could be monitored and managed within the fixed amount that was made available pursuant to the terms of the 2009 Agreement.

For additional information on the Labour Market Adjustment process see:
<https://www.bcma.org/committee/specialist-services-committee-ssc>

Section of Anesthesia

This SCC fee item is not specialty restricted.

	Total Fee \$
G01195 Minimum Anesthetic Procedural fee, per case.....	103.53
Notes:	
i) <i>May claim for G01195 or one of the procedural fee items 01172, 01173, 01174, 01175, 01176, 01177, 01178, 01179, 01180, 01181, 01005, 01106, 01110, or 01111, but not both.</i>	
ii) <i>Start and end times must be included with claim submission.</i>	
iii) <i>Anesthetic procedural fee modifiers are payable in addition.</i>	
iv) <i>Not paid with cataract surgery.</i>	
v) <i>Not payable for procedural services provided in the Emergency Department.</i>	

Section of General Internal Medicine

	Total Fee \$
G32307	121.20
Subsequent follow-up office visit, complex patient – 3 medical conditions.....	
Notes:	
i) Payable only for General Internal Medicine specialists who do not hold a sub specialty.	
ii) Payable only if 00311 paid within the previous 6 months.	
G32308	83.83
Subsequent hospital visit, complex patient – 3 medical conditions.....	
Notes:	
i) Payable only for General Internal Medicine specialists who do not hold a sub specialty.	
ii) Payable only for an admitted patient.	
iii) Payable only if 00311 paid within the previous 6 months.	
iv) Payable for ongoing inpatient follow up care, for each day hospitalized during the first ten days of hospitalization, thereafter bill 00308.	
v) The total of all daily billing under this fee item that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. Daily totals will be paid as follows:	
- 1-15 visits paid at 100%	
- 16 or more visits paid at 50%	
G32312	196.95
Complex Consultation - 2 medical conditions	
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 2 or more of the conditions listed in note iv), below.	
iv) Payable for patients that have 2 of the following listed chronic diseases, (if patient has more than 2 diagnoses from the list, use 00311). 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)	
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)*

G32317 Subsequent follow-up office visit, complex patient – 2 medical conditions.....70.70

Notes:

- i) *Payable only for General Internal Medicine specialists who do not hold a sub specialty.*
- ii) *Payable only if G32312 paid within the previous 6 months.*

G32318 Subsequent hospital visit, complex patient – 2 medical conditions.....50.50

Notes:

- i) *Payable only for General Internal Medicine specialists who do not hold a sub specialty.*
- ii) *Payable only for an admitted patient.*
- iii) *Payable only if G32312 paid within the previous 6 months.*
- iv) *Payable for ongoing inpatient follow up care, for each day hospitalized during the first ten days of hospitalization, thereafter bill 00308.*
- v) *The total of all daily billing under this fee item that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. Daily totals will be paid as follows:*
 - *1-15 visits paid at 100%.*
 - *16 or more visits paid at 50%.*

