SGFP
GENERAL & FAMILY PRACTICE

Common Billing Codes 2015

Common Fee Codes

A001	Minor Assessment	21.70
A007	Intermediate Assessment	33.70
A003	General Assessment with diagnosis other than 917, all ages	77.20
A004	General Reassessment	38.35
K013	Counselling - Up to 3 units/yr	62.75
K033 n o	Counselling - When billing more than 3 units/yr	38.15
K040 n o	Group counselling, per unit, where no group member received more than 3 units K013 or K040 per 12 months period	62.75
K041 n o	Group counselling additional units where any group member received more than 3 units K013 or K040 per 12 months period	38.80
A005 n o	Consultation family practice and practice in general	77.20
A911 n o	Special family and general practice consultation (minimum 50 minutes)	144.75
A912 n o	Comprehensive family and general practice consultation (minimum 75 minutes)	217.15
A008	Mini Assessment - Billed with WSIB minor assess.	13.05
A888 n o	Emergency Dept Equivalent	33.70
A903	Preoperative Assessment	65.05
E080 n o	First Post Hospital Premium - within 2 weeks	25.00
A901 n	House Call Assessment (1st Patient) + Premiums	45.15

MENTAL HEALTH

K005	Primary Mental Health Care	62.75
K002 n	Interview with authorized individual	62.75
K007	Psychotherapy	62.75
K623 n o	Form 1 - Application for Psychiatric Assessment	104.80

SCREENING, HEALTH PROMOTION, CHRONIC DISEASE MANAGEMENT

A002 n o	18 Month Developmental Assessment	62.20
K017	Child Periodic Health Visit 2 to 15 years - no diagnostic code needed	43.60
K130	Adolescent Periodic Health Visit 16 or 17 years - no diagnostic code needed	77.20
K131	Adult Periodic Health Visit age 18-64 - no diagnostic code needed	50.00
K132	Adult Periodic Health Visit age 65 and older - no diagnostic code needed	77.20
K030 n o	Diabetic Management Assessment 4 per year	39.20
K032 n o	Neurocognitive Assessment	62.75
K037 n o	Chronic fatigue/ fibromyalgia care	62.75
Q150 n o	FOBT distribution and counselling	7.00
Q152 n o	FOBT completion (see restrictions)	5.00

FOCUSED PRACTICE

A957	Addiction Medicine - focused practice assessment	33.70
A927	Allergy - focused practice assessment	33.70
A967	Care of the Elderly - focused practice assessment	33.70
A937	Pain Management - focused practice assessment	33.70
A947	Sleep Medicine - focused practice assessment	33.70
A917	Sports Medicine - focused practice assessment	33.70

SUBSTANCE ABUSE

E079 n o	Smoking Cessation Premium	15.40
K039 n o	Smoking Cessation Followup	33.45
A680 n o	Initial Assessment - Substance Abuse	144.75
K680 n o	Extended Assessment- Substance Abuse	62.75
A957	Family practice - focused practice assessment- Addiction Medicine	33.70
K683 n o	Family practice - focused practice assessment- opioid agonist maintenance (per month)	38.00

SEXUALLY TRANSMITTED ILLNESS

K022 n o	HIV - Primary Care	62.75
K028 n o	STD Management Max 2 Unit/Patient/Doc/Day & 4 Units/Patient/Doc/Yr	62.75

OBSTETRICS

P004 n o	Minor Prenatal Assessment	33.70
P003 n o	Major Prenatal	77.20
P005 n o	Antenatal Preventative Assessment	45.15
P007 n o	Postnatal Care Hospital	55.15
P008 n o	Postnatal Care Office	33.70
P006 n o	Vaginal Delivery	498.70
P009 n o	Attendance labour and delivery, c-section	498.70
P023 n o	Oxytocin Stimulation	67.75
P030 n o	Cervical Ripening (max 1 per pregnancy)	58.60
C989 n o	Sacrifice Office Hours	76.40
E409 n o	Premium Days (0500-1200), 24 hours Sat. Sun * 50%	249.35
E410 n o	Premium Nights (midnight-0700) *75%	374.03
E411 n o	Sole Del Premium * 100%	498.70

