Premium	Minor	Comprehensive	Multiple	Reassessment
Day 8:00am-5:00pm	**H101** $17.10	**H102** $43.05	**H103** $40.00	**H104** $17.10
Evening 5:00pm-12:00am	**H131** $20.95	**H132** $52.55	**H133** $47.45	**H134** $20.95
Night 12:00am-8:00am	**H121** $30.70	**H122** $76.95	**H123** $68.80	**H124** $30.70
Weekend/Holiday 8:00am-12:00am	**H151** $26.35	**H152** $66.15	**H153** $58.90	**H154** $26.35

***Note:** Reassessments are not eligible for payment for: discharge services, when the patient is admitted by the ED physician and when it leads to a referral for consultation. Limited to 2/physician/patient/day.*

CONSULTATIONS

Consult to ED for FRCP: **H055**
Consult to ED for CFPC: **H065**

} Write referring MD's billing number or contact info

PHONE CONSULTATIONS - Cannot lead directly to a follow-up (≥ 10min)

Referring physician: **K734**
Consultant physician: **K735**

ON-CALL CODES - (max refers to the total of first and additional person seen, per time period.)

Premium	Weekdays Daytime	Weekdays Evening	Sat., Sun. and Holidays	Nights
Travel Premium	**H960** - $36.40 Max. 2	**H962** - $36.40 Max. 2	**H963** - $36.40 Max. 4	**H964** - $36.40 Unlimited
First person seen	**H980** - $20 Max. 5	**H984** - $60 Max. 5	**H988** - $75 Max. 10	**H986** - $100 Unlimited
Additional person(s) seen	**H981** - $20 Max. 5	**H985** - $60 Max. 5	**H989** - $75 Max. 10	**H987** - $100 Unlimited

CRITICAL CARE

- Document times of arrival/departure, and that you have been called to see the patient.
- Cannot see other patients at the same time.
- Re-assessments are not allowed with Critical Care. Just add an additional CC unit.

Imminent Life Threatening	Codes	1st MD	2nd MD	3rd MD
OHIP #				
1st 15 min	G521			
2nd 15 min	G523			
Next 15 min ea. (max 6)	G522	X___	X___	X___
Overnight	H112			
Weekend	H113			
Trauma ISS > 15	E420			

Potential life-threatening	Codes	1st MD	2nd MD	3rd MD
OHIP #				
1ST 15 min:	G395			
Next 15 min ea. (max 7)	G391	X___	X___	X___
Overnight Premium	H112			
Weekend Premium	H113			
Trauma ISS>15	E420			

Other Critical Care Procedures (allowed to bill with G395 but not G521)

Cardioversion (max 3/d) included in G521 – Z437
Central Line – G269
Intubation – G211
Chest Tube – Z341
Catheter – Z611
Ultrasound – H100

COUNSELLING/FORMS: Counselling must be minimum 20 min and must have mental health diagnoses + times documented.

Mental Health care- **K005**
STD Management- **K028**
Counselling family re death/catastrophic illness- **K015**
Form 1 (application for psychiatric assess.) - **K623**
Homecare application- **K070**
Death Certificate – **A771**
Pronouncement of death + Death Cert - **A777**
Medical conditions report- **K035**

Time	Code	Checkbox
Overnight	H112	
Weekend/ Holiday	H113	

ANESTHESIA

Write 2nd MD's Billing number:

Step 1: Write procedure billing code here >
PROCEDURE MUST HAVE A **DOT •**
TO BE ELIGIBLE FOR ANESTHESIA UNITS

C

Step 2: Write the number of time units after the C

Step 3: Write a second line if the patient qualifies:

If patient is:	Then write:
< 1 year old	E009 C 4
1-8 years old	E019 C 2
70-79 years old	E007 C 1
>80 years old	E018 C 3
Prone	E011 C 4
Sitting	E024 C 4
ASA III	E022 C 2
ASA IV	E017 C10
ASA V	E016 C 20
ASA E	E020 C 4
BMI > 40	E010 C 2
ISS > 15	E420 C + %50

Step 4:

Write a third line if the patient qualifies:

If evening or weekend, write: E400 C
If overnight, write E401 C

Write the sum of the units from step 2 and 3 here:

SUTURES

Sutures	0-5cm	5.1-10cm	10.1-15cm	15.1-20cm
Face	Z154 •	Z177 •	Z190 •	Z192 •
Body	Z176 •	Z175 •	Z179 •	Z191 •

Adhesive strips or skin glue, check off (50%):

PROCEDURE PREMIUMS

Time	Code	Check
Overnight	E413	
Evening/ Weekend/ Holiday	E412	

COMPLEX LACERATIONS (≥ 20 mins, must document times)

Acute earlobe-	R024	Complex Zone 1 finger-	Z189
Complex face-	Z187	Phalanx amputation-	R606 •
Complex non-face-	Z188	Vaginal laceration-	P036 •
Repair muscle & skin-	R525 •	Extensor tendon-	R578 •

ROUTINE PROCEDURES (note: nerve blocks must provide analgesia > 4 hrs)

