MINISTRY OF HEALTH

SUMMARY OF CHANGES
MEDICAL SERVICES COMMISSION
PAYMENT SCHEDULE

June 1, 2026 – September 30, 2026

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INTRODUCTION

The purpose of this document is to summarize changes to the Medical Services Commission (MSC) Payment Schedule that occurred between November 1, 2025, and January 31, 2026 (additions in **bold**, deletions ~~struck-through~~).

For full understanding and interpretation of fees listed in this document, and how to bill for them, refer to the complete MSC Payment Schedule.

CARDIOLOGY

Deletion of Fee Items effective June 1, 2026:

Technical fee for scanning:

33063 **LEVEL 2:**
Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data 41.53

33065 **LEVEL 4:**

(i) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine.

(ii) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly summary of heart rate, minimum and maximum R-R intervals, premature beats, and ventricular complexes of abnormal width.....13.88

FAMILY MEDICINE

Amendment effective June 1, 2026:

14540 Insertion of intrauterine ~~contraceptive~~ device **(IUD)** (operation only)
Notes:
i) Includes ~~Pap smear if required~~ ***cervical cancer screening, if clinically indicated****.*
ii) Not payable in addition to 14541.
~~ii) Surgical assists are not billable in conjunction with fee items 04503, 04508, 04509, 04510, 04515, 04530, 04533, 04536, 04545 or 14540 except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.~~

14541 Removal of intrauterine device (IUD)-operation only
Notes*:*
i) Not payable ~~with a pap smear (14560) or IUD insertion (14540)~~ ***in addition to 14540 or 14560****.*
ii) Not billable by Family Physicians.

14560 ~~Routine p~~**P**elvic examination ~~including Papanicolaou smear (no charge when done as a pre and postnatal service)~~
Notes:
i) ~~Services billed under this code must include both a pelvic examination and Pap smear.~~
Includes cervical cancer screening, if clinically indicated.
ii) Not billable by Family Physicians.

Amendment effective August 1, 2026

The following replaces fee item 00127 under the Section of Family Medicine.

00127 Palliative Care In-Person Facility Visit

Notes:

i) Payable for palliative care provided to a patient with a life-limiting illness whose goals of care are primarily focused on comfort, quality of life, and symptom management rather than curative treatment.

ii) Payable for an in-person visit for a patient in a facility setting when:
- *a. The patient is located in a hospital, long-term care facility, or palliative care facility;*
- *b. The patient has a life expectancy of six months or less; and*
- *c. The focus of care is palliative rather than treatment aimed at cure.*

iii) Payable for visits during the last 180 days of the patient's life. Services which exceed the 180 days prior to death will be given independent consideration when a claim note record is submitted.

iv) For essential and non-emergent care, a subsequent in-person visit on the same calendar day can be billed under fee item 00127 with submission code D. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.

v) For urgent or emergent care when the attending physician is specially called back because the patient's condition has changed requiring the physician's attendance, an in-person visit can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.
- *a. When the physician must immediately leave home, office, or hospital to render care, an additional weekday daytime in-person emergency visit can be billed as fee item 00112, if the billing criteria are met.*
- *b. When the physician is specially called on an evening, nighttime, or weekend to render emergency or non-elective services and must travel from one location to another to attend the patient, call-out charges can be billed under fee items 01200, 01201, 01202 in addition to fee item 00127. Continuing care fee surcharges 01205, 01206, 01207 can be billed if the billing criteria are met.*

vi) When the physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 can be billed.

vii) Chemotherapy fee items (00578, 00579, 00580, 33581, 33582, and 33583) are not payable to the same physician for the same patient on the same day.

viii) Not payable if the patient dies unexpectedly during a hospitalization and was not considered palliative.

New Fee Items effective September 1, 2026:

Immunizations and Injections

		$
PB10051	Injection	16.61

Notes:

i) Payable for an intramuscular or subcutaneous injection administered to a patient of any age.

ii) Payable at 100% per injection.

iii) Payable to a maximum of 3 units per patient, per physician, on the same day. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.

iv) Payable in addition to 10052 and 10053.

v) When an injection is provided as part of a visit, it is included in the visit fee and is not payable as 10051.

vi) Not payable for immunizations. Immunizations are payable as 10052 (Adult) or 10053 (Pediatric).

