

Schedule of Facility Costs

**For Integrated Community Health
Services Centre
Under the
*Integrated Community Health Services
Centres Act***

(May 2024)

GENERAL PREAMBLE

PREAMBLE

1. Every licensee is responsible for ensuring that facility costs are charged to the Ministry, and payment accepted, only in accordance with the *Integrated Community Health Services Centres Act* (ICHSCA) and its regulations.
2. Facility costs shall be charged to the Ministry only in respect of a service rendered by a physician for which an amount payable is prescribed by the regulations under the *Health Insurance Act* (HIA), or a service prescribed as an insured service under the HIA rendered by a practitioner within the meaning of that Act (i.e., OHIP-insured medically necessary services provided to an insured person pursuant to a requisition.*)
3. Previous payment of a facility cost shall not be construed as approval of any particular billing practice.
4. Each Integrated Community Health Services Centre (ICHSC) licence is issued with respect to a specified single location or, in the case of mobile ICHSCs, with respect to specified multiple locations. Licensees are not permitted to charge facility costs to the Ministry, or to receive payment, in respect of services provided at locations other than the location(s) specified on the ICHSC licence. The unique billing number issued by the Ministry to each ICHSC shall only be used to charge facility costs to the Ministry for services provided at the location(s) specified on the facility licence. Non-compliance may lead to recovery of funds, licensing action in accordance with the ICHSCA, prosecution pursuant to the *Provincial Offences Act*, and/or such other legal action may be appropriate in the circumstances.
5. Where a referring physician requests a single site imaging study (for example, one breast, one limb), any additional imaging of a portion of the anatomy for comparison purposes is not an insured service and shall not be charged to the ministry.
6. Where a referring physician requests a single site imaging study, any additional imaging study is not an insured service and shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record.
7. Where a licensee provides breast ultrasound services, a scan of the axilla is an integral part of the breast imaging exam. The licensee shall not charge any facility costs to the ministry in connection with an additional insured service fee code such as J182 (extremity ultrasound).
8. Where a referring physician requests mammography, the addition of ultrasound breast imaging services shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record.
9. Where a copy of an imaging study is requested for the purpose of continuing medical care, the licensee shall not charge any person for costs of preparing a CD or other imaging media. If a licensee charges a patient in such circumstances, the ministry will reimburse the patient and recover the full amount from the licensee through set-off from future billings, in addition to applying an administrative penalty of \$50 per occurrence, pursuant to the ICHSCA and regulations.

* "written requisition" means: a written requisition from a referring physician or a requisition from a practitioner as may be permitted under the ICHSCA or the HIA and the regulations.

NUCLEAR MEDICINE IN VIVO

PREAMBLE

SPECIFIC ELEMENTS

For Facility Cost Component (F fee)

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure(s).
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.
- G. Providing premises, equipment, supplies and personnel for all *specific elements* of the facility cost components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility cost components are claimed separately. Claims for the facility cost component F are submitted using listed fee code with suffix B. Where the ICHSC is submitting professional fee claims on behalf of the interpreting physician, claims for professional component are submitted using fee code with suffix C (e.g. J802C).
2. If examination of Brain, Lung, Liver or Spleen is limited to one view, the benefit (F fee) is to be reduced by 50%.
3. Repeat studies on the same day may be claimed only after exercise or drug intervention.

NUCLEAR MEDICINE IN VIVO

CARDIOVASCULAR SYSTEM

F

| | |
|---|--------|
| Venography | |
| J802 - peripheral and superior vena cava | 101.75 |
| First Transit | |
| J804 - without blood pool images | 17.00 |
| J867 - with blood pool images | 60.55 |
| Cardioangiography | |
| J806 - first pass for shunt detection, cardiac output and transit studies | 100.45 |
| Myocardial Perfusion Scintigraphy | |
| J807 - resting, immediate post stress | 229.80 |
| J866 - application of SPECT (maximum one per examination), to J807 add | 45.95 |
| J808 - delayed | 84.60 |
| J809 - application of SPECT (maximum two per examination), to J808 add | 45.95 |
| Myocardial scintigraphy | |
| J810 - acute infarction, injury | 93.20 |
| Myocardial wall motion | |
| J811 - studies | 100.45 |
| J812 - repeat same day (to a maximum of three repeats) | 50.85 |
| J813 - studies with ejection fraction..... | 142.75 |
| J814 - repeat same day (to a maximum of three repeats) | 50.85 |
| Note: | |
| J811 and/or J812 rendered in conjunction with J813 and/or J814 are insured services payable at nil. | |
| J815 Detection of venous thrombosis using radioiodinated fibrinogen up to ten days | 139.10 |

NUCLEAR MEDICINE IN VIVO

ENDOCRINE SYSTEM

F

Adrenal scintigraphy

| | | |
|------|---|--------|
| J816 | - with iodocholesterol..... | 407.60 |
| J868 | - with iodocholesterol and dexamethasone suppression..... | 476.70 |
| J869 | - with MIBG..... | 586.55 |

Thyroid scintigraphy

| | | |
|------|----------------------------|--------|
| J818 | - with Tc99m or I-131..... | 67.75 |
| J871 | - with I-123..... | 108.90 |

[Commentary:

1. Indications for thyroid scanning include:

- a. Hyperthyroidism (including nodules associated with hyperthyroidism); or
- b. Congenital hypothyroidism; or
- c. Masses in the neck or mediastinum suspected to be thyroid in origin.
- d. Assessment of multinodular glands to guide tissue sampling; or
- e. Assessment of nodules with equivocal Fine Needle Aspiration findings.

2. Nuclear thyroid assessment is not generally indicated for the investigation of adult hypothyroidism.

3. Thyroid nodules of less than 1 cm in size may not be accurately assessed by thyroid scintigraphy.]

Thyroid

| | | |
|------|---------------|-------|
| J817 | - uptake..... | 30.25 |
| J870 | - repeat..... | 15.45 |

Parathyroid scintigraphy

| | | |
|------|---|--------|
| J820 | - dual isotope technique with Tl201 and Tc99m Iodine..... | 247.90 |
| J872 | Metastatic survey with I-131..... | 254.10 |

NUCLEAR MEDICINE IN VIVO

GASTROINTESTINAL SYSTEM

F

Schilling test

| | |
|-----------------------------|-------|
| J821 - single isotope | 47.20 |
| J823 - dual isotope | 50.85 |

Malabsorption test

| | |
|---|--------|
| J824 - with C ¹⁴ substrate | 60.55 |
| J873 - with whole body counting | 145.40 |

Gastrointestinal

| | |
|--|--------|
| J825 - protein loss | 87.05 |
| J874 - blood loss using – Cr ⁵¹ | 65.40 |
| J829 - transit..... | 108.90 |

Calcium absorption

| | |
|--|--------|
| J826 - Ca ⁴⁵ | 65.40 |
| J875 - Calcium ⁴⁷ absorption/excretion..... | 267.30 |
| J827 Oesophageal motility studies – one or more | 125.55 |

Gastro-oesophageal

| | |
|------------------------|-------|
| J876 - reflux..... | 59.90 |
| J877 - aspiration..... | 42.40 |

Abdominal scintigraphy – for gastrointestinal bleed

| | |
|--|--------|
| J830 - Tc99m sulphur colloid or Tc ⁰⁴ | 91.90 |
| J878 - labelled RBCs..... | 151.25 |
| J879 - LeVeen shunt patency | 70.05 |
| J831 Biliary scintigraphy..... | 120.95 |
| J832 Liver/spleen scintigraphy | 84.60 |
| J833 Salivary gland scintigraphy..... | 101.65 |

NUCLEAR MEDICINE IN VIVO

GENITOURINARY SYSTEM

F

| | | |
|--|--|--------|
| J834 | Dynamic renal imaging | 101.65 |
| Computer assessed renal function | | |
| J835 | - includes first transit | 139.10 |
| J880 | - repeat after pharmacological intervention..... | 47.40 |
| J836 | Static renal scintigraphy | 35.15 |
| J837 | ERPF by blood sample method | 42.40 |
| J838 | GFR by blood sample method | 42.40 |
| J839 | Cystography for vesicoureteric reflux..... | 127.30 |
| Testicular and scrotal scintigraphy | | |
| J840 | - includes first transit | 87.05 |

NUCLEAR MEDICINE IN VIVO

HAEMATOPOIETIC SYSTEM

F

| | |
|---|--------|
| J841 Plasma volume..... | 45.95 |
| J843 Red cell volume..... | 50.85 |
| J847 Ferrokinetics – clearance, turnover, and utilization | 423.50 |
| J848 Red cell, white cell or platelet survival..... | 108.40 |
| J849 Red cell survival with serial surface counts..... | 156.60 |

Bone marrow scintigraphy

| | |
|--------------------------|--------|
| J881 - whole body | 120.05 |
| J882 - single site | 89.60 |

In-111 leukocyte scintigraphy

| | |
|--------------------------|--------|
| J883 - whole body | 384.80 |
| J884 - single site | 338.85 |

NUCLEAR MEDICINE IN VIVO

MUSCULOSKELETAL SYSTEM

F

Bone scintigraphy

| | | |
|------|-----------------------|--------|
| J850 | - general survey..... | 109.50 |
| J851 | - single site | 89.60 |

Gallium scintigraphy

| | | |
|------|-----------------------|--------|
| J852 | - general survey..... | 187.55 |
| J853 | - single survey | 130.65 |

Application of Tomography (SPECT)

| | | |
|------|--|-------|
| J819 | - where each SPECT image represents a different organ or body area, to J852, maximum three images per examination..... add | 45.95 |
|------|--|-------|

Note:

J850 and J851 are not to be billed together. J804 may be claimed in addition to J850 or J851 for blood pool study.

NUCLEAR MEDICINE IN VIVO

NERVOUS SYSTEM

T

CSF circulation

| | | |
|------|---------------------------------|--------|
| J857 | - with Tc99m or I-131 HAS | 127.00 |
| J885 | - with In-111 | 325.50 |
| J886 | - via shunt puncture..... | 93.55 |
| J858 | Brain scintigraphy..... | 95.50 |

NUCLEAR MEDICINE IN VIVO

RESPIRATORY SYSTEM

F

| | | |
|------|--|--------|
| J859 | Perfusion lung scintigraphy..... | 90.75 |
| J887 | Ventilation lung scintigraphy | 113.75 |
| J860 | Perfusion and ventilation scintigraphy – same day..... | 181.55 |

NUCLEAR MEDICINE IN VIVO

MISCELLANEOUS

F

| | | |
|--|--|--------|
| J861 | Radionuclide lymphangiogram | 118.50 |
| J862 | Ocular tumour localization | 79.85 |
| J864 | Tear duct scintigraphy..... | 102.85 |
| J865 | Total body counting..... | 198.50 |
| Application of Tomography (SPECT), other than to J808 or J852 | | |
| J866 | - maximum one per Nuclear Medicine examination.....add | 45.95 |

NUCLEAR MEDICINE IN VIVO

SCINTIMAMMOGRAPHY

F

Scintimammography is not eligible for payment unless at least one of the following conditions is met:

- a. the patient has a dense breast(s) and one or both of the following risk factors:
 - i. a first degree relative with breast cancer diagnosed prior to age 50;
 - or
 - ii. a first degree relative with breast cancer diagnosed over age 50 and patient is within 5 years of the age when the relative was diagnosed with breast cancer.
- b. architectural distortion of the breasts due to prior breast surgery, radiotherapy, chemotherapy or the presence of breast prosthesis rendering mammography interpretation difficult;
- c. malignant breast lesion when mammography is unable to exclude multifocal disease;
- or
- d. solitary lesion identified on mammography of greater than 1 cm

Scintimammography

J863 - unilateral or bilateral 105.60

Note:

For the purpose of this provision, “dense breast(s)” means (a) breast(s) occupied by over 75% fibroglandular tissue as noted on mammography.

DIAGNOSTIC RADIOLOGY

PREAMBLE

SPECIFIC ELEMENTS

For Facility Cost Component (F fee)

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure or assisting in the performance of fluoroscopy.
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.
- G. Providing premises, equipment, supplies and personnel for all specific elements of the technical components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility cost components are claimed separately. Claims for facility cost component F are submitted using the listed fee code with suffix B.
2. If less than the minimum number of views are performed, reduce listed fees by 25%.
3. If insured diagnostic radiology procedures yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient governed by the needs of the patient and the requirements of the referring physician or practitioner, the radiologist may add further views and claim for the additions which are to be noted in the report.
4. Where a referring physician requests a single site imaging study (for example, one breast, one limb), any additional imaging of a portion of the anatomy for comparison purposes is not an insured service and shall not be charged to the ministry.
5. A stereo pair is to be counted as two views.
6. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.
7. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examination requests.
8. Mandible X006 and Temporomandibular joints X007 are not both to be routinely claimed on the same patient but only when specifically ordered.
9. Conventional films of the spine should not be routinely done and claimed for before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they have been done at an outside office, then it is a matter for the radiologist and the referring physician to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required procedure of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.
10. Lumbar or lumbosacral spine X028 does not include the entire sacrum. An x-ray of the sacrum may be carried out and claimed for only when specifically indicated.

DIAGNOSTIC RADIOLOGY

PREAMBLE

11. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.
12. Chest studies should not be routinely done and claimed in mammography cases.
13. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examinations, e.g. examinations of the GI tract, urinary tract, and special procedures.
14. 'Colon - air contrast' may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.
15. 'Oesophagus, stomach and duodenum - double contrast' presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.
16. 'Pharynx and oesophagus - cine or videotape' (X106) should not be claimed routinely with X108 and X109 but only when specifically indicated.
17. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.
18. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.
19. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who has the authority to determine what examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed, a single film is usually inadequate.
20. No extra fee should be claimed for rapid sequence IVP.
21. Nephrotomography is covered by the listings for intravenous pyelogram and planigram.
22. Preoperative and Routine Chest X-rays
 - a. The technical and professional fee components for chest x-ray, X090, X091 and X092 are not eligible for payment in the routine preoperative preparation or screening of a patient for non-cardiac, non-thoracic surgery, unless there is a clinical indication requiring a chest x-ray other than solely for preoperative preparation or screening of the patient.

[Commentary:
Examples of indications could include but are not limited to:

 1. suspected active airway or airspace disease
 2. workup of shortness of breath
 3. metastatic workup]
 - b. The technical and professional fee components for chest x-ray, X090, X091 and X092 are only eligible for payment when rendered for a patient who has symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.
23. Mammography or x-ray of the chest, ribs, arm, wrist, hand, leg, ankle or foot, rendered in an Integrated Community Health Services Centre or a hospital in-patient or out-patient department is insured in accordance with the *Health Insurance Act* when referred by a registered nurse holding an extended certificate of registration (RN(EC)).

DIAGNOSTIC RADIOLOGY

HEAD AND NECK

F

Skull

| | |
|--|-------|
| X001 - four views | 34.00 |
| X009 - five or more views | 42.40 |
| X003 Sella turcica (when skull not examined) | 16.95 |

Facial bones

| | |
|--------------------------|-------|
| X004 - three views | 24.70 |
|--------------------------|-------|

Nose

| | |
|-----------------------|-------|
| X005 - two views..... | 16.95 |
|-----------------------|-------|

Mandible

| | |
|--|-------|
| X006 - three views (unilateral or bilateral) | 24.70 |
| X012 - four or more views..... | 34.00 |
| X007 Temporomandibular joints – four views including open and closed mouth views | 24.70 |

Mastoids

| | |
|--|-------|
| X010 - bilateral – six views | 32.60 |
| X011 Internal auditory meati (when skull not examined) | 24.70 |

Note:

Dental x-rays of the teeth are not an insured benefit.

| | |
|--|-------|
| X016 Eye, for foreign body | 16.90 |
| X017 Eye, for localization, additional | 17.40 |
| X018 Optic foramina | 19.20 |
| X019 Salivary gland region | 15.65 |

Neck for soft tissues

| | |
|-----------------------|-------|
| X020 - two views..... | 15.65 |
|-----------------------|-------|

DIAGNOSTIC RADIOLOGY

SPINE AND PELVIS

F

Cervical spine

| | | |
|------|----------------------------|-------|
| X025 | - two or three views | 29.50 |
| X202 | - four or five views | 38.00 |
| X203 | - six or more views..... | 45.90 |

Thoracic spine

| | | |
|------|----------------------|-------|
| X027 | - two views | 26.90 |
| X204 | - three or more..... | 34.00 |

Lumbar or lumbosacral spine

| | | |
|------|----------------------------|-------|
| X028 | - two or three views | 29.50 |
| X205 | - four or five views | 38.00 |
| X206 | - six or more views..... | 45.90 |

Entire spine (scoliosis series)

| | | |
|------|------------------------------------|-------|
| X032 | - four views | 60.90 |
| | - orthoroentgenogram (3 foot film) | |
| X033 | - single view..... | 24.70 |
| X031 | - two or more views | 33.75 |

Sacrum and/or coccyx

| | | |
|------|----------------------------|-------|
| X034 | - two views | 27.25 |
| X207 | - three or more views..... | 35.30 |

Sacro-iliac joints

| | | |
|------|----------------------------|-------|
| X035 | - Two or three views | 24.70 |
| X208 | - four or more views..... | 32.95 |

Pelvis and/or hip(s)

| | | |
|------|---|-------|
| X036 | - one view | 16.95 |
| X037 | - two views (e.g. AP and frog view, both hips, or AP both hips plus lateral one hip)..... | 31.55 |
| X038 | - three or more views (e.g. pelvis and sacro-iliac joints, or AP both hips plus lateral each hip) | 36.25 |

DIAGNOSTIC RADIOLOGY

UPPER EXTREMITIES

F

Clavicle

| | | |
|------|-----------------------------|-------|
| X045 | - two views | 16.95 |
| X209 | - three or more views | 26.05 |

Acromioclavicular joints (bilateral) with or without weighted distraction

| | | |
|------|-----------------------------|-------|
| X046 | - two views | 24.70 |
| X210 | - three or more views | 33.65 |

Sternoclavicular joints (bilateral)

| | | |
|------|----------------------------|-------|
| X047 | - two or three views | 20.40 |
| X211 | - four or more views | 29.10 |

Shoulder

| | | |
|------|-----------------------------|-------|
| X048 | - two views | 20.40 |
| X212 | - three or more views | 29.10 |

Scapula

| | | |
|------|-----------------------------|-------|
| X049 | - two views | 20.40 |
| X213 | - three or more views | 29.35 |

Humerus including one joint

| | | |
|------|-----------------------------|-------|
| X050 | - two views | 16.95 |
| X214 | - three or more views | 25.85 |

Elbow

| | | |
|------|-----------------------------|-------|
| X051 | - two views | 16.95 |
| X215 | - three or four views | 26.05 |
| X216 | - five or more views | 35.10 |

Forearm including one joint

| | | |
|------|-----------------------------|-------|
| X052 | - two views | 16.95 |
| X217 | - three or more views | 26.05 |

Wrist

| | | |
|------|----------------------------|-------|
| X053 | - two or three views | 16.95 |
| X218 | - four or more views | 26.05 |

Hand

| | | |
|------|----------------------------|-------|
| X054 | - two or three views | 16.95 |
| X219 | - four or more views | 26.05 |

Wrist and hand

| | | |
|------|----------------------------|-------|
| X055 | - two or three views | 24.70 |
| X220 | - four or more views | 31.45 |

Finger or thumb

| | | |
|------|-----------------------------|-------|
| X056 | - two views | 13.05 |
| X221 | - three or more views | 16.95 |

DIAGNOSTIC RADIOLOGY

LOWER EXTREMITIES

F

| | |
|---|-------|
| Hip (unilateral) | |
| X060 - two or more views | 27.05 |
| Femur including one joint | |
| X063 - two views | 16.95 |
| X223 - three or more views | 25.25 |
| Knee including patella | |
| X065 - two views | 16.95 |
| X224 - three or four views | 26.05 |
| X225 - five or more views | 35.10 |
| Tibia and fibula including one joint | |
| X066 - two views | 16.95 |
| X226 - three or more views | 26.05 |
| Ankle | |
| X067 - two or three views | 16.95 |
| X227 - four or more views | 26.05 |
| Calcaneus | |
| X068 - two views | 16.95 |
| X228 - three or more views | 26.05 |
| Foot | |
| X069 - two or three views | 16.95 |
| X229 - four or more views | 26.05 |
| Toe | |
| X072 - two views | 13.05 |
| X230 - three or more views | 16.95 |
| X064 Leg length studies (orthoroentgenogram)..... | 24.70 |

DIAGNOSTIC RADIOLOGY

SKELETAL SURVEYS

F

Skeletal survey for bone age

| | | |
|------|------------------------------------|-------|
| X057 | - single film | 16.95 |
| X058 | - two or more films or views | 24.70 |

Other survey studies – e.g. rheumatoid, metabolic or metastatic

| | | |
|------|--------------------------------------|------|
| X080 | - single view | 8.45 |
| X081 | - each additional film or view | 8.45 |

DIAGNOSTIC RADIOLOGY

CHEST AND ABDOMEN

F

Chest

| | | |
|------|----------------------------|-------|
| X090 | - single view..... | 16.95 |
| X091 | - two views..... | 24.90 |
| X092 | - three or more views..... | 32.05 |

Note:

Miniature chest film for survey purposes only is not an insured benefit.