U/S guide procedure-	J149C	Central line	G269
Nerve block (i.e ring block, includes procedure)	G224	Arterial line	G268
Major nerve block	G060	Diag. Thoracentesis	Z331
Minor nerve block	G061	Ther. Thoracentesis	Z332 •
Major plexus block (3 in 1)	G360	Diag. paracentesis	Z590
Dental block	G231	Ther. Paracentesis	Z591
Knee aspiration	G370	NG tube	G356
Joint aspiration other than knee	G328	G tube change	Z520
U/S guided joint aspiration failed blind	E446	Hernia reduction	Z538 •
Wound / ulcer debridement's (**≥ 10 min)**	Z080	Proctoscopy	Z543
Subungual Hematoma	Z110	Manual foley declot by MD	Z608
Nail removal (or partial)	Z128 •	Misoprostol for SA - includes assessment	A920
Nail removal & cautery nail bed	Z130 •	Removal P.O.C. from OS	S756 •
EKG (must be d/c'd)	G313	Lumbar puncture	Z804
Endoscopy	Z400 •	Description of CSF	L810
Tonometry	G435	Exam under anesthesia	Z432

INCISION & DRAINAGE:

One abscess (LA)	Z101	Elbow bursa	Z226 •
One abscess (GA)	Z102 •	Oral abscess	Z506 •
Two abscesses (LA)	Z173	Bartholin's abscess (LA)	Z714
≥ 3 abscesses (LA)	Z174	Bartholin's abscess (GA)	Z715 •
Perianal abscess (LA)	Z104	Breast (LA)	Z140
Perianal abscess (GA)	Z105 •	Breast (GA)	Z740 •
Pilonidal abscess (LA)	Z106	Intramuscular abscess or hematoma	Z227 •
Pilonidal abscess (GA)	Z107 •	PTA	Z510 •
Hemorrhoid	Z545 •	Pinna hematoma	E318

FOREIGN BODIES:

Skin (LA)	Z114	Ear (LA)	Z915
Skin (GA)	Z115 •	Ear (GA)	Z866 •
Muscle	R517 •	Rectum (or disimpaction)	Z756
Nose (LA)	Z311	Rectum (GA)	Z541 •
Nose (GA)	Z312 •	Vagina (No sedation)	No fee
Eye	Z847	Vagina (GA)	Z432A
Urethra	S547 •	**FB vagina sedation	E023C •

ENT:

Ear syringe	G420	Epley	G403
Anterior packing	Z315 •	Direct laryngoscopy	Z321 •
Posterior packing	Z316 •	Direct laryngoscopy w/ foreign body removal	Z322 •
Nasal cautery	Z314 •	Indirect laryngoscopy w/ foreign body removal	Z324 •
Nasal # reduction	F136 •	TMJ reduction	D062 •

FRACTURES:

	# Code	With reduction		# Code	With reduction
Phalanx finger (closed	F004	F005 •	Pelvis (pelvic binder)	No fee	F134 •
- each additional	N/A	E558	Femur	No fee	F095 •
Phalanx finger (open)	F004	F007 •	Patella (no cast)	F085	n/a
Metacarpal	F008	F009 •	Tibia +/- fibula	F078	F079 •
Bennett's	F012	F013 •	Fibula	F082	F083 •
Scaphoid	F018	N/A	Ankle	F074	F075 •
Other carpal	F102	F016 •	Ankle with plafond burst	F074	F104 •
Colles/smith	F027	F028	Calcaneus	F070	F071 •
Colles/smith (w/ sedation)	N/A	F046 •	Metatarsal (no cast)	F061	n/a
Radius or ulna	F031	F032 •	Metatarsal (with cast)	F062	F063 •
Olecranon	F034	F035 •	Tarsal bone	F066	F067 •
Epicondyle (no cast)	F029	F037 •	Phalanx toe	F056	F058 •
Humeral shaft (no cast)	F042	F043 •	- Each additional	E560	E561
Humeral neck (no cast)	F053	F054 •			

DISLOCATION REDUCTIONS:

Phalanx finger	D001 •	A/C or S/C joint (no reduction required)	D014 •
- each additional	G576	Hip	D042 •
Phalanx finger (open)	D003 •	Knee (no cast)	D038 •
Metacarpal/phalangeal	D004 •	Patella (no sedation, no cast)	D040
Carpal	D007 •	Patella (with sedation, no cast)	D031 •
Pulled elbow	D012 •	Ankle	D035 •
Elbow	D009 •	Tarso-metatarsal (no cast)	D026 •
Shoulder (no sedation)	D015	Metatarsophalangeal	D030 •
Shoulder (with sedation)	D016 •	Interphalangeal toe	D027 •

SPLINTS AND JOINTS (only if no F or D code):

Finger:	Z201	Below-knee	Z213 •
Hand:	Z202 •	Long leg	Z211 •
Arm, forearm or wrist	Z203 •	Cast removal	Z204

Note: All Z-codes and F-codes are eligible for procedure premiums, while only the highlighted G & J-codes are eligible.

NOTES: