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SPECIFIC ELEMENTS

In addition to the *common elements*, all surgical services include the following *specific elements*.

A. Supervising the preparation of and/or preparing the patient for the procedure(s).

B. Performing the procedure(s), by any method, or assisting another physician in the performance of the procedure and carrying out appropriate recovery room procedures, being responsible for the transfer of the patient to the recovery room, ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any related assessments or procedures, including obtaining any specimens from the patient and interpreting the results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care, and post-procedure monitoring of the patient's condition, including intervening, until the first post-operative visit.

E. Discussion with, providing any advice and information, including prescribing therapy, to the patient or *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the *specific elements*:

- **a.** for services not identified with prefix **#**, for all elements; or
- **b.** for services identified with prefix **#**, for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the surgical procedure(s) is performed.

SURGICAL SERVICES WHICH ARE NOT LISTED AS A "Z" CODE

In addition to the above, the fee for this service includes the following:

1. **Pre-operative Care and Visits**

   Pre-operative hospital visits which take place 1 or 2 days prior to surgery.

2. **Post-operative Care and Visits**

   Post-operative care and visits associated with the procedure for up to two *week*s post-operatively, and making arrangements for discharge, to a hospital in-patient except for:

   - **a.** the first and second post-operative visits in hospital (payable at the specialty specific subsequent visit fee); and
   - **b.** subsequent visit by the *Most Responsible Physician* (*MRP*) - *day* of discharge (C124).

The *specific elements* for pre- and post-operative visits are those for assessments.

[Commentary:
For surgical services not listed with a "Z" code, C122 or C123 (subsequent visit by the *MRP* - *day* following, or second *day* following the hospital admission assessment) and C142 or C143 (first and second subsequent visits by the *MRP* following transfer from an Intensive Care Area/Neonatal Intensive Care) are *not eligible for payment* to the surgeon for visits rendered either 1 or 2 days prior to surgery or in the first two *week*s following surgery.]

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OTHER TERMS AND DEFINITIONS

FOR DEFINITION OF THE ROLE OF THE SURGICAL ASSISTANT - SEE GENERAL PREAMBLE GP54.

FOR DEFINITION OF THE ROLES OF THE ANAESTHESIOLOGIST - SEE GENERAL PREAMBLE GP58.

With the exception of the listings in the "Consultations and Visits" section, all references to surgeon in this *Schedule* are references to any physician performing the surgical procedure.

1. If the surgeon is required to perform a service(s) not usually associated with the original surgical procedure, he/she may claim for these on a fee-for-service basis.

If special visits to hospital are required at any time post-operatively, the surgeon may claim the minimum special visit premiums even if the basic hospital visit fees may not be claimed (under these circumstances the hospital visits should be claimed on an N/C ($00.00) basis).

The surgical benefit as noted above does not include the major pre-operative visit - i.e. the consultation or assessment fee which may be claimed when the decision to operate is made and the operation is *schedule*d, regardless of the time interval between the major pre-operative visit and surgery.

The hospital or *day* care admission assessment (consultation, repeat consultation, general or specific assessment or re-assessment, partial assessment) may not be claimed by the surgeon unless it happens to be the major pre-operative visit as defined above.

Routine subsequent hospital visits may be claimed for visits rendered more than two days prior to surgery. Other visits (excluding admission assessments) prior to admission may be claimed for in addition to the surgical fee.

Because the number of hospital visits is limited to three per *week* after the fifth *week* of hospitalization and six per *month* after the thirteenth *week* of hospitalization, the starting point for calculating the number of hospital visits is based on the date of admission if the operating surgeon has admitted the patient or the date of *referral* if the patient has been referred to the operating surgeon while in hospital.

The listed benefit for a procedure normally includes repair of any iatrogenic complications occurring during the course of the surgery performed by the same surgeon. Other major interventions should be handled on an individual basis. The surgical benefit includes the generally accepted surgical components of the procedure.