Section of Endocrinology and Metabolism

	Total Fee \$
G33260 Initial virtual consultation, with patient or representative/family	119.21
Notes:	
i) Includes review of referral materials, acquisition of additional necessary data, communication with the patient as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received.	
ii) Restricted to Endocrinology and Metabolism specialists.	
iii) Not paid within 6 months of a 33210 (consultation), 33270 (Telehealth consult), or G33260 (virtual consult), for the same diagnosis.	
G33262 Repeat or limited virtual consultation within the same calendar year as G33260, 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	59.61
Notes:	
i) Restricted to Endocrinology and Metabolism specialists.	
ii) Not paid with face to face repeat or limited consultation (33212) or Telehealth repeat/limited consult (33272), same date of service.	
G33267 Subsequent virtual office visit, requiring a written individualized report to the GP.....	37.93
Notes:	
i) Restricted to Endocrinology and Metabolism specialists.	
ii) Maximum 6 per calendar year, per patient.	
G33250 Virtual communication with patient, or representative/family, for medically pertinent matters.....	10.10
Notes:	
i) Restricted to Endocrinology and Metabolism specialists.	
ii) Maximum 12 per calendar year, per patient.	
GY33255 Insulin start	40.40
Notes:	
i) Paid with endocrinology consultations or visits (33210, G33260, 33206,33207,33208,33209, G33262, G33267).	
ii) Restricted to Endocrinology and Metabolism specialists.	
iii) Maximum one per day, per patient.	
iv) Not paid same day as GY33256.	
v) Also payable for the other injected non-insulin diabetes medications: liraglutide and exenatide.	
GY33256 Insulin pump start	80.80
Notes:	
i) Paid with face to face endocrinology consultations or visits (33210, 33206,33207,33208,33209, G33260, G33262 or G33267).	
ii) Restricted to Endocrinology and Metabolism specialists.	
iii) Maximum one per patient, per day.	
iv) Not paid same day as GY33255.	
G33240 Premium for patients 75 years and over, billed in addition to 33210, 33212, 33270, 33272, G33260 or G33262.....	53.19
Notes:	
i) Restricted to Endocrinology and Metabolism specialists.	
ii) Maximum one premium, per patient, per day.	

**Total
Fee \$**

G33241 Premium for patients 75 years and over, billed in addition to 33207, 33209,
33277, G33267, G33250, GY33255, or GY3325614.26

Notes:

- i) *Restricted to Endocrinology and Metabolism specialists.*
- ii) *Maximum one premium, per patient, per day.*

Section of Geriatric Medicine

**Total
Fee \$**

G33445 Geriatric Care Conference (planning for patient age 65+), - per 15 minutes, or greater portion thereof47.98

Notes:

- i) *Restricted to Geriatric Medicine.*
- ii) *Requires interdisciplinary team meeting of at least one allied health professional, and may or may not include family members and/or representatives.*
- iii) *Paid only if 33401 or a consult from General Internal Medicine, or sub-specialty paid for same patient in previous 6 months.*
- iv) *Maximum four paid per patient, per sitting.*
- v) *Maximum eight paid per patient, per calendar year.*
- vi) *The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in patient's chart, and result communicated to FP/GP.*
- vii) *Claim must state start and end times of this service.*
- viii) *Not paid to physicians who are employed by, or who are under contract to a facility: or physician working under salary, service contract, or sessional arrangements.*
- ix) *Visit paid in addition, if medically required and does not take place concurrently with the conference. Medically required visits performed consecutive to this fee will be paid.*

G33450 Family Conference (planning for patient age 65+), - per 15 minutes or greater portion thereof42.93

Notes:

- i) *Restricted to Geriatric Medicine.*
- ii) *One or more family members/representatives must be present.*
- iii) *Paid only if 33401 or a consult from General Internal Medicine, or sub-specialty paid for same patient in previous 6 months.*
- iv) *Maximum of four per patient, per sitting.*
- v) *Annual maximum of eight per patient.*
- vi) *The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in patient's chart, and result communicated to FP/GP.*
- vii) *Claim must state start and end times of this service.*
- viii) *Not paid to physicians who are employed by, or who are under contract to a facility: or physician working under salary, service contract, or sessional arrangements.*
- ix) *Visit paid in addition, if medically require and does not take place concurrently with the conference. Medically required visits performed consecutive to this fee will be paid.*

G33455 Geriatric reassessment subsequent to comprehensive assessment - patients 65-74 years95.16

Notes:

- i) *Restricted to Geriatric Medicine.*
- ii) *See Geriatric Preamble for billing criteria.*
- iii) *Minimum time requirement for service is 20 minutes.*
- iv) *Payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments.*
- v) *Payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.*

Section of Infectious Diseases

**Total
Fee \$**

G33645 Infectious Disease Care Management of HIV/AIDS - in or out of office visit
- per half hour or major portion thereof.....99.75

Notes:

- i) Payable to Infectious Diseases specialists only.
- ii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid.
- iii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.
- iv) Start and end times must be included on claim, and in patient's chart.
- v) Services that are less than 15 minutes should be billed under the appropriate visit fee item.