PB10052 Adult Immunization (per vaccine administered) 16.61
Notes:
i) Payable for immunization of a patient 19 years or older.
ii) Payable at 100% per vaccine administered (any route). A combination vaccine is payable as a single service.
iii) Payable to a maximum of 6 vaccines per patient, per physician, on the same day. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.
iv) When an immunization is provided on the same day as another in-person service:
a. The immunization is included in the visit fee and not payable as 10052, except for the immunizations described in (b).
b. 10040 is payable for influenza, pneumococcal, pertussis, or COVID-19 immunization provided in addition to a visit in a clinic or the patient's home.
v) Not payable for an immunization required for travel, employment, or emigration.

P10053 Pediatric Immunization (per vaccine administered) (extra) 6.54
Notes:
i) Payable for an immunization of a patient under 19 years of age.
ii) Payable at 100% per vaccine administered (any route). A combination vaccine is payable as a single service.
iii) Payable at 100% in addition to a visit.
iv) Payable to a maximum of 6 vaccines per patient, per physician, on the same day. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.
v) Not payable for an immunization required for travel, employment, or emigration.

Amendment effective September 1, 2026:

10040 ~~Respiratory immunization for patients 19 years of age or older (with visit)~~ **Add-on Adult Respiratory Immunization (per vaccine administered) (extra)**
Notes:
i) Payable for ***one or more of the following respiratory immunizations for a patient 19 years or older:*** *influenza (using ICD-9 code V048), pneumococcal (using ICD-9 code V05), pertussis (using ICD-9 code V036), ~~and~~ COVID-19 (using ICD-9 code C19)* ***and RSV (using ICD-9 code 33C)*** *~~immunizations~~.*
ii) Payable to a maximum of 4 vaccines per patient, per physician, on the same day.
iii) ~~Payable in full with an office visit.~~
Payable at 100% in addition to an in-person service provided in a clinic or a patient's home on the same date of service.
iv) ~~If the primary purpose of the service is for immunization, bill fee item 10041~~.
If the primary purpose of the service is for other immunizations, bill fee item 10052.

Deletions effective September 1, 2026:

The following fee items are deleted with the cancellation date of August 31, 2026:

Immunizations

B00010 Intramuscular-injections, including immunizations for patients 19 years or older

Notes:

i) Payable per injection.
ii) Up to 3 injections per patient on the same date of service are billable at 100%.
iii) When performed in conjunction with a visit, the injection is included in the visit fee.
iv) Not payable for immunizations required for travel, employment, and emigration.
v) Not payable on the same day as 10010-10029.

B00034 Subcutaneous injections, including desensitization treatments and immunizations for patients 19 years or older

Notes:

i) Payable per injection.
ii) Up to 3 injections per patient on the same date of service are billable at 100%.
iii) When performed in conjunction with a visit, the injection is included in the visit fee.
iv) Not payable for immunizations required for travel, employment, and emigration.
v) Not payable on the same day as 10010-10029.

Immunizations for Patients 18 Years of Age or Younger

Notes:

i) Payable per immunization.
ii) Payable in full with an office visit to a maximum of 4 immunizations per patient per day.
iii) Not payable on the same day as B00010, B00034.
iv) Not payable for immunizations required for travel, employment and emigration.

10047 Pediatric COVID-19 immunization

Notes:

i) Payable for COVID-19 immunization (ICD-9 code C19 must be entered on claim).
ii) Payable in full with an office visit.
iii) Not payable on the same day with B00010, B00034.