2. When a physician makes a special visit to perform a non-elective surgical procedure, he/she may claim the following benefits for procedures commencing:

a. 07:00h -17:00h - Mon*day* to Fri*day*
A consultation (if the case is referred) or the appropriate assessment, the appropriate special visit premium plus the procedural benefit.

b. 17:00h - 07:00h - Any night or on Satur*days*/Sun*day*s or *Holiday*s
A consultation or assessment, the appropriate special visit premium, the procedural benefit plus the surgical premium E409 or E410.

(see General Preamble GP44 to GP52 and GP65).

3. When more than one procedure is carried out by a surgeon under the same anaesthesia or within 14 days during the same hospitalization for the same condition, the full benefit applies to the major procedure and 85% of the listed benefit(s) applies to the other procedure(s) performed unless otherwise stated in the Preamble(s) or *Schedule*. The above statement applies to staged or bilateral procedures but does not apply when a normal appendix or simple ovarian or para-ovarian cyst is removed incidentally during an operation, for which no claim should be made.

4. When a subsequent operation becomes necessary for the same condition because of a complication or for a new condition, the full benefit should apply for each procedure.

5. When a subsequent non-elective procedure is done for a new condition by the same surgeon, the full benefit will apply to each procedure. When a subsequent elective procedure is done for a different condition within 14 days during the same hospitalization by the same surgeon, the benefit for the lesser procedure shall be reduced by 15%.

6. When different operative procedures are done by two different surgeons under the same anaesthesia for different conditions, the benefit will be 100% of the listed benefit for each condition. Under these circumstances, the basic assistant's benefit should not be claimed by either operating surgeon; however time units may be claimed.

7. As a general rule, when elective bilateral procedures are performed by two surgeons at the same time, one surgeon should claim for the surgical procedures and the other surgeon should claim the assistant's benefit.

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8. Where two surgeons are working together in surgery in which neither a team fee nor other method of billing is set out in the benefit *schedule*, the surgeon should identify him/herself as the operating surgeon and claim accordingly; the surgeon who is assisting the operating surgeon should identify him/herself as such and claim the assistant's benefit.

Where the second or assistant surgeon is brought into the case on a consultation basis, he/she may, when indicated, claim a consultation as well but should be prepared to justify it on an IC basis.

Except where otherwise provided in this *Schedule*, if the nature or complexity of a procedure requires more than one operating surgeon, each providing a separate service in his/her own specialized field, e.g. one surgeon carries out the ablative part and another surgeon the reconstructive part of the procedure, then each surgeon should claim the listed benefit for his/her services. This statement applies when the additional procedure(s) are not the usual components of the main procedure. If one surgeon, in addition to performing a specialized portion of a procedure, acts as an assistant during the remainder of the procedure, he/she may also claim time units for assisting.

When surgical procedures are rendered to trauma patients who have an Injury Severity Score (ISS) of greater than 15 for individuals age 16 or more, or an Injury Severity Score (ISS) of greater than 12 for individuals less than age 16, and it is required that two surgeons perform components of the same procedure, the full surgical fee for that procedure is payable to each surgeon.

[Commentary:
The full surgical fee is payable to each surgeon for surgical procedures rendered either on the *day* of the trauma or within 24 hours of the trauma.]

9. Unless otherwise stated, the listed benefits are for unilateral procedures only.

10. When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 11), is not in keeping with the intent of the benefit *schedule*.

11. When a surgical benefit (non-*IOP*, Complete Care, Fracture or Dislocation) is less than the surgical consultation benefit, and the case is referred, a physician may claim a surgical consultation benefit instead of the surgical benefit. However, to avoid the consultation being counted as such under the Ministry of Health and Long-Term Care limitation rules on the number of consultations allowed per year, the physician should claim the consultation fee under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.

12. If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician should claim for the procedure as well as the appropriate assessment.