G33655 Home Parenteral Antibiotic Management Fee, for active antibiotic
treatment only 18.51

Notes:

- i) Restricted to Infectious Diseases specialists.
- ii) This fee may be billed for advice by telephone, fax, e-mail, or in written form.
- iii) This fee may be billed to a maximum of one per patient, per physician, per day.
- iv) This fee may not be billed in addition to visits, out-of-office premiums, or other services provided on the same day, by the same physician, for the same patient
- v) A note record must be included for payment past 42 days.

Section of Respiriology

**Total
Fee \$**

G32011 Complex Respiratory Medicine Assessment, for patients with advanced multi-system disease, per 15 minutes or greater portion thereof59.06

Notes:

- i) *Restricted to Respiratory Medicine specialists who provide care in the following clinics:
Adult Cystic Fibrosis: St. Paul's and Royal Jubilee Hospital
Interstitial Lung Disease: Vancouver General and Saint Paul's
Severe Asthma: Vancouver General, Saint Paul's and Surrey Memorial Lung Transplant Clinic (includes pre and post lung transplant assessment)
Pulmonary Hypertension: Vancouver General and Saint Paul's.*
- ii) *Maximum of 7 hours per day, per clinic.*
- iii) *When consult, repeat or limited consult or visit is charged in addition to G32011, for billing purposes, the consultation fee shall constitute the first ½ hr. and the repeat or limited consult or visit will constitute the first 15 minutes of the time spent with the patient.*
- iv) *Includes time spent in multidisciplinary case conferencing and teleconferencing with other health care providers and/or patients.*
- v) *A written consultation report is required for each patient seen in the clinic.*
- vi) *Start and end times must be included on claims.*

Section of Rheumatology

**Total
Fee \$**

G31050 Extended consultation-exceeding 61 minutes (actual time spent with patient).
To consist of examination, review of history, laboratory, x-ray findings,
necessary to initiate care.....266.59

Notes:

- i) *Restricted to Rheumatology.*
- ii) *Applicable to patients with chronic and complex medical needs. Paid with the following diagnostic codes:*
 - a. *Diffuse Diseases of Connective Tissue (710), Systemic Lupus Erythematosus (710.0), Systemic Sclerosis (710.1), Sicca Syndrome (710.2), Dermatomyositis (710.3), Polymyositis 710.4, Other (710.8), Unspecified (710.9);*
 - b. *Rheumatoid Arthritis and other Inflammatory Polyarthropathies (714), Rheumatoid Arthritis (714.0), Felty's Syndrome (714.1), Other Rheumatoid Arthritis with Visceral or Systemic Involvement (714.2), Juvenile Chronic Polyarthritits (714.3), Chronic Postrheumatic Arthropathy (714.4), Other (714.8), Unspecified (714.9);*
 - c. *Polyarteritis Nodosa and Allied Conditions (446), Polyarteritis Nodosa (446.0), Acute Febrile Mucocutaneous Lymphnode Syndrome (MCLS) (446.1), Hypersensitivity Angiitis (446.2), Lethal Midline Granuloma (446.3), Wegener's Granulomatosis (446.4), Giant Cell Arteritis (446.5), Thrombotic Microangiopathy (446.6), Takayasu Disease (446.7);*
 - d. *Ankylosing Spondylitis and Other Inflammatory Spondylopathies (720), Ankylosing Spondylitis (720.0), Spinal Enthesopathy (720.1), Sacroiliitis, not Elsewhere Classified (720.2), Other Inflammatory Spondylopathies (720.8), Unspecified Inflammatory Spondylopathy (720.9);*
 - e. *Other Disorders of Bone and Cartilage (733), Osteoporosis (733.0), Pathologic Fracture (733.1), Cyst of Bone (733.2), Hyperostosis of Skull (733.3), Aseptic Necrosis of Bone (733.4), Osteitis Condensans (733.5), Tietze's Disease (733.6), Algoneurodystrophy (733.7), Malunion and Nonunion of Fracture (733.8), Other and Unspecified (733.9);*
 - f. *Psoriasis and Similar Disorders (696), Psoriatic Arthropathy (696.0), Other Psoriasis (696.1), Parapsoriasis (696.2), Pityriasis rosea (693.3), Pityriasis Rubra Pilaris (694.4), Other Unspecified Pityriasis (696.5), Other (696.8).*
 - g. *Arthropathy associated with infections (711);*
 - h. *Polymalgia rheumatic (725);*
 - i. *Gout (274), (712).*
- iii) *Paid to a maximum of one per patient within six months of the last visit.*
- iv) *Not paid in addition to 31010, 31012, 31006, 31007, 31008, 31110, 31112, 31106, 31107 or 31108.*
- v) *Start and end times must be recorded on claim and in the patient's chart.*
- vi) *Not paid when there is no change in condition from previous assessment.*