Ribs

| | | |
|------|---------------------------|-------|
| X039 | - two or more views | 20.40 |
|------|---------------------------|-------|

Sternum

| | | |
|------|---------------------------|-------|
| X040 | - two or more views | 20.40 |
|------|---------------------------|-------|

Thoracic inlet

| | | |
|------|---------------------------|-------|
| X096 | - two or more views | 16.95 |
|------|---------------------------|-------|

Abdomen

| | | |
|------|---------------------------|-------|
| X100 | - single view..... | 16.95 |
| X101 | - two or more views | 25.90 |

DIAGNOSTIC RADIOLOGY

GASTROINTESTINAL TRACT

F

| | |
|--|-------|
| Palatopharyngeal analysis | |
| X105 - cine or videotape | 33.55 |
| Pharynx and oesophagus | |
| X106 - cine or videotape | 33.55 |
| X107 Oesophagus when X103, X104, X108 or X109 not claimed..... | 30.35 |
| Oesophagus, stomach and duodenum | |
| X108 - including survey film, if taken | 52.70 |
| X104 - double contrast, including survey film, if taken..... | 55.20 |
| X103 - double contrast, including survey film, if taken, and small bowel | 69.30 |
| X110 Hypotonic duodenogram..... | 44.80 |
| X109 Oesophagus, stomach and small bowel | 67.20 |
| Small bowel only | |
| X111 - when only examination performed during patient's visit..... | 30.05 |
| Colon | |
| X112 - barium enema including survey film, if taken | 55.05 |
| X113 - air contrast, primary or secondary, including survey films, if taken | 69.70 |
| Gallbladder | |
| X114 - one or multiple day examinations..... | 34.05 |
| X120 - one or multiple day examinations with preliminary plain film..... | 45.30 |
| X116 T-tube cholangiogram..... | 24.70 |
| X123 Operative pancreatogram or ERCP..... | 24.70 |

DIAGNOSTIC RADIOLOGY

GENITOURINARY TRACT

F

| | | |
|------|---|-------|
| X129 | Retrograde pyelogram, unilateral or bilateral..... | 24.70 |
| X130 | Intravenous pyelogram including preliminary film..... | 56.45 |
| X137 | Cystogram (catheter)..... | 27.15 |
| X135 | Cystourethrogram, stress or voiding (catheter) | 31.25 |
| X131 | Cystourethrogram (non-catheter) | 6.55 |
| X191 | Intestinal conduit examination or nephrostogram | 24.70 |
| X138 | Percutaneous antegrade pyelogram..... | 24.70 |
| X139 | Percutaneous nephrostogram | 24.70 |
| X134 | Retrograde urethrogram | 20.40 |
| X136 | Vasogram..... | 20.40 |
| X141 | Cavernosography | 23.50 |

DIAGNOSTIC RADIOLOGY

OBSTETRICS AND GYNAECOLOGY

F

X147 Hysterosalpingogram.....

33.90

DIAGNOSTIC RADIOLOGY

FLUOROSCOPY – BY PHYSICIAN WITH OR WITHOUT SPOT FILMS

| | F |
|--|-------|
| X195 Chest | 10.50 |
| X196 Skeleton..... | 10.50 |
| X197 Abdomen | 10.50 |
| X189 Fluoroscopic control of clinical procedures done by another physician per ¼ hour | 8.30 |

DIAGNOSTIC RADIOLOGY

SPECIAL EXAMINATIONS

F

Abdominal, thoracic, cervical or cranial angiogram by catheterization

Using single films

| | | |
|------|---|-------|
| X179 | - non-selective | 33.65 |
| X180 | - selective (per vessel, to a maximum of 4) | 44.25 |

Using film changer, cine or multiformat camera

| | | |
|------|---|--------|
| X181 | - non-selective | 67.85 |
| X182 | - selective (per vessel, to a maximum of 4) | 90.20 |
| X140 | - selective (5 or more vessels)..... | 360.95 |

Carotid angiogram by direct puncture

| | | |
|------|-------------------|-------|
| X160 | - unilateral..... | 55.60 |
| X161 | - bilateral..... | 89.40 |

Peripheral angiogram

| | | |
|------|-----------------------------|-------|
| X174 | - unilateral..... | 33.90 |
| X175 | - bilateral..... | 44.80 |
| X198 | Splenoportogram | 67.20 |
| X199 | Translumbar aortogram | 67.20 |

Vertebral angiogram – direct puncture or retrograde brachial injection

| | | |
|------|---|-------|
| X132 | - unilateral..... | 55.60 |
| X133 | - bilateral..... | 90.90 |
| X156 | Arthrogram, tenogram or bursogram | 29.85 |
| X200 | - with fluoroscopy and complete positioning throughout by physician.. | 41.70 |

Bronchogram

| | | |
|------|--|-------|
| X158 | - unilateral..... | 32.95 |
| X159 | - bilateral..... | 43.65 |
| X122 | Cholangiogram, percutaneous trans-hepatic..... | 33.55 |

DIAGNOSTIC RADIOLOGY

BONE MINERAL DENSITY (BMD) MEASUREMENT

F

Dual-energy X-Ray Absorptiometry (DXA) – by axial technique only

Definition:

For the purpose of second and subsequent testing,

“**high risk patient**” means a patient;

1. at risk for accelerated bone loss (in the absence of other risk factors, patient age is deemed not to place a patient at high risk for accelerated bone loss);
2. with osteopenia or osteoporosis on any previous BMD testing;
or
3. with bone loss in excess of 1% per year as demonstrated by previous BMD testing.

“**low risk patient**” means a patient who is not a high risk patient

Definition/Required Elements of Service:

BMD measurement by DXA is an insured service only when all the following conditions have been met:

1. the service is rendered for the prevention and management of osteoporosis or osteopenia;
2. when more than one site is measured, the sites include both hip and spine and where measurement of both hip and spine is not technically feasible the site measured consists of either hip or spine.

[Commentary:

Measurement of hip and spine would be considered not technically feasible due to prosthesis or deformity.]

Baseline Test

| | | |
|------|---------------------------|-------|
| X145 | - one site | 48.70 |
| X146 | - two or more sites | 62.80 |

Second test - low risk patient

| | | |
|------|---------------------------|-------|
| X152 | - one site | 48.70 |
| X153 | - two or more sites | 62.80 |

Subsequent test - low risk patient

| | | |
|------|---------------------------|-------|
| X142 | - one site | 48.70 |
| X148 | - two or more sites | 62.80 |

Subsequent test - high risk patient

| | | |
|------|---------------------------|-------|
| X149 | - one site | 48.70 |
| X155 | - two or more sites | 62.80 |

Payment rules:

1. Patients are limited to one baseline test (X145 or X146) in their lifetime.
2. Second test – low risk patient (X152/X153) is limited to a maximum of one test rendered not earlier than 36 months following the baseline test (X145/X146).

DIAGNOSTIC RADIOLOGY

BONE MINERAL DENSITY (BMD) MEASUREMENT

F

3. Subsequent test – low risk patient (X142/X148) is not eligible for payment when rendered earlier than 60 months following the second or any subsequent test.
4. Any combination of services described by X152 or X153 that were rendered to a patient between July 1, 2007, and April 1, 2008, for which claims were submitted and paid as insured services under the *Health Insurance Act* constitutes, a “second test – low risk patient” for the purpose of determining service maximums for a second or subsequent test – low risk patient, and is deemed to have been rendered on July 1, 2010.
5. Any service described by X152 or X153 rendered between April 1, 2008, and July 1, 2010, for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes a subsequent test – low risk patient for the purpose of determining service maximums for second or subsequent test – low risk patient and is deemed to have been rendered on July 1, 2010.
6. Subsequent test - high risk patients (X149/X155) is limited to a maximum of one test every 12 months unless the ordering physician obtains written prior authorization from a medical consultant.