10010 Tdap-IPV or DTaP-IPV (Diphtheria, Tetanus, Pertussis, Polio)
10011 DTaP-IPV-Hib (Diphtheria, Tetanus, Pertussis, Polio, Hib)
***Note**: Not payable with 10010 or 10018 on the same day, same patient.*
10012 Td (Tetanus, Diphtheria)
10013 Td/IPV (Tetanus, Diptheria, Polio)
***Note:** Not payable with 10012 or 10019 on the same day, same patient.*
10014 TdaP (Tetanus, Diphtheria, Pertussis)
***Note:** Not payable with 10013 on the same day, same patient.*
10015 Influenza (Flu)
10016 Hepatitis A
10017 Hepatitis B
10018 Haemophilus influenza type b (Hib)
***Note**: Not payable with 10011 on the same day, same patient.*
10019 Polio (IPV)
***Note:** Not payable with 10010, 10011 or 10013 on the same day, same patient.*
10020 Meningococcal C Conjugate (Men-C)
10021 Meningococcal Quadrivalent Conjugate (Groups A,C,Y, W-135)
10022 MMR (Measles, Mumps, Rubella)
10030 MMR/V (Measles, Mumps, Rubella and Varicella)

10023 Pneumococcal Conjugate
10024 Pneumococcal Polysaccharide (PPV23)
10025 Rabies
10026 Varicella (Chickenpox)
10027 DTap-HB-IPV-Hib (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib)
Note: *Not billable with fee items 10010,10011,10012, 10013, 10014,10017, 10018.*
10028 HPV (Human Papillomavirus)
10029 Rotavirus

B10041 Respiratory immunization for patients 19 years of age or older (without visit)
Notes:
i) Payable for influenza (using ICD-9 code V048), pneumococcal (using ICD-9 code V05), pertussis (using ICD-9 code V036), and COVID-19 (using ICD-9 code C19) immunizations when the primary purpose of the service is for immunization.
ii) Not payable with an office visit.

GENERAL PREAMBLE

Amendment effective June 1, 2026:

C. 11. Reciprocal Claims

All Provinces, and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid Provincial Health Registration Card. Claims can be submitted electronically and details of this process may be obtained by contacting MSP. However, the services listed below are exempt from this agreement and should be billed directly to the non-resident patient.

Medical Practitioner Services Excluded under the Inter-Provincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims

1. Surgery for alteration of appearance (cosmetic surgery)
2. Gender-reassignment surgery
3. Surgery for reversal of sterilization
4. Routine periodic health examinations including routine eye examinations (~~including PAP tests for screening only~~)
5. In-vitro fertilization, artificial insemination
6. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
7. Services to persons covered by other agencies; Armed Forces, WorkSafe BC, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)
8. Services requested by a “Third Party”
9. Team conference(s)
10. Genetic screening and other genetic investigation, including DNA probes
11. Procedures still in the experimental/developmental phase
12. Anesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the BC medical practitioner.

Amendment effective June 1, 2026:

C. 19. Services to Family and Household Members

1. Services are not benefits of MSP if a medical practitioner provides them to the following members of the medical practitioner's family:

   a) a spouse,
   b) ~~a son or daughter,~~ **a child or stepchild,**
   ~~c)~~ ~~a step-son or step-daughter,~~
   c) a parent or ~~step-parent~~ **stepparent**,
   d) a parent of a spouse,
   e) a grandparent,
   f) a grandchild,
   g) a ~~brother or sister,~~ **sibling,** or
   h) a spouse of a person referred to in paragraph (b) to (~~h~~ **g**).

2. Services are not benefits of MSP if a medical practitioner provides them to a member of the same household as the medical practitioner.

Deletions effective August 1, 2026:

Deletion:

The following sections of the General Preamble are deleted:

B. DEFINITIONS

"Palliative care"

Care provided to a terminally ill patient during the final 6 months of life, where a decision has been made that there will be no aggressive treatment of the underlying disease, and care is directed to maintaining the comfort of the patient until death occurs.

D. TYPES OF SERVICES

D. 4. 10. Palliative Care

The Palliative Care listings are applicable to the visits for palliative care delivered to patients with any life-limiting illness with life expectancy of up to 6 months, when the focus of care is palliative rather than treatment aimed at cure. These listings only apply where aggressive treatment of the underlying disease process is no longer taking place and care is directed instead to maintaining the comfort of the patient until death occurs.