* dollar value calculated for P006
n common fees outside the FHN basket
o common fees outside the FHO basket

For further information on CCMs, FHGs, FHNs and FHOs, you may access the OMA Primary Care Renewal Tutorials at www.oma.org/Member/Resources/PrimaryCareModels/Pages/default.aspx or contact your Primary Health Care Team Ministry Site at 1-866-766-0266

OHIP Information: 416.314.7444

Common Fees - Palliative Care

COMMON FEES-PALLIATIVE CARE				
K023	n	o	Palliative Care Support (>20 min)	62.75
K015			Counseling of Relatives (scheduled visit)	62.75
G512	n	o	Palliative Care Case Management (weekly)	62.75
G511	n	o	Telephone Management of Palliative Care (per call)	17.75
A945	n	o	Special Palliative Care Consultation (office, home, OPD)	144.75
C945	n	o	Special Palliative Care Consultation (hospital)	144.75
CASE CONFERENCE, TELEPHONE MANAGEMENT, FORMS-PALLIATIVE CARE				
K121	n	o	In-Hospital Case Conference - acute, chronic or rehab (per unit)	31.35
K700			Outpatient Palliative Case Conference (per unit)	31.35
K708	n	o	Multidisciplinary Cancer Conferences (per patient)	31.35
G511	n	o	Telephone Management of Palliative Care	17.75
K070	n	o	Home care application	31.75
K071	n	o	Acute home care supervision	21.40
***Can be billed concurrently for a home visit to a palliative care patient**				
HOME VISITS-PALLIATIVE CARE				
B998	n	o	Special visit, first person seen, for purpose of providing palliative care (0700-2400)*	82.50
B997	n	o	Special visit, first person seen - nights (2400-0700)*	110.00
B966	n		Travel premium*	36.40
K023	n	o	Palliative Care Support (>20 min)	62.75
A901	n		Housecall Assessment	45.15
A900	n		Complex Housecall Assessment	45.15
HOSPITAL VISITS-PALLIATIVE CARE				
C122	n	o	Most Responsible Physician Day 1	58.80
C123	n	o	Most Responsible Physician Day 2	58.80
C124	n	o	Subsequent visit – day of discharge (not for deceased patients)	5
C945	n	o	Special Palliative Care Consultation (hospital)	14
C882	n		Palliative Care Assessment - GP, acute care	3
C982	n	o	Palliative Care Assessment Specialist, acute care	3
W882	n	o	Palliative Care Assessment GP, chronic care/rehab	3
W982	n	o	Palliative Care Assessment Specialist, chronic care/rehab	3
W872	n	o	Palliative Care Assessment - GP, LTC	3
W972	n	o	Palliative Care Assessment - Specialist, LTC	3
K023	n	o	Palliative Care Support (>20 min)	6
PRONOUNCEMENT AND DEATH CERTIFICATES				
A902	n	o	Pronouncement of death in the home (includes death certificate)	4
A777	n		Pronouncement of death other than patients home (includes certificate)	3
A771	n	o	Certification of death (Completion of death certificate alone)	2
C777	n	o	Hospital Pronouncement of death - subject to the same conditions as A777 (includes certificate)	3
C771	n	o	Certification of death - subject to same conditions as A771	2
W777	n	o	Long Term Care Pronouncement of death - subject to th same conditions as A777 (includes certificate)	3
W771	n	o	Certification of death - subject to same conditions as A771	2