G31055 Rheumatology Immunosuppressant Review40.40

Notes:

- i) *Restricted to Rheumatology.*
- ii) *Applicable only to patients with chronic systemic inflammatory diseases requiring aggressive immunosuppression.*
- iii) *Annual maximum - one per patient.*
- iv) *Immunosuppressant tool must be recorded in patients' chart.*

**Total
Fee \$**

G31060 Multidisciplinary Conference for community-based patients. To consist of assessment, written treatment plan and any other counselling the patient needs for management of their particular diagnosis222.72

Notes:

- i) *Restricted to Rheumatology.*
- ii) *For the ongoing management of complex disorders of the musculoskeletal system, where the complexity of the condition requires the continuing management by a rheumatologist. It is not intended for the evaluation and/or management of uncomplicated rheumatologic disorders (e.g.: osteoarthritis, bursitis/tendonitis, neck and back pain).*
- iii) *Only paid when a Registered Nurse or Licensed Practical Nurse is present.*
- iv) *Applicable to patients with rheumatoid arthritis diagnoses or similar inflammatory disease.*
- v) *Maximum one per patient in 6 month period.*
- vi) *Not paid in addition to 31010, 31012, 31007 or G31050.*

Section of Neurology

**Total
Fee \$**

G00468 Neurology Outpatient Transcranial Doppler Ultrasound: To consist of static and dynamic insonation and definition of intracranial circulation, within 72 hours of stroke onset. This study is designed to assist with a CVA.....117.15

Notes:

- i) *Restricted to Neurologists.*
- ii) *Paid for outpatients at provincial stroke prevention clinics.*
- iii) *Billable only in addition to 00441, 00442, 00443, 00444 and with 00410, 00411, 00407, 00409, 00470, 00471, or 00477 for patients with sickle cell disease or subarachnoid hemorrhage.*
- iv) *The physician must be present throughout the study.*
- v) *Start and end times must be entered on the patient's chart and on the claim.*
- vi) *Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation, as indicated by the clinical setting*

G00469 Neurology Outpatient Transcranial Doppler Ultrasound – Prolonged Study – per 15 minutes or greater portion thereof: To consist of prolonged study, which includes fitting of halo-type head brace or other device, and review of study29.28

Notes:

- i) *Restricted to Neurologists.*
- ii) *Paid for outpatients at provincial stroke prevention clinics.*
- iii) *Paid after 45 minutes of G00468.*
- iv) *The physician must be present throughout the study.*
- v) *Start and end times must be entered on patient's chart and on the claim.*
- vi) *Paid to a maximum of 8 units per patient, per study.*
- vii) *Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation as indicated by the clinical setting.*

G00465 Acute Stroke Intra-Arterial Thrombolysis.....1047.98

Notes:

- i) *Restricted to Neurologists.*
- ii) *Paid once per study, regardless of number of arterial territories treated.*
- iii) *Includes all diagnostic and superselective angiograms, angioplasties or stent insertions performed during procedure and immediate post-procedure CT scans.*
- iv) *For repeats within 24 hours, a note record must be submitted.*
- v) *Paid only if 00441 performed within the previous 48 hours.*
- vi) *Not paid concurrently with fee item 00442 or 00443.*

G00462 Neurological interpretation and written report of submitted x-ray films (including CT scan, TCD, MRI) – per case.....51.73

Notes:

- i) *Restricted to Neurologists.*
- ii) *For repeats within 24 hours, a note record must be submitted.*
- iii) *Not paid with a consultation (00410, 00411, 00470, 00471, 00441, 40441) within 2 months of this service on the same patient.*
- iv) *Not paid with specialist telephone services G10001, G10002 or G10003 on the same day for the same patient.*
- v) *Not paid for interpretations rendered to inpatients.*
- vi) *Paid to a maximum of 5 services per Neurologist per month.*

		Total Fee \$
G00450	Complex Care - Extended Consultation - per 15 minutes or major portion thereof.....	57.26
	Notes:	
	<i>i) Paid in addition to 00410, 00411, 00470 and 00471, after 45 minutes.</i>	
	<i>ii) Paid to a maximum of 3 units per patient, during same sitting.</i>	
	<i>iii) Start and end times must be entered on patient's chart and on claim.</i>	
G00457	Complex Care – Extended Visit- per 15 minutes or major portion thereof.....	36.09
	Notes:	
	<i>i) Paid in addition to 00406, 00407, 00408, 00409, 00476, 00477 or 00478 after 15 minutes.</i>	
	<i>ii) Paid to a maximum of 2 units per patient, during same sitting.</i>	
	<i>iii) Start and end times must be entered on patient's chart and claim.</i>	
G00460	Transfer of Care from Pediatrics - Extended Consultation: To consist of an examination, review of history, previous laboratory & x-ray findings, and written report on a patient with a complex and chronic neurologic condition requiring active neurologist support transferring from pediatric to adult care. In addition, specific and special documentation as outlined below must be included in the patient's chart and copies sent with the patient and/ or family as appropriate.....	382.62
	Notes:	
	<i>i) For pediatric patients 16 years of age and older.</i>	
	<i>ii) This fee is payable to a neurologist who accepts the primary responsibility for the neurologic management of a patient transferring from pediatric to adult care, and includes review of ALL necessary data, including birth and developmental assessments.</i>	
	<i>iii) Paid once per patient in that patient's lifetime.</i>	
	<i>iv) Not paid with to 00410, 00411, 00441, 40441, 00470, 00471 G00450 or G00457.</i>	

Section of Obstetrics and Gynecology

	\$	Anes Level
G04701 Repeat urinary incontinence procedure for cases of a previously failed retropubic or vaginal procedure.....	411.13	4
Notes:		
i) Restricted to Obstetrics and Gynecology specialists.		
ii) Fee items 00704, 00705, 08202, 08282, or 08283 not paid in addition.		
G04702 Transection or removal of suburethral mesh sling	411.13	4
Notes:		
i) Restricted to Obstetrics and Gynecology specialists.		
ii) Fee items 00704, 00705 or 08232 not paid in addition.		
G04703 Augmented anterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to Arcus Tendinous	410.03	2
Notes:		
i) Fee items 00704, 00705 or 04227 not paid in addition.		
ii) Restricted to Obstetrics and Gynecology specialists.		
G04704 Augmented posterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to sacrospinous ligament	410.03	2
Notes:		
i) Fee items 04421 or 04422 not paid in addition.		
ii) Restricted to Obstetrics and Gynecology specialists.		
G04705 Removal of trans-vaginal placed synthetic mesh where indicated, from anterior or posterior compartment, due to pain or complications	492.03	2
Notes:		
i) Fee items 00704, 00705 are not paid in addition.		
ii) Claims for surgical assistance for G04705 are payable under G04710, G04711, G04712.		
iii) Paid at 50% when done with 04605 or 04408.		
iv) Restricted to Obstetrics and Gynecology specialists.		
G04706 Vaginal vault suspension – Apical support procedure	399.82	2
Notes:		
i) Paid for sacrospinous, pre-spinous, iliococcygeal suspension or high, uterosacral ligament plication performed for vault suspension (synthetic or biologic).		
ii) Paid for Stage 3 and Stage 4 prolapse with or without hysterectomy.		
iii) Fee items 00704, 00705, 04408, 04424, 04605 not paid in addition.		
iv) 04227, 04421, 04422, G04703, G04704, paid in addition, as per Preamble D. 5. 3.).		
v) Restricted to Obstetrics and Gynecology specialists.		
G04707 Laparoscopic sacrocolpopexy, includes oophorectomy and/or salpingectomy	771.70	5
Notes:		
i) Fee items 00704, 00705, 00815, 04001, 04003, 04041, 04042, 04408, 04605, 04232, 04233 or G04706 not paid in addition.		
ii) Fee items 04040 and 04047 payable in addition but the maximum payable under these items shall not exceed the value of fee item 04229.		
iii) Other items listed under laparoscopic operations are not payable in addition to this item.		
iv) In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus the open procedure.		
v) G04708 will apply after 2 hours.		
vi) Claims for surgical assistance for G04707 are payable under G04710, G04711, G04712.		
vii) Restricted to Obstetrics and Gynecology specialists.		

	\$	Anes Level
G04708	Prolonged laparoscopic surgery, per 15 minutes or major portion thereof (extra)70.70	
	Notes:	
	i) <i>Restricted to Obstetrics and Gynecology.</i>	
	ii) <i>Fee item 00815 is considered included in G04708.</i>	
	iii) <i>Paid as an extra to laparoscopic surgical procedures when surgical time exceeds 2 hours.</i>	
	iv) <i>Start and end times (for total time of surgery) must be entered on the claim and in the patient's chart.</i>	
G04709	Laparoscopic total or supracervical hysterectomy, and/or laparoscopic assisted vaginal hysterectomy (LAVH) (includes oophorectomy and/or salpingectomy).....856.08	5
	Notes:	
	i) <i>Fee items 00815, 04001, 04003, 04041, 04042, 04048, 04202, 04228, 04229, 04232 and 04233 are not paid in addition.</i>	
	ii) <i>Fee items 04043, 04044, 04047, 04660, and 04662 are payable in addition, but the maximum payable under these items shall not exceed the value of fee item 04229.</i>	
	iii) <i>Other items listed under laparoscopic operations are not payable in addition to this item.</i>	
	iv) <i>Claims for surgical assist are payable under fee items G04710, G04711, G04712, G04713.</i>	
	v) <i>In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus open procedure.</i>	
	vi) <i>G04708 will apply after 2 hours.</i>	
	vii) <i>Restricted to Obstetrics and Gynecology specialists.</i>	
G04710	Gynecological certified surgical assistant – for up to one hour254.22	
	Notes:	
	i) <i>Paid only with G04705, G04707 or G04709.</i>	
	ii) <i>Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.</i>	
	iii) <i>Restricted to Obstetrics and Gynecology specialists.</i>	
G04711	Gynecological certified surgical assistant, time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient – each 15 minutes or fraction thereof26.54	
	Notes:	
	i) <i>After 3 hours of continual surgical assistance for one patient, bill under fee item G04712 (time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof).</i>	
	ii) <i>Please indicate start and end time of service on claim.</i>	
	iii) <i>Restricted to Obstetrics and Gynecology specialists.</i>	
G04712	Gynecological surgical assistant (certified or second), time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof27.75	
G04713	Laparoscopic hysterectomy second surgical assistant242.57	
	Note:	
	i) <i>Paid only with G04709.</i>	

G04714	Prolonged surgery – Open procedure per 15 minutes or major portion thereof (extra)	70.70
	Notes:	
	i) <i>Restricted to Obstetrics and Gynecology specialists.</i>	
	ii) <i>Paid as an extra to an open surgical procedure, when surgical time exceeds 2 hours.</i>	
	iii) <i>When an open case results from conversion of a laparoscopic procedure, G04714 is paid after 2 hours total surgical time.</i>	
	iv) <i>Start and end times (for total time of surgery) must be entered on the claim and patient's chart.</i>	
G04715	Obstetrical surcharge therapeutic abortion (D&E) at 18 weeks and over (extra)	80.80
	Notes:	
	i) <i>Paid only with 04114.</i>	
	ii) <i>Restricted to Obstetrics and Gynecology specialists.</i>	
G04716	Obstetrical surcharge for therapeutic abortion (D&E) at 14 to 18 weeks (extra)	60.60
	Note: <i>Paid only with 04110.</i>	
G04717	Prenatal office visit for complex obstetrical patient	46.22
	Notes:	
	i) <i>Paid only for the following diagnoses:</i>	
	a) <i>Fetal conditions:</i>	
	<ul style="list-style-type: none"> • <i>Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g.: open neural tube defect, body wall defect such as omphalocele, or gastroschisis, congenital; fetal arrhythmia, hydrocephalus).</i> • <i>Hydrops fetalis</i> • <i>Iso-immunization</i> 	
	b) <i>Maternal conditions:</i>	
	<ul style="list-style-type: none"> • <i>Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrhythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilatation).</i> • <i>Renal disease (e.g.: renal failure, renal transplant)</i> • <i>Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)</i> • <i>Endocrine disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)</i> • <i>Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)</i> • <i>Infectious disease (HIV, severe pneumonia, systemic sepsis)</i> 	
	c) <i>Pregnancy qualifying conditions: hypertension on medication, IUGR with growth less than 10%, oligohydramnios AFI less than 8, hydraminos AFI greater than 23, Type 1 Diabetes Mellitus.</i>	

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- d) Current pregnancy conditions: preterm labour, cervical incompetence, or abruption occurring in this pregnancy; (the high risk antenatal visit fee reverts to 14091 after 36 weeks gestation, multiple gestation.
- e) Previous pregnancy conditions: 2 preterm births, or 1 previous preterm birth less than 30 weeks (reverts to 14091 after 36 weeks gestation).
- ii) Restricted to Obstetrics and Gynecology specialists.

G04718 Care of complex antepartum patient prior to transfer to higher level of care facility for delivery276.51

Notes:

- i) Restricted to Obstetrics and Gynecology specialists.
- ii) Not paid with 04038, 04039, 04025, 04050, 04052, 14104, 14105.
- iii) Start and end times required in claim submission and patient's chart.
- iv) Paid only when time spent stabilizing patient by obstetrician exceeds 60 minutes, and patient is transferred to a higher level of care.
- v) Payable on the same date as a GP is paid for 14105.
- vi) Payable for pre-eclampsia, preterm labour, and for serious maternal condition(s) that requires stabilization prior to transfer.

G04719 Gynecology surgical surcharge for patients 75 years and older63.13

Notes:

- i) Restricted to Obstetrics and Gynecology specialists.
- ii) Fee item G04719 will only be paid once whether single or multiple procedures are performed under the same anesthetic.
- iii) Paid with the following surgical procedures: G04701, G04702, G04703, G04704, G04705, G04706, G04707, G04709, 00704, 00705, 00807, 00808, 00874, 00875, 00878, 04001, 04003, 04011, 04029, 04032, 04033, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04201, 04202, 04203, 04204, 04206, 04212, 04217, 04218, 04219, 04220, 04221, 04222, 04223, 04224, 04225, 04227, 04228, 04229, 04230, 04232, 04233, 04301, 04303, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04401, 04402, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04502, 04503, 04508, 04509, 04510, 04512, 04515, 04516, 04517, 04530, 04531, 04536, 04551, 04602, 04605, 04620, 04621, 04622, 04623, 04624, 04625, 04626, 04627, 04628, 04660, 04662, 06020, 06063, 07027, 07597, 07634, 08178, 08250, 08254, 08255, 08257, 08263, 08278, 08282, or 08283.
- iv) Applies to procedures performed in hospital operating room, ambulatory care or office setting.