[Commentary:

Authorization will be dependent on the referring physician demonstrating that the test is generally accepted as necessary for the patient under the circumstances.]

[Commentary:

1. Baseline, second test and subsequent tests should be ordered only in accordance with current practice guidelines. In those situations where testing is ordered on a particular patient for reasons that vary from the guidelines, the ordering physician should ensure that the patient’s medical record sufficiently explains the justification for the test in this particular case.
2. In the event a patient with a previous normal baseline test (X145/X146) or second test (X152/X153) or normal subsequent test – low risk patient (X142/X148) meets any of the criteria listed for high risk patients as stated above, the patient would be eligible for subsequent test – high risk patient services (X149/X155) subject to the restriction stated in payment rule #6.
3. The 2023 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada (reviewed in 2006) can be found at <https://www.cmaj.ca/content/cmaj/195/39/E1333.full.pdf>
4. Individuals under age 65 without one major or two minor risk factors typically do not benefit from BMD measurement.]

DIAGNOSTIC RADIOLOGY

MISCELLANEOUS EXAMINATIONS

F

| | |
|---|-------|
| X163 Dacrocystogram..... | 33.65 |
| Discogram(s) | |
| X164 - one or more levels | 32.95 |
| X167 Fistula or sinus..... | 24.45 |
| X169 Laminogram, planigram, tomogram..... | 45.40 |
| X170 Laryngogram..... | 32.95 |
| X171 Lymphangiogram..... | 55.75 |
| X192 Mammary ductography..... | 28.50 |

Mammogram – Signs or Symptoms

[Commentary:

For individuals with identified signs or symptoms or follow-up of established disease.]

Dedicated equipment

| | |
|------------------------|-------|
| X184 - unilateral..... | 31.95 |
| X185 - bilateral..... | 42.30 |

Mammogram – No Signs or Symptoms

[Commentary:

Where the sole reason for the request for a mammogram is for an individual with identified risk factors in accordance with clinical practice guidelines]

Dedicated equipment

| | |
|---|-------|
| X172 - unilateral..... | 31.95 |
| X178 - bilateral..... | 42.30 |
| X194 Additional coned views with or without magnification (limit of two per breast) per film..... | 6.80 |
| X201 Breast biopsy specimen x-ray, per specimen..... | 6.80 |
| X150 Mechanical evaluation of knee..... | 28.95 |
| X193 Microradiology of the hands..... | 16.45 |
| X173 Myelogram – spine and/or posterior fossa..... | 39.75 |
| X190 Pantomography..... | 20.20 |
| X154 Penis..... | 18.15 |
| X176 Sialogram..... | 33.90 |
| X177 Skin thickness measurement..... | 17.75 |
| X166 Examination using portable machine “in home” add to first examination only..... | 73.65 |

Note:

X166 does not apply to the use of a portable machine in a hospital. Can only be claimed once per day regardless of the number of people x-rayed in the same “home” including “nursing home”.

DIAGNOSTIC ULTRASOUND

PREAMBLE

SPECIFIC ELEMENTS

For Facility Cost Component (F Fee)

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure(s).
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring physician.
- G. Providing premises, equipment, supplies and personnel for all specific elements of the technical components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility cost components are claimed separately. Claims for the facility cost component F are submitted using listed fee code with suffix B. Claims for professional component are submitted using fee code with suffix C (e.g. J102C).
2. A-Mode - implies a one-dimensional ultrasonic measurement procedure.
3. M-Mode - implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
4. Scan B-Mode - implies a two-dimensional ultrasonic scanning procedure with a two dimensional display. All ultrasound examinations include a permanent record and interpretative report.
5. All benefits listed apply to unilateral examinations unless otherwise specified. When imaging of only one anatomical area is requested, comparison ultrasound(s) initiated by the interpreting physician or facility are not eligible for payment.
6. Ultrasound of the abdomen, pelvis or breast, rendered in an Integrated Community Health Services Centre or a hospital in-patient or out-patient department, is insured in accordance with the *Health Insurance Act* when referred by a registered nurse holding an extended certificate of registration (RN(EC)).
7. Ultrasound for normal, complicated or high risk pregnancy (but not for the postpartum period) rendered in an Integrated Community Health Services Centre is insured when referred by a midwife who is a member of the College of Midwives of Ontario or an aboriginal midwife.
8. The diagnostic ultrasound benefit includes the generally accepted components of the procedure. For example, where a licensee provides breast ultrasound services, a scan of the axilla is an integral part of the breast imaging exam. The licensee shall not charge any facility costs to the ministry in connection with an additional insured service fee code such as J182 (extremity ultrasound)
9. Where a referring physician requests a single site imaging study (for example, one breast, one limb), any additional imaging of a portion of the anatomy for comparison purposes is not an insured service and shall not be charged to the ministry.

DIAGNOSTIC ULTRASOUND

PREAMBLE

10. Ultrasound of extremity (J182) are to be claimed per limb, not per joint. Scanning two joints on one limb and claiming two services for J182 is incorrect.
11. The practice of routinely submitting claims for more diagnostic ultrasound services than were requested by the referring physician for the majority of patients scanned, will result in a ministry review and potential recovery of funds and/or potential licensing actions. Examples of this unacceptable practice include;
- Bilateral Scans

2 Breasts routinely imaged and billed when only one was requested without the approval of the site radiologist , J127

2, 3, or 4 Extremities routinely imaged and billed when only one or two were requested J182 Axilla scanned and routinely billed as J182 (extremity) during a breast ultrasound [J127 includes scanning of the axilla]
 - Routine Addition of scans

Addition of trans vaginal US J138 to a requisition for pelvic US J162

Addition of extremity ultrasound J182 to peripheral vessel assessment, J202

Addition of chest US, J125 to abdominal imaging studies where this is not indicated

Addition of limited pelvis US, J163 to abdominal US, J135, or to limited abdomen, J128
12. Ultrasound services are not insured when rendered in support of in-vitro fertilization services or artificial insemination services.

DIAGNOSTIC ULTRASOUND

HEAD AND NECK

Brain

J122 - complete, B-mode 49.85

Echography – ophthalmic (excluding vascular study)

J102 - quantitative, A-mode 23.65

J103 - B-scan immersion 46.40

J107 - B-scan contact 22.95

J108 - biometry (Axial length – A-mode) 24.05

Face and/or neck

J105 - excluding vascular study 49.95

Note:

J105 is not eligible for payment when rendered for ultrasound imaging of the sinus(es).

DIAGNOSTIC ULTRASOUND

THORAX, ABDOMEN AND RETROPERITONEUM

Thorax

J125 Chest masses, pleural effusion – A & B-mode 51.50

Abdomen and Retroperitoneum

Abdominal scan

J135 - complete 51.50

J128 - limited study (e.g. gallbladder only, aorta only or follow-up study) 33.90

DIAGNOSTIC ULTRASOUND

PREGNANCY

Complete

| | | |
|------|---|-------|
| J159 | - on or after 16 weeks gestation (maximum one per normal pregnancy) | 51.50 |
| J160 | - for high risk pregnancy or complications of pregnancy | 51.50 |
| J166 | - multiple gestation, for each additional fetus, to J160 | 43.75 |

Gestational age for Maternal Serum Screening Program

| | | |
|------|--|-------|
| J157 | - before 16 weeks gestation (maximum one per normal pregnancy) ... | 33.90 |
|------|--|-------|

Limited

| | | |
|------|---|-------|
| J158 | - for high risk pregnancy or complications of pregnancy | 33.90 |
| J167 | - fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158.....add | 33.90 |

Payment rules:

J167 is only eligible for payment when rendered by a physician for assessment of:

- a. fetal anemia, or
- b. intrauterine growth retardation
 - i. with estimated fetal weight OR abdominal circumference measuring below the 10th percentile, or
 - ii. ≥ 30 percentile decrease in estimated fetal weight since previous imaging, or
- c. in high-risk pregnancies.

| | | |
|------|--|-------|
| J168 | - nuchal translucency for Prenatal Genetic Screening (maximum one per pregnancy) | 41.20 |
| J169 | - multiple gestation, for each additional fetus, to J168 | 35.00 |

Payment rules:

Payment rules: Ultrasound services listed under the headings "Abdomen and Retroperitoneum" or "Pelvis" or "Pregnancy" rendered on the same day to the same patient by any physician as J168 are not eligible for payment.

DIAGNOSTIC ULTRASOUND

PELVIS

Pelvis

| | | |
|------|--|-------|
| J162 | - complete* | 51.50 |
| J138 | Intracavitary ultrasound* (e.g. transrectal, transvaginal) | 51.50 |

Note:

*For ovulation induction purposes, the limit is one per cycle. Additional ultrasounds may be claimed as J164.

| | | |
|------|--|--------|
| J165 | Transvaginal sonohysterography – may include saline or other intracavitary contrast media except Echovist for demonstration of tubal patency | 105.60 |
| J476 | Transvaginal sonohysterography – including Echovist contrast media for demonstration of tubal patency | 246.00 |

Note:

J138 and J161 rendered in conjunction with J165 are insured services payable at nil.

| | | |
|------|--|-------|
| J163 | - limited study – for other than pregnancy | 33.90 |
|------|--|-------|

Intracavitary ultrasound

| | | |
|------|--|-------|
| J161 | - limited – for other than pregnancy | 33.90 |
| J164 | Follicle monitoring studies | 25.75 |

[Commentary:

Ultrasound services are not insured when rendered to support in-vitro fertilization services or artificial insemination services.]

DIAGNOSTIC ULTRASOUND

VASCULAR SYSTEM

Extra-cranial vessel assessment – above the aortic arch

Bilateral carotid and/or subclavian and/or vertebral arteries only

| | | |
|------|---|-------|
| J190 | - doppler scan or B scan, includes frequency/spectral analysis, if rendered | 45.05 |
| J201 | - duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis | 58.15 |

Note:

Only one of J190 or J201 is eligible for payment per patient per day.

Peripheral vessel assessment (distal to inguinal ligament or axilla), artery and/or vein evaluation per extremity. Not to be billed routinely with J190.

| | | |
|------|---|-------|
| J193 | - doppler scan or B scan, includes frequency/spectral analysis, if rendered, unilateral | 23.30 |
| J202 | - duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis, unilateral | 30.10 |

Note:

Only one of J193 or J202 is eligible for payment per extremity per patient per day.

Venous assessment

| | | |
|------|---|------|
| J198 | - bilateral – includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manoeuvres and permanent record | 7.80 |
|------|---|------|

Note:

Note to be claimed during surgery or during patient's post-operative stay in hospital.

Doppler evaluation of organ transplantation

| | | |
|------|-------------------------------|-------|
| J205 | - arterial and/or venous..... | 23.30 |
|------|-------------------------------|-------|

Duplex evaluation of portal hypertension

| | | |
|------|--|-------|
| J206 | - must include doppler interrogation and documentation of superior mesenteric vein, splenic vein, portal veins, hepatic veins and hepatic arteries | 23.30 |
|------|--|-------|

Note:

Not to be billed unless study specifically requested by referring physician.

Duplex assessment of patency obstruction, and flow direction of vascular shunts

| | | |
|------|--|-------|
| J207 | - must include doppler interrogation and documentation of vascular shunts..... | 23.30 |
|------|--|-------|

Note:

Not to be billed unless study specifically requested by referring physician.

DIAGNOSTIC ULTRASOUND

VASCULAR LABORATORY FEES

Ankle pressure measurements

| | | |
|------|---|-------|
| J200 | - requires a minimum of 4 segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings - unilateral or bilateral | 21.50 |
| J196 | - with exercise and/or quantitative measurement, to J200.....add | 8.45 |

Note:

- 1.G517 is not eligible for payment in addition to J200.
- 2.This service is only eligible for payment when the device used produces a hard copy output.

[Commentary:

For ankle pressure determination and ankle-arm index, see G517 under Cardiovascular Diagnostic & Therapeutic Procedures of the Schedule of Benefits.]

Penile pressure recordings

| | | |
|------|-------------------------------|------|
| J197 | - two or more pressures | 7.25 |
|------|-------------------------------|------|

Penile Doppler Evaluation

| | | |
|------|---------------------|------|
| J199 | - Doppler scan..... | 7.25 |
|------|---------------------|------|

Note:

Penile Doppler is only insured for the following indications:

- 1.priapism;
- 2.trauma;
- 3.revascularization;
- 4.primary erectile dysfunction; or
- 5.failure of both oral and injectable therapy for erectile dysfunction.

[Commentary:

Penile Doppler performed for other indications is not an insured service.]

Transcutaneous tissue

| | | |
|------|--|-------|
| J203 | - oxygen tension measurements | 25.45 |
| J204 | - when done in addition to Doppler studies | 13.90 |

DIAGNOSTIC ULTRASOUND

MISCELLANEOUS

Extremities

J182 - per limb (excluding vascular study) 26.95

Breast

J127 - scan B-mode (per breast)..... 25.05

Scrotal

J183 - scan..... 49.95

DIAGNOSTIC ULTRASOUND

ULTRASONIC GUIDANCE

SPECIFIC ELEMENTS

In addition to the common elements, the components of Ultrasonic Guidance include the following specific elements.

- A. Preparing the patient for the procedure.
- B. Assisting at the performance of the procedure.
- C. Making arrangements for follow-up care.
- D. Discussion with, and providing information and advice to the patient or patient's representative(s), whether by telephone or otherwise, on matters related to the service.
- E. Providing premises, equipment, supplies and personnel for all specific elements of the technical and professional components except for the premises for any aspect(s) of A and D of the professional component that is(are) not performed at the place in which the procedure is performed.

| | | |
|------|--|-------|
| J149 | Ultrasonic Guidance of biopsy, aspiration, amniocentesis or drainage procedures (one physician only) | 49.95 |
|------|--|-------|

Note:

J138 and J161 performed during the same visit as J149 is an insured service payable at nil.

PULMONARY FUNCTION STUDIES

PREAMBLE

SPECIFIC ELEMENTS

For Facility Cost Component (F Fee)

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.
- G. Providing premises, equipment, supplies and personnel for all specific elements of the technical components.