Special Visit Premiums

					Maximum Patients	Maximum Travel	Additional Patient	Travel Premiur
HOME VISIT PREMIUMS							**ADD TRAVEL PREMIUM**	**36.40**
B990	n		27.50	Daytime Monday-Friday elective home visit	10	2	visit fee	B960
B994	n		66.00	Evenings Monday - Friday	10	2	visit fee	B962
B996	n		110.00	Night every day	no limit	no limit	visit fee	B964
B997	n	o	110.00	Palliative care patient - night	no limit	no limit	no limit	B966
B998	n	o	82.50	Palliative care patient (all other times)	no limit	no limit	no limit	B966
B992	n		44.00	Sacrifice office hours	10	2	visit fee	B961
B993	n		82.50	Saturday, Sunday, Holidays	20	6	visit fee	B963
OFFICE VISIT PREMIUM							**ADD TRAVEL PREMIUM**	**36.40**
For other non-professional sites substitute "Q" for "A"								
A990			20.00	Day Monday - Friday	1	1	visit fee	A960
A994			60.00	Evenings Monday - Friday	1	1	visit fee	A962
A996			100.00	Night every day	no limit	no limit		A964
A998			75.00	Saturday, Sunday, Holidays	1	1	visit fee	A963
HOSPITAL PREMIUM C=HOSP, K=ER, U=OPD, W=LTC - Substitute appropriate site prefix for "C"							**ADD TRAVEL PREMIUM**	**36.40**
C990	n	o	20.00	Day Monday - Friday	10	2	C991	C960
C994	n	o	60.00	Evenings Monday - Friday	10	2	C995	C962
C996	n	o	100.00	Night	no limit	no limit	C997	C964
C992	n	o	40.00	Sacrifice office hours	10	2	C993	C961
*C986	n	o	75.00	Sat, Sun, Holidays	20	6	*C987	C963

**Please note that the numbers and C987 apply only to the "C" codes because C998 and C999 were already assigned to Surgical Assistants. all other letters i.e. A, B, K, U & W the numbers remain 998 and 999.*

Geriatric Premiums (automatically applied)

The amount payable for the following services to an insured person who is at least 65 years of age increases by 15%: (A003, A9 C003, W102, W109, or W903) (A004, C004, W004) (A007) (A901) (A917, A927, A937, A947, A957 or A967) (K132)

Forms

K071	n	o	Acute Home Care Supervision (1 per patient per week per MD for 8 weeks)	21.40
K072	n	o	Chronic Home Care Supervision (2 per month per patient per MD after 8 weeks)	21.40
K051	n	o	Health Status Report (HSR) Form	80.00
K070	n	o	Home Care Application	31.75
K038	n	o	Long Term Care Application	45.15
K052	n	o	MCFSC Activities Of Daily Living (ADL) Index	20.00
K050	n	o	MCFSC HSR & ADL Amalgamated Form	100.00
K054	n	o	MCFSC Mandatory Special Necessities Benefit Form	25,00
K056	n	o	MCFSC Pregnancy, Breast Feeding Allowance Application Form	20.00
K055	n	o	MCFSC Special Diet Application Form	20.00
K035	n	o	MTO Mandatory Reporting Medical Condition	36.25
K036	n	o	Northern Travel Grant Application	10.25
K053	n	o	Ontario Works Program - Limitation to Participation	15.00

Sports Medicine and MSK

CONSULTATIONS AND VISITS

	A917		Sports medicine focused practice assessment	33.70
	A937		Pain management focused practice management	33.70
	A005	n o	Consultation	77.20
	K013		Counselling up to 3 units/year	62.75
	K033	n o	Counselling - When billing more than 3 units/year	38.15
+	G700	x x	Basic Fee	5.10
>	E542	n	Office Premium (tray fee)	11.15

INJECTION & ASPIRATION

>	E542	n	Outside of hospital: injection, aspiration of joint, ganglion,tendon or bursa add	11.15
>+	G370	n	Injection Bursa, Aspiration joint, ganglion, tendon sheath	20.25
>	G371	n	each additional injection, aspiration up to 5	19.90
>	G328	n o	Aspiration bursa or complex joint, with or without injection	39.80
>	G329	n o	Each additional bursa/complex joint up to 2	20.25
	E446	n o	Injection joint with image guidance, (following a failed attempt without imaging) add to G370/G371	30.00
	G372		Injection im, sc, intradermal, with visit	3.89
	G373		Injection, sole reason	6.75
	G372		Each additional injection	3.89
	G384		Infiltration of tissue for trigger point	8.85
	G385		Infiltration of tissue for trigger point, each additional site, max 2, add	4.55