Claims for these listings should be billed continuously from time of determination of patient's palliative status, for a period not to exceed 180 days prior to death. Under extenuating circumstances palliative listings billed beyond 180 days will be given independent consideration upon receipt of an explanatory note record.

The listings are applicable to patients in acute care hospitals, hospice facilities or other institutions whether or not the patient is in a designated palliative care unit. The palliative care listings do not apply when unexpected death occurs after long hospitalization for a diagnosis unrelated to the cause of death.

Amendment effective August 1, 2026:

The following sections of General Preamble D. 4. are renumbered

D. 4. ~~11~~**10**. Sub Acute Care

D. 4. ~~12~~**11**. Emergency Department Examinations

D. 4. ~~13~~**12**. House Calls

Amendment effective August 1, 2026

The following fee item is amended to reflect the renumbering of General Preamble D. 4.

Home Visits

00103 Home visit
Notes:
i) Payable for a home visit between 0800 and 2300 hours any day of the week.
*ii) Additional patients seen during the same house call are to be billed under the applicable out-of-office visit fee items (12200, 13200, 15200, 16200, 17200, 18200). Please see Preamble D. 4. ~~13~~**12**.*
iii) Not payable for a patient admitted under a Hospital at Home program.

GENERAL SURGERY

Deletion of fee item effective August 31, 2026:

~~S00789 Peritoneal lavage~~

Amendment effective September 1, 2026:

07497 Biopsy or segmental resection of non-palpable breast lesion following radiological fine wire **or seed** localization.

NEUROLOGY

New Fee Items effective July 1, 2026:

P00433 Electroencephalogram with video monitoring, 2-12 hour study – professional ……..…..…… 200.00
***Note**: 00416 not payable in addition.*

P00436 Ambulatory electroencephalogram, one day (minimum 20-hour study) – professional fee ……..…….……..... 275.00

P00438 Ambulatory electroencephalogram, two days (minimum 44-hour study) – professional fee ……..... 385.00

P00439 Ambulatory electroencephalogram, three days (minimum 68-hour study) – professional fee ..……..……..…… 495.00

New Fee Item effective July 1, 2026:

P00493 Pediatric neurology developmental assessment.....40.00

Notes:

i) Restricted to Pediatric Neurologists.

ii) Must include completion of standardized developmental assessment scales including motor, fine motor, communication, cognitive and behavioural development.

iii) Payable once per patient in a 12-month period.

iv) Limited to 24 assessments per practitioner per month.

vi) Payable only in addition to a consult or visit.

Amendments effective July 1, 2026:

P00413 **Electroencephalogram** - technical fee 80.41

Note: Payable only in addition to 00416, P00433, P00436, P00438, and P00439.

P00416 Electroencephalogram ~~– interpretation~~ **under 2-hour study** – **professional fee** ..... ~~82.65~~ **110.00**

Deletion of fee items effective July 1, 2026:

~~00415 Electroencephalogram and interpretation..... 163.06~~

~~00418 Fee for intravenous activating agents when given by a qualified electroencephalographer.....24.15~~

~~00426 Electroencephalogram - sleep only .....161.42~~

~~***Note**: Not applicable to the segments of sleep which may occur in the course of recording a standard EEG.*~~

~~00427 professional fee .....43.52~~

~~00428 technical fee ....117.92~~

~~S00914 Insertion of sphenoidal electrodes temporal lobe epilepsy, E.E.G.: recording .....46.81~~

~~S00926 Seizure activation with intravenous activating agents associated with insertion of sphenoidal and/or orbital electrodes ..... 158.70~~

Amendments effective September 1, 2026:

P00440 ~~Virtual Neurologic Assessment~~

Neurologic review and written care plan 122.66

Notes:

i) Restricted to Neurology specialists.

ii) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received.

*iii) ~~Not paid~~ **If** billed within 6 months of a 00410 ~~(Consultation)~~, 00470 ~~(Telehealth Consultation)~~, ~~or~~ 00440 ~~(Virtual Assessment)~~, **00441, 0485, or 40441** for the same diagnosis**, the medical necessity must be provided in the note record.***

*iv) Not payable in addition to a consult**ation** or visit.*

*v) Not payable ~~on the same day~~ with ~~fee items~~ 00487, 00488, 00491, 00492, 00900, 00901, **or** 00902~~, 00441, 40441~~ by the same practitioner **on the same date of service.***

*vi) Limited to ~~8~~ **20** virtual assessments per practitioner per month.*

OBSTETRICS AND GYNECOLOGY

Amendment effective June 1, 2026:

04029 ~~Either o~~**O**mentectomy~~ and/or removal of extrapelvic soft tissue mass - 5 - 10 cm~~

*Note**s:***

***i)** Not to be billed in addition to 04011.*

ii) Only payable for:

a) High-risk endometrial cancer (grade ≥ 2, and/or p-53 abnormal, and/or MMR-deficient [MSH2/6, MLH1, PMS2], or stage 1 ovarian cancers, or

b) Elevated CA125 or ER negative or enlarged nodes on imaging.

iii) Exceptional circumstances will be given independent consideration upon receipt of an explanatory note record.

Amendment effective June 1, 2026:

(g) Gynecological

S00785 Endometrial biopsy – procedural fee

Note: ~~*Includes pap smear if required.*~~

Includes cervical cancer screening, if clinically indicated.

Amendment effective June 1, 2026:

Vaginal Operations on the Cervix and Uterus

Note: *Surgical assists are not billable in conjunction with fee items 04503, 04508, 04509, 04510, 04515, 04530, 04533, 04536, **or** 04545 ~~or 14540~~ except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.*

PALLIATIVE MEDICINE

Amendments effective May 1, 2026:

Complete understanding of the following paragraphs is essential to appropriate billing of the palliative medicine fees. Not payable to physicians for services when working under salary, service contract, or sessional arrangement.

Preamble
These listings are applicable for referred services to a palliative medicine physician.

Palliative medicine fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

The palliative medicine fees are comprehensive time-based fees.

- Applicable only for palliative care patients and diagnostic code V66.7 must be submitted on the claim.
- Start and end times are for direct face-to-face time with the patient and include all services provided within those times.
- **Travel time is not billable in addition.**
- Documentation which occurs outside of the direct face-to-face times is not billable in addition and is compensated through the rate set for the palliative medicine fees.

When a referral from a physician is not available, referrals from a registered nurse for specialist palliative care can be accepted by indicating the practitioner number of the requesting nurse in the “referred by” field when submitting claims. For registered nurses not registered with MSP, use practitioner number 99987. The name of the referring registered nurse should be documented in the note field of the claim and in the patient’s clinical record.

Referred Cases

		$
P43000	Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof	75.75

Notes:
*i) Paid to a maximum of ~~4~~ **6** units.*
ii) Start and end times must be included with the claim and documented in the patient chart.
iii) Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43100	**Consultation in patient’s home: To consist of examination, review of history, laboratory and imaging findings, and written report – first 15 minutes or greater portion thereof**	**175.75**
P43101	**– each additional 15 minutes or greater portion thereof (extra)**	**75.75**

Notes:
*i) **Paid to a maximum of 6 units (43100 and 43101 combined).***
*ii) **Start and end times must be included with the claim and documented in the patient chart.***
*iii) **Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble.***

iv) ***Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.***

Continuing care by consultant

Subsequent office ~~or home~~ visit
P43001 – per 15 minutes, or greater portion thereof.....50.50

Notes:

i) Paid to a maximum of 2 units. ***Submit an explanatory note record for additional units claimed beyond the maximum.***

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Subsequent hospital or facility visit
P43002 – per 15 minutes, or greater portion thereof.....50.50

Notes:

i) Paid to a maximum of 2 units. ***Submit an explanatory note record for additional units claimed beyond the maximum.***

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Subsequent visit in patient's home
P43200 – first 15 minutes or greater portion thereof 150.50
P43201 – each additional 15 minutes or greater portion thereof (extra).....50.50

Notes:

i) Paid to a maximum of 4 units (43200 and 43201 combined). Submit an explanatory note record for additional units claimed beyond the maximum.

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble.

iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Complex End-of-Life Visits

P43006 **Complex end-of-life visit in hospital or facility (extra) – per 15 minutes, or greater portion thereof 75.75**

Notes:

i) Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient's family, notifying other healthcare providers or services.

ii) Payable only in addition to 43002.

iii) Paid once per patient to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.

iv) Start and end times must be included with the claim and documented in the patient chart.

v) Not payable in addition to out-of-office-hours premiums.

vi) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43007 **Complex end-of-life visit in patient's home (extra) – per 15 minutes, or greater portion thereof 75.75**

Notes:

i) Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient's family, notifying other healthcare providers or services.

ii) Payable only in addition to 43200 and 43201.

iii) Paid once per patient to a maximum of 4 units. Submit an explanatory note record for additional units claimed beyond the maximum.

iv) Start and end times must be included with the claim and documented in the patient chart.

v) Not payable in addition to out-of-office-hours premiums

vi) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

<u>Telehealth Service</u>:

P43010 Telehealth Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof.....75.75

Notes:

*i) Paid to a maximum of ~~4~~ **6** units.*

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Telehealth subsequent visit

P43011 – per 15 minutes, or greater portion thereof.....50.50

Notes:

i) Paid to a maximum of 2 units. ***Submit an explanatory note record for additional units claimed beyond the maximum***

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Miscellaneous

P43008 First palliative hospital or facility visit of the day bonus (extra).....100.00

Notes:

i) Paid only if 43002 paid the same day.

ii) Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended.

iii) Not payable same day for same physician as 13338 or 13339.

P43009 First palliative home visit of the day bonus (extra).....200.00

Notes:

i) Paid only if 43200 paid the same day.

ii) Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended.

iii) Not payable same day for same physician as 13338 or 13339.

Palliative hospital or facility admission examination

P43003 – per 15 minutes, or greater portion thereof.....~~75.75~~ **80.00**

Notes:

*i) Paid to a maximum of ~~4~~ **6** units.* ***Submit an explanatory note record for additional units claimed beyond the maximum.***

ii) Start and end times must be included with the claim and documented in the patient chart. ***Start and end times must not be concurrent with another service.***

iii) Not payable with a consultation or visit (43000, 43001, 43002, 43010, 43011, 43100, 43101, 43200 or 43201).

iv) *Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Palliative Family Conference (planning for patient)

P43004 – per 15 minutes or greater portion thereof.....~~43.99~~ **75.75**

Notes:

i) Restricted to Palliative Medicine.

ii) Paid to a maximum of 4 units per patient, per sitting. ***Submit an explanatory note record for additional units claimed beyond the maximum.***

*iii) Annual maximum of ~~8~~ **12** units per patient.*

iv) Start and end times must be included with the claim and documented in the patient chart. ***Start and end times must not be concurrent with another service.***

v) One or more family members/representatives must be present.

vi) Service may be provided face-to-face, telephone, or video technology.

vii) The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in the patient's chart, and result communicated to the Family Physician, Specialist and/or appropriate Allied Care Provider involved in the care of the patient.

~~viii) Claim must state start and end times of this service.~~

ix) Visit paid in addition, if medically required and does not take place concurrently with the conference. ~~Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.~~

x) Not ~~billable or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Palliative Interdisciplinary Conference with Allied Care Provider and/or Physician

P43005 – per 15 minutes or greater portion thereof.....75.75

Notes:

i) Restricted to Palliative Medicine.

*ii) Paid to a maximum of 2 units per sitting. **Submit an explanatory note record for additional units claimed beyond the maximum.***

*iii) Start and end times must be included with the claim and documented in the patient chart. **Start and end times must not be concurrent with another service.***

iv) Service may be provided face-to-face, telephone, or video technology.

v) Payable for two-way collaborative conferencing with another physician and/or an allied care provider.

vi) Details of care conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, roles(s) in care, and information on clinical discussion and decisions made.

vii) Not ~~billable by or~~ payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.