OTHER TERMS AND DEFINITIONS

1. Professional and facility cost components are claimed separately. Claims for facility cost component F are submitted using listed fee code with suffix B. Claims for professional component P are submitted using listed fee code with suffix C.
2. Each of the following tests designated by an individual code number is considered to be specific and requires individual ordering.
3. Exercise assessment (J315, E450, E451, J316) requires a physician to be in attendance at all times.

PULMONARY FUNCTION STUDIES

PULMONARY FUNCTION STUDIES

Functional residual capacity

| | | |
|------|--------------------------------|-------|
| J311 | - by gas dilution method..... | 17.25 |
| J307 | - by body plethysmography..... | 18.45 |

Note:

J311 not to be claimed same patient same day as J307.

| | | |
|------|--|-------|
| J305 | Lung compliance (pressure volume curve of the lung from TLC to FRC) | 54.90 |
| J306 | Airways resistance by plethysmography or estimated using oesophageal catheter..... | 17.10 |
| J303 | Extra pulmonary airways resistance by plethysmography | 17.10 |
| J340 | Maximum inspiratory and expiratory pressures | 2.97 |
| J310 | Carbon monoxide diffusing capacity by single breath method..... | 22.60 |
| J308 | Carbon dioxide ventilatory response..... | 21.00 |

Stage I

| | | |
|------|---|-----------|
| J315 | Graded exercise to maximum tolerance (exercise must include continuous heart rate, oximetry and ventilation at rest and at each workload) | 65.95 |
| E450 | - J315 plus J301 or J304 before and/or after exercise | add 14.05 |
| E451 | - J315 plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise | add 19.15 |

Stage II

| | | |
|------|--|-------|
| J316 | Repeated steady state graded exercise (must include heart rate, oximetry, ventilation, VO ₂ , VCO ₂ , BP, ECG, end tidal and mixed Venous CO ₂ at rest, 3 levels of exercise and recovery)..... | 95.05 |
| J330 | Assessment of exercise induced asthma (workload sufficient to achieve heart rate 85% of predicted maximum; performance of J301 or J304 before exercise and 5-10 minutes post exercise) | 35.25 |
| J319 | Blood gas analysis – pH, PO ₂ , PCO ₂ , bicarbonate and base excess ... | 11.90 |
| J318 | Arterialized venous blood sample collection (e.g. ear lobe)..... | 4.00 |
| J320 | A-a oxygen gradient requiring measurement of RQ by sampling mixed expired gas and using alveolar air equation | 29.10 |
| J331 | Estimate of shunt (Qs/Qt) breathing pure oxygen..... | 29.10 |
| J313 | Mixed venous PCO ₂ , by the rebreathing method | 11.90 |

Oxygen saturation

| | | |
|------|--|-------|
| J323 | - by oximetry at rest, with or without O ₂ | 4.45 |
| J332 | - by oximetry at rest and exercise, or during sleep with or without O ₂ . | 18.55 |
| J334 | - J332 with at least two levels of supplemental O ₂ | 32.30 |
| J336 | - with single blind assessment of exercise on room air and with supplemental oxygen..... | 32.30 |

Note:

- 1.J323 is not eligible for payment when rendered with J332, J315, J316 or any overnight sleep study.
- 2.J332 is not eligible for payment when rendered with J315, J316, or any overnight sleep study.

PULMONARY FUNCTION STUDIES

PULMONARY FUNCTION STUDIES

3.J336 is only eligible for payment for evaluation of a patient to determine eligibility for funding under the Ontario Home Oxygen Program.

4.J336 is not payable in addition to J332 or J334.

Medical record requirements: J323, J332, J334 or J336 are not eligible for payment unless a permanent record of the study is maintained.

| | | |
|------|--|-------|
| J322 | Standard O ₂ consumption and CO ₂ production..... | 5.60 |
| J333 | Non-specific bronchial provocative test (histamine, methacholine, thermal challenge) | 50.95 |
| J335 | Antigen challenge test..... | 54.80 |

Note:

For home/self-care ventilation listing – see Diagnostic and Therapeutic Procedures page J27 of the Schedule of Benefits.

SLEEP STUDIES

PREAMBLE

SPECIFIC ELEMENTS

For Facility Cost Component (F)

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure(s).
- C. Making arrangements for any appropriate follow-up care.
- D. Preparing and providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring physician.
- G. Providing premises, equipment, supplies and personnel for all specific elements of the technical components.

OTHER TERMS AND DEFINITIONS

SLEEP STUDIES

For the purpose of sleep studies (including overnight sleep studies in non-specialized facilities, overnight sleep studies rendered in specialized facilities and daytime sleep studies),

“Prior approval” means approved for payment as an insured service, before the service is rendered, by the Ministry of Health following assessment on a case-by-case basis in accordance with all medically relevant criteria.

Sleep studies are subject to limits set out below. Unless otherwise specifically provided, service(s) in excess of these limits are not insured services except when prior approval to exceed the limit is obtained from the Ministry of Health. Despite the foregoing, where prior approval to exceed a limit is not requested from the Ministry of Health but the service would otherwise satisfy one or more of the conditions for which prior approval to exceed the limit is routinely granted (had prior approval been requested) any service in excess of the limit is not eligible for payment.

Claims submission instructions:

Submit claims for professional and facility components separately. Submit claims for the facility cost component F using listed fee code with suffix B. Submit claims for professional component using fee code with suffix C (e.g. J890C).

Facility Cost Component

Payment rules:

The facility cost component of the procedure is eligible for payment only if it meets all of the following requirements:

1. A technician is in constant attendance with the patient(s) during the period of the sleep study.

SLEEP STUDIES

PREAMBLE

2. The qualifications of technical staff participating in the sleep study comply with the criteria set out by the in the inspecting body's quality and safety standards.
3. All equipment and test components comply with the criteria set out in the inspecting body's quality and safety standards.

Medical record requirements:

Records of the facility cost component must conform to the standards for facilities and facility operators (including records required prior to data analysis) as set out in the inspecting body's quality and safety standards, or the facility cost component is not eligible for payment.

SLEEP STUDIES

SLEEP STUDIES

OVERNIGHT SLEEP STUDIES

For the purpose of sleep studies (including overnight sleep studies and daytime sleep studies), “prior approval” means approved for payment as an insured service, before the service is rendered, by the Ministry of Health following assessment on a case-by-case basis in accordance with all medically relevant criteria.

Terms and Conditions

Facility costs for sleep studies meeting the eligibility parameters are payable under the *Integrated Community Health Services Centres Act* and are listed in the Schedule of Facility Costs.

Sleep studies are subject to limits set out below. Unless otherwise specifically provided, service(s) in excess of these limits are not insured services except when prior approval to exceed the limit is obtained from the Ministry of Health. Despite the foregoing, where prior approval to exceed a limit is not requested from the Ministry of Health but the service would otherwise satisfy one or more of the conditions for which prior approval to exceed the limit is routinely granted (had prior approval been requested) any service in excess of the limit is not eligible for payment.

[Commentary:

Services rendered in excess of a maximum are not eligible for payment.]

ICHSC Facility Cost Payment rules:

The facility cost for the procedure is eligible for payment only if it meets all of the following requirements:

1. It satisfies the conditions set out under “Sleep Studies Services Rendered at a licensed Integrated Community Health Services Centre (ICHSC)”.
2. It is rendered at a licensed ICHSC.
3. A technician is in constant attendance with the patient(s) during the period of the sleep study.
4. The qualifications of technical staff participating in the sleep study comply with the criteria set out in the inspecting body’s quality and safety standards.
5. All equipment and test components comply with the criteria set out in the inspecting body’s quality and safety standards.

“Sleep Studies Services Rendered at a licensed Integrated Community Health Services Centre (ICHSC)”.

A. Incomplete Overnight Sleep Studies

If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with the inspecting body’s quality and safety standards, the professional fee is not eligible for payment and the service constitutes one of the following, as determined by time in bed (total study time):

| | | |
|------|---|--------|
| J898 | Sleep study less than 1 hour | 97.90 |
| J899 | Sleep study between 1 and 4 hours | 195.80 |
| J990 | Sleep study more than 4 hours..... | 391.55 |

SLEEP STUDIES

SLEEP STUDIES

Payment rules:

1. A maximum of one of any of J898, J899 and J990 is eligible for payment, per patient, per facility, per 12 month period.
2. J898, J899 and J990 are not included in the limits for overnight studies set out below.

B. Overnight Sleep Studies in Integrated Community Health Services Centres

Level 1

Is a overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG).

Initial Diagnostic Study

“Initial Diagnostic Study” means the first overnight sleep study rendered to an insured person as an insured service in Ontario for the purpose of establishing the diagnosis of a sleep disorder (and includes a split night study). Every overnight diagnostic sleep study rendered before July 1, 2010, for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes an “initial diagnostic study” and is deemed to have been rendered on July 1, 2010.

Initial Diagnostic Study – Level 1

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| J896 - diagnostic study | 391.55 |
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Note:

1. A maximum of one initial diagnostic study is eligible for payment per patient per lifetime.
2. All subsequent overnight sleep studies constitute “repeat diagnostic” or “therapeutic” studies.

Repeat Diagnostic Study

“Repeat Diagnostic Study” means an overnight diagnostic sleep study rendered:

- a. for the purpose of obtaining a second opinion at a different facility than the facility where the preceding study was rendered, provided that the following conditions are met:
 - i. prior to the repeat diagnostic study, the patient has been assessed by a physician who practices sleep medicine at the different facility,

[Commentary:

The different facility requirement above applies to a repeat diagnostic study rendered at a hospital, a hospital off-site premise or an Integrated Community Health Services Centre.]

- ii. where the previous study was rendered at an Integrated Community Health Services Centre and the repeat diagnostic study is rendered at a different Integrated Community Health Services Centre (the “different facility”) than the Integrated Community Health Services Centre where the preceding study was rendered (the “first facility”), neither the owner nor the operator of the different facility is, at the time the repeat study is rendered, an associate of the owner or operator of the first facility, where “associate” has the same meaning as in the *Integrated Community Health Services Centres Act*;

OR

- b. for one or more of the following purposes, after pre-study assessment by a physician practicing sleep medicine:
 - i. re-evaluation of a previous negative or inconclusive diagnostic sleep study as indicated by persistent or progressive symptoms;

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- ii. re-evaluation, other than primarily for Positive Airway Pressure therapy (PAP) adjustment, of patients previously diagnosed with a primary sleep disorder in which there has been symptom development suggesting another co-morbid sleep disorder; or
- iii. re-evaluation of patients with an established diagnosis of a sleep disorder other than a sleep related breathing disorder who have significant symptom progression or non-response to therapy.

[Commentary:

1. In the case of patients with previously diagnosed sleep related breathing disorders, although PAP treatment may be adjusted during a repeat study, a repeat study is not eligible for payment if rendered primarily for PAP treatment adjustment.
2. Examples of sleep disorders other than a sleep related breathing disorder are Narcolepsy, Idiopathic hypersomnia and Periodic Limb Movement Disorder.]

J897 - diagnostic study 391.55

Payment rules:

1. Repeat diagnostic studies are limited to one per patient, per facility, per 12 month period except where prior approval has been given.
2. Repeat diagnostic studies performed in the same facility that performed the initial diagnostic study are not eligible for payment in the 12 month period following an initial diagnostic study except where prior approval has been given.

Therapeutic study

“Therapeutic Study” means a sleep study rendered after pre-study assessment by a physician practicing sleep medicine, for any of the following purposes:

- a. To establish optimal settings for nasal positive airway pressure therapy (CPAP/BiPAP/ASV etc.) and/or oxygen therapy for sleep related breathing disorders;

[Commentary:

Examples of sleep related breathing disorders are obstructive sleep apnea syndrome (OSAS), central sleep apnea syndrome (CSAS), Cheyne-Stokes breathing, complex sleep apnea syndrome, or hypoventilation syndromes.]

- b. To evaluate the response to surgical procedures for the treatment of OSAS;
- c. To determine the efficacy of oral appliance therapy for OSAS;
- d. To evaluate the efficacy of positional therapy for the treatment of OSAS;
- e. To evaluate the efficacy of substantial weight loss for the treatment of OSAS; or
- f. To titrate ventilatory settings for patients with respiratory control disorders, neuromuscular or neurodegenerative diseases.

Therapeutic Study for Sleep Related Breathing Disorders – Level 1

J895 - therapeutic study 391.55

Payment rules:

1. There is a limit of one therapeutic study (J895) per patient during any two consecutive 12 month periods except where prior approval has been given.
2. J895 rendered to the same patient during the same 12 hour period as J896 or J897 is not eligible for payment.

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[Commentary:

Subject to the prior approval requirements, an additional therapeutic study in excess of the above limits may be payable when necessary to evaluate a change in the treatment modality for a sleep related breathing disorder.]

Note:

1. For payment purposes, repeat diagnostic studies or therapeutic studies for indications or in circumstances other than listed above, or in excess of the limits set out below, require prior approval.
2. A repeat diagnostic study rendered without the required pre-study assessment by a physician practicing sleep medicine, is not eligible for payment.

[Commentary:

1. An example of an exceptional circumstance may be where a patient is required to travel a long distance to a sleep facility and requires an initial diagnostic or repeat diagnostic study followed by a therapeutic study on a subsequent night. For payment purposes, a pre-study assessment by a physician practicing sleep medicine is not required provided the therapeutic study is rendered in accordance with a clinical protocol or medical directive that has been approved by an authority other than a physician affiliated with the sleep facility (e.g. a Medical Advisory Committee for a sleep clinic affiliated with a hospital). The physician should be prepared to provide any necessary supporting documentation to the ministry upon request.
2. Prior approval, where required, will typically be dependent on the physician demonstrating that the study is generally accepted as necessary for the patient under the circumstances.
3. Sleep studies that require prior approval also require a pre-study assessment by a physician practicing sleep medicine. It is this assessment upon which the request for prior approval is considered.
4. Prior approval requires a written request accompanied by supporting documentation including the pre-study assessment and the relevant previous sleep study reports.
5. Split-night sleep studies are claimed as J896 or J897 only, as appropriate to the study rendered.]

C. Daytime Sleep Studies

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|------|---------------------------------------|-------|
| J893 | Multiple sleep latency test | 72.85 |
| J894 | Maintenance of wakefulness test | 72.85 |

Payment rules:

1. J894 rendered to same patient same day as J893 is not eligible for payment.
2. A maximum of one J893 and a maximum of one J894 are payable per 12 month period per facility per patient.
3. If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with inspecting body's quality and safety standards, the service is not eligible for payment.