Notes: Only one of G370, G371, G328, G329 are payable for the same site

NERVE BLOCKS

G227	n		Cranial nerve block	54.65
G243	n o		Femoral nerve unilateral	54.65
G244	n o		Femoral nerve bilateral	81.95
G264 *	n o		Occipital nerve first block per day	34.10
G265 **	n o		Occipital nerve, each additional per spinal level, max 3/day	17.10
G238	n o		Scapular nerve	34.10
G230	n o		Sciatic nerve, unilateral	54.65
G226	n o		Sciatic nerve, bilateral	82.45
G231	n		Somatic or peripheral nerve, one nerve or site, not otherwise specified	34.10
G223	n		Somatic or peripheral nerve, nerve(s) or site(s), not otherwise specified, additional	17.10
G228	n		Spinal: paravertebral, cervical, thoracic, lumbar, sacral, coccygeal	34.10
G123	n		Spinal: peripheral, cervical, thoracic, LS, for each additional one, max 4	17.10
E958	n o		When alcohol or other sclerosing agents are used	add 50%

Notes: *G264 maximum one per day, up to 16 per calendar year. Use G291/G292 when more than 16 per year.
**G265 for each additional, up to 3, when G264 is payable in full.

REDUCTION OF FRACTURES SEE SCHEDULE OF BENEFITS

DISLOCATIONS

D009	n o	Elbow closed reduction	84.45
D012	n o	Radial head, closed reduction pulled elbow	39.00

CASTS

E584	n o	Application of plaster cast outside of hospital	11.15
Z201	n o	Cast finger	10.25
Z202	n o	Cast hand	14.90
Z203	n o	Cast, forearm or wrist	24.10
Z208	n o	Cast, shoulder spica	97.35
Z205	n o	Cast, head and torso	97.35
Z213	n o	Cast below knee, knee splints	24.10
Z211	n o	Cast whole leg	28.80
Z199	n o	Cast foot	14.90
Z198	n o	Cast toes	10.25
Z200	n o	Unna's paste	14.90
Z204	n o	Cast removal	10.25

> E542 may be charged with these fees
+ add G700 to these fees if sole reason for visit
n common fees outside the FHN basket
o common fees outside the FHO basket
x Pays 15% for FHN/FHO on rostered patients

Hospital Care, Surgical Assists, LTC and Continuing LTC

HOSPITAL CARE

C002	n o	Hospital Care - subsequent visit for first 5 weeks	31.00
C008	n o	Concurrent Care	31.00
C010	n o	Supportive Care	18.85
C122	n o	Most Responsible Physician Day 1	58.80
C123	n o	Most Responsible Physician Day 2	58.80
C124	n o	Most Responsible Physician Discharge Day	58.80
C933	n o	On-Call Admission Assessment	79.90
E082	n o	Admission assessment by the MRP, to admission assessment	add 30%
E083*	n o	Subsequent visit by the MRP to subsequent visit	add 30%
H001	n o	Newborn Care (In hospital or in home)	52.20

SURGICAL ASSISTS - per unit (x2 after 1 hour; x3 after 2.5 hours) 12.04

E400B	n o	**Evenings** Monday - Friday (5 pm - 12am), Saturday/Sunday/Holidays	50%
E401B	n o	**Nights** - Midnight to 7 am	75%

LONG TERM CARE (LTC)

K124	n o	LTC Case Conf./10 min. unit max. 4/year	31.35
W003	n o	First 2 visits/month	32.20
W008	n o	Additional 2 subsequent visits/month	21.20
W010**	n o	Monthly Management Fee	108.85
W102	n o	Admission Assessment Type 1	69.35
W107	n o	Admission Assessment Type 3/readmit from acute	30.70
W109	n o	Periodic Health Visit	70.50
W121	n o	Intercurrent illness additional visit	31.00
W771	n o	Cert. of Death (other HP pronounced) (LTC)	20.60
W777	n o	Pronouncement of Death (LTC)	33.70
W872	n o	Palliative Care visit -no limit	32.20
W903	n o	Preoperative general assessment (2 per year)	65.05

COMPLEX CONTINUING CARE & CONVALESCENT CARE IN LTC

W002	n o	First 4 visits/month	32.20
W001	n o	Additional Subsequent Visits - 4/month	21.20
W882	n o	Palliative Care Visit - no limit	32.20

***E083 applies to C002,C007,C009,C122,C123,C124,C143 C882 or C982**

**If you are billing the W010 monthly LTC code, the following services are included in the code and may not be billed as separate services: W003; W008; W121; W872; W102; W104; W107; W903; W109; W004; W777; W771; G271; K070; K071; K072; G489; G372; G373; G538; G539; G590; G591; G365; G394; E430; G379; G001; G002; G481; G003; G004; G005; G006; G007; G008; G009; G010; G011; G012;& G014.

n common fees outside the FHN basket
o common fees outside the FHO basket

Home Care, Case Conferences, Telephone and E-Consultations

CCAC HOME CARE FORMS

K070	n o	Home care application	31.75
K038	n o	Long-Term Care health report form	45.15

CCAC HOME CARE SUPERVISION

K071	n o	Acute home care supervision (first 8 weeks)	21.40
K072	n o	Chronic home care supervision (after 8 weeks)	21.40

CASE CONFERENCES OUT-PATIENTS* (MAY INVOLVE CCAC)

K703	o	Geriatric out-patient case conference	
K700		Palliative care out-patient case conference	
K707	n o	Chronic pain out-patient case conference	
K701	n o	Mental health out-patient case conference	
K704	n o	Paediatric out-patient case conference	
K702		Bariatric out-patient case conference	

CASE CONFERENCES LTC PATIENTS* (MAY INVOLVE CCAC)

K124	n o	Long-term care/CCAC-client case conference	
K705	n o	Long-term care - high risk patient conference	

CASE CONFERENCES CONVALESCENT CARE* (MAY INVOLVE CCAC)

K706	n o	Convalescent care program case conference	

CASE CONFERENCES IN-PATIENTS* (MAY INVOLVE CCAC)

K121	n o	Hospital in-patient case conference	

TELEPHONE CONSULTATION

K730	Referring physician	31.35
K731	Consulting physician	40.45

E-CONSULTATION

K738	n o	Referring physician	31.35
K739	n o	Consulting physician	40.45

CRITICALL TELEPHONE CONSULTATION

K732	Referring physician	31.35
K733	Consulting physician	40.45

*Physicians are advised to consult with the OHIP Schedule of Benefits for the specific details of each of these codes. The Schedule of Benefits describes mandatory service requirements and billing restrictions.

See www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

Commonly Billed Q Codes

ENROLLMENT Q CODES - MANDATORY FOR ROSTERING PATIENTS

Q200A	Per Patient Rostering Fee	no payment*
Q202A	FHN and FHO Long Term Care Patient Rostering	no payment*

CCM, FHG, FHN & FHO (ALL MODELS):

Q023A	Unattached pt. fee, from hospital, no max	150
Q043A	New patient fee FOBT + or colorectal increased risk	150-230**
Q053A	HCC Complex vulnerable new patient	350***
Q150A	FOBT distribution and counselling fee	7
Q050A	Heart Failure Management Incentive	125
Q040A	Diabetes Management incentive - Annual Flow Sheet	60/yr
Q042A	Smoking Cessation Counselling Fee	7.50

FHN ONLY:

Q014A	Newborn Episodic Care (<1year old, max 8)	15.05

FHO ONLY:

Q015A	Newborn Episodic Care (<1year old, max 8)	13.99

FHG ONLY:

FHGS - 10% PREMIUM AUTOMATICALLY ADDED TO

A001, A002, A003, K130, K131, K132, A007, A008, A888, A900, A901, A902, C010, C882, G365, G538, G539, G590, G840, G84[illegible] G842, G843, G844, G845, G846, G847, G848, K005, K013, K01[illegible] K022, K023, K030

AFTER HOURS PREMIUM Q012A/Q016A APPLY TO:

A001A, A003A, K130A, K131A, K132A, A004A, A007A, A008A A888A, K005A, K013A, K017A, K030A, K033A, Q050A

**Q043A

Patients 75 years and over:	230.00
Patients over 64:	170.00
Patients up to 64:	150.00

***Q053

Same payment regardless of age.
Requires patient be registered with Health Care Connect.
No maximum number

* reduced from $5.00 as part of MOHLTC unilateral action

Telephone/Criticall Consultations

Minimum 10 minutes

Type and/or Location of Call	Referring Physician 31.35	Consulting Physician $40.45
Office or other Locations	K730 One/ patient/day	K731 One/patient/day
Emergency, Hospital, Urgent Care Clinic	K734 One/patient/day	K735 One/patient/day
Criticall	*K732 Two/patient/day	*K733 One/MD/ patient/day
Criticall, Emergency, Hospital, Urgent Care Clinic	*K736 Two/patient/day	*K737 One/MD/ patient/day

Consultant physicians can bill these fees for referrals and e-consults from physicians or nurse practitioners.
Review preamble for detailed payment rules 3 K733 or K737 (any combo)/patient/day. *No time restrictions

E-Consultation

Only eligible if provided within 30 days of e-consult request		
K738 n o	Referring Physician	16.00
K739 n o	Consulting Physician	20.50

Consultant physicians can bill these fees for referrals and e-consults from physicians or nurse practitioners.

Review Schedule of Benefits for all Payment Rule

Preventive Care Tracking Codes

(optional to use) (Enrolled Patients Only)

Q130A	Influenza Vaccine	age over 65 years
Q011A	Pap	age 21-69 years
Q131A	Mammogram	age 50-74 years
Q132A	Immunization	age 18-24 months
Q1331	Colorectal Screening	age 50-74 years

EXCLUSION CODE:

(Improves efficiency when calculating yearly bonus payments)

Q140A	Pap	age 21-69 years
Q141A	Mammogram	age 50-74 years
Q142A	Colorectal Screening	age 50-74 years

SERIOUS MENTAL ILLNESS

Q020	Bipolar
Q021	Schizophrenia
	(for FHG Diagnostic Code 295)

5-9 Patients: $1,000/year
10+ patients: $2,000/year

Preventive Care Service Enhancement Fees

FHN, FHO, FHG & CCM Paid annually based on percentage of enrolled patients serviced.

INFLUENZA VACCINE

Q100A	60%	220
Q100A	65%	440
Q012A	70%	770
Q103A	75%	1,100
Q104A	80%	2,200

PAP SMEAR

Q105A	60%	220
Q106A	65%	440
Q107A	70%	660
Q108A	75%	1,320
Q109A	80%	2,200

MAMMOGRAM

Q110A	55%	220
Q111A	60%	440
Q112A	65%	770
Q113A	70%	1,320
Q114A	75%	2,200

CHILDHOOD IMMUNIZATIONS

Q115A	85%	440
Q116A	90%	1,100
Q117A	95%	2,200

COLORECTAL SCREENING

Q118A	15%	220
Q119A	20%	440
Q120A	40%	1,100
Q121A	50%	2,200
Q122A	60%	3,300
Q123A	70%	4,000

APPLIES TO FFS OR PATIENT ENROLLED MODEL WITH LESS THAN MINIMUM ROSTER SIZE

Q152	FOBT completion fee	5.00

Immunization Codes

G840		DTaP-IPV (Quadracel)	4.50
G841		DTaP-IPV-Hib (Pediacel)	4.50
G538		Hepatitis A (Havrix)	4.50
G842		Hepatitis B (Engerix)	4.50
G538		Hepatiis A and B (Twinrix)	4.50
G843		Human Papilloma Virus (HPV) (Gardasil, Gardasil-9, Cervarix)	4.50
G844		Meningococcal C Conjugate (Men-C) (Menjugate, NeisVac-C, Meningitec)	4.50
G538		Meningococcal conjugate quadrivalent (Men-C-ACYW) (Menactra, Menveo, Nimenrix)	4.50
G538		Meningococcal polysaccharide quadrivalent (Men-P-ACYW-135) (Menomune)	4.50
G538		Meningococcal B (4CMenB) (Bexsero)	4.50
G845		Measles, Mumps, Rubella (MMR, Priorix)	4.50
G538		Measles, Mumps, Rubella, Varicella (MMRV)	4.50
G846		Pneumococcal Conjugate (Prevnar-13)	4.50
G538		Pneumococcal Polysaccharide (Pneumovax)	4.50
G847		Tdap (Adacel, Boostrix)	4.50
G538		Tdap-IPV (Adacel-Polio, Boostrix-Polio)	4.50
G538		Td-IPV	4.50
G538		Td	4.50
G848		Varicella (Varilrix, Varivax)	4.50
G538		Varicella (Zostavax)	4.50
G538		Other immunizing agents	4.50
G590	o	Influenza	4.50
Q590	n o	FHO/FHN ONLY If Infuenza immunization is sole reason add to G590	5.10
G700		Basic fee per visit premium if sole reason for procedure	5.10

Emergency Room Codes

D= Day E=Evening N=Night
W=Holidays & Weekends

	A100	n o	Family Physician ER Department Assessment	76.90
D	H101	n o	Minor Assessment	15.00
D	H102	n o	Comprehensive Assessment	37.20
D	H103	n o	Multiple Systems Assessment	35.65
D	H104	n o	Reassess	15.00
N	H121	n o	Minor Assessment	29.80
N	H122	n o	Comprehensive Assessment	73.90
N	H123	n o	Multiple Systems Assessment	65.95
N	H124	n o	Reassess	29.80
E	H131	n o	Minor Assessment	18.70
E	H132	n o	Comprehensive Assessment	46.30
E	H133	n o	Multiple Systems Assessment	42.40
E	H134	n o	Re-Assessment	18.70
W	H151	n o	Minor Assessment	25.50
W	H152	n o	Comprehensive Assessment	63.30
W	H153	n o	Multiple Systems Assessment	56.95
W	H154	n o	Reassess	25.50
	H105	n o	Inpatient Interim Orders	26.25
	G521	n o	Life threatening emergency situation - first 1/4 hour	110.55
	G522	n o	Life threatening emergency situation after 1st half hour per 1/4 hour	36.35
	G523	n o	Life threatening emergency situation - 2nd 1/4 hour	55.20
	G391	n o	Other resuscitation after first 1/4 hour	28.35
	G395	n o	Other resuscitation - first 1/4 hour	58.60
	E412	n o	Premium evenings Monday - Friday (1700-2400) Saturday, Sunday, Holidays	***20%**
	E413	n o	Premium nights 7 days (midnight-0700)	***40%**

n common fees outside the FHN basket
o common fees outside the FHO basket
***percentage Increase to procedural fee(s)**

Office Procedures

OFFICE PROCEDURES

+	G700	x x	Basic Fee	5.10
>	E542	n	Office Premium (tray fee)	11.15
	G271		Anticoagulation supervision	12.75
	G202		Allergy inj. (1 or more) with visit	4.45
	G212		Allergy injection alone	9.75
+	Z117	n	Chemical rx wart (plantar, genital)	11.65
>	D012	n o	Pulled elbow	39.00

Immunization- see unique codes

+	G538		Other immunization with visit if sole reason add G700	4.50
+	G590	o	Flu shot with visit - sole reason + Q590	4.50
	G372		Injection with visit	3.89
	G373		Injection - sole reason	6.75
+	G365		Pap - ages 21-69 every 36 months	6.75
+	G394	n o	Pap - if prev abnormal/inadequate	6.75
	E431		When Pap performed outside hospital/G394	11.55
	E430	n o	Pap Smear Tray Fee Not payable if uninsured	11.55
>	Z770	n o	Endometrial sampling	34.05
>	G378	n	I.U.D. insertion	25.50
	Z139	n	Breast cyst aspiration	37.20
+	G420		Ear syringe, curette	11.25
	Z314	n	Epistaxis - nasal cauterization	11.50
	Z315	n	Epistaxis - unil. anterior packing	15.35
	G403	n o	Epley (BPV) particle repositioning	21.15
	Z543	n	Proctoscopy	8.70
>	Z104	n o	Haematoma, perianal	20.10
>	Z106	n o	Abscess, ischiorectal/pilonidal I&D	44.35
+	G375		Intralesional infiltration - 1 or 2 lesions	8.85
+	G377		Intralesional infiltration- 3 or more	13.30
	G384		Injection trigger point	8.85
	G385		Injection each additional trigger point (2 max) add	4.55
>	G370	n	Injection bursa, joint, ganglion and/or aspiration	20.25
>	G371	n	Each additional bursa, joint, ganglion, tendon up to 5	19.90
>	Z114	n	Foreign body removal - local anesthetic	25.25
>	Z101		Abscess, haematoma I&D (one)	25.75
	Z080	n o	Debride wound or ulcer to s.c tissue 10 min 1	20.00
	Z081	n o	Debride wound or ulcer to s.c tissue 10 min 2	30.00
	Z082	n o	Debride wound or ulcer to s.c. tissue 10 min 3	45.00
	Z113	n	Biopsy without sutures	29.60
>	Z116	n	Biopsy with sutures	29.60
>	R048	n	Malignant lesion Face - single, simple excision	92.15
>	R094	n	Malignant lesion Other - single, simple excision	58.15
>	Z176		Suture	20.00
	Z154	n	Suture - Face, layers, bleeders	35.90
>	Z128	n	Nail resection	33.10

LABORATORY IN GP'S OFFICE

G010		Urinalysis	2.07
G002		Glucose	2.18
G012		Wet prep	1.86
G004		Stool for O.B.	1.53
G005		Pregnancy test	3.88
G014		Rapid Strep	5.50
+ G480	n o	Venipuncture - Infant - <2 years	9.90
+ G482		Venipuncture - Child 2 - 15 years	7.35
+ G489		Venipuncture - Adult 16+ years	3.54

CARDIAC, PULMONARY FUNCTION

J301**	n	Simple Spirometry P	7.85
J301**	n o	Simple Spirometry T	9.30
J324**	n	Repeat After Bronchodilator P	4.20
J324**	n o	Repeat After Bronchodilator T	2.81
J304**	n	Flow Volume Loop P	10.75
J304**	n o	Flow Volume Loop T	18.55
J327**	n	Repeat After Broncholdilator P	6.45
J327**	n o	Repeat After Broncholdilator T	2.81

** Not payable without indication-see A2 Schedule of Benefits
> E542 may be charged with these fees
+ add G700 to these fees if sole reason for visit
n common fees outside the FHN basket
o common fees outside the FHO basket
x pays 15% for FHN/FHO on rostered patients

OMA ONTARIO MEDICAL ASSOCIATION
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While the SGFP has taken considerable care with the Common Family Practice Codes as imposed by the Ministry of Health, January 2015 to ensure its accuracy, it does not guarantee the accuracy of the information contained in the document. Members are advised that the ultimate authority in matters of interpretation and payments rests with the MOHLTC and, as such, members are advised to consult the Schedule of Benefits on the Ministry's website for definitive information.
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