13. Where a procedure is listed with a "Z" code, the procedure is an "*Independent Operative Procedur*e (*IOP*)". If the major pre-operative visit is rendered in the previous *12-month period* prior to the *IOP* service by the same physician, only the following assessment services are eligible for payment on the same *day* prior to the *IOP* service:

a. a minor assessment if rendered by a General and Family Physician; or

b. a partial assessment if rendered by a *specialist*.

When the major preoperative assessment is rendered on the same *day* as the *IOP*, no other consultation or assessment is eligible for payment if rendered prior to the *IOP* service by the same physician on the same *day*.

When multiple or bilateral *IOP* are performed at the same time by the same physician, the listed procedural benefits should be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed.

When an *IOP* service is rendered on the same *day* as a non-*IOP* service by the same physician, the terms and conditions for payment as described in the 'Surgical Services which are not listed as a "Z" code' section of this *Schedule* are also applicable to the *IOP* service(s).

14. When procedures are specifically listed under Surgical Procedures, surgeons should use these listings rather than applying one of the plastic surgery listed fees under Skin and Subcutaneous Tissue in the Integumentary System Surgical Procedures section of this *Schedule*.

15. For excision of tumours not specifically listed in this *Schedule*, claims should be made on an IC basis (code R993). Independent Consideration also will be given (under code R990) to claims for other unusual but generally accepted surgical procedures which are not listed specifically in the *Schedule* (excluding non-major variations of listed procedures). In submitting claims, physicians should relate the service rendered to comparable listed procedures in terms of scope and difficulty (see General Preamble GP8).

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16. **Cosmetic or esthetic surgery:** means a service to enhance appearance without being medically necessary. These services are not insured benefits (see Appendix D.)

17. **Reconstructive surgery:** is surgery to improve appearance and/or function to any area altered by disease, trauma or congenital deformity. Although surgery solely to restore appearance may be included in this definition under certain limited conditions, emotional, psychological or psychiatric grounds normally are not considered sufficient additional reason for coverage of such surgery. Appendix D of this *Schedule* describes the conditions under which surgery for alteration of appearance only may be a benefit. Physicians should submit requests to their regional *OHIP* Office for authorization of any proposed surgery which may fall outside of Ministry of Health and Long-Term Care coverage. (See Appendix D.)

18. Additional claims for biopsies performed when a surgeon is operating in the abdominal or thoracic cavity will be given Independent Consideration.

19. When a listed procedure is performed and no anaesthetic is required, the procedure should be claimed under the “local anaesthetic” listing.

20. Except as described in the paragraph below, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.

    A major or minor peripheral nerve block, major plexus block, neuraxial injection (*with or without* catheter) or intrapleural block (*with or without* catheter) for post-operative pain control (with a duration of action more than 4 hours) is eligible for payment as G224 when rendered in conjunction with a procedure which the physician performs on the same patient.

    [Commentary:
    For additional information, refer to the Nerve Blocks - Acute Pain Management, Nerve Blocks - Interventional Pain Injections or Nerve Blocks - Peripheral/Other sections of the *Schedule*.]

21. If claims are being submitted in coded form, the surgeon should add the suffix A to the listed procedural code, the surgical assistant should add the suffix B to the listed procedural code and the anaesthetist should add the suffix C to the listed procedural code.

22. When Z222/Z223 is claimed for a patient for whom the physician submits a claim for rendering another insured service on the same *day*, the amount payable for Z222/Z223 is reduced to nil.

23. When a surgical procedure is attempted laparoscopically in the digestive system or the female genital system, but requires conversion to a laparotomy, unless otherwise specified, the diagnostic laparoscopic fee E860 is payable in addition to the procedural fee.

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24. Morbidly obese patients

E676 is eligible for payment once per patient per physician in addition to the amount eligible for payment for the major surgical procedure(s) where a morbidly obese patient undergoes major surgery to the neck, hip, peritoneal cavity, pelvis or retroperitoneum and:

a. the patient has a *Body Mass Index (BMI)* greater than 40 for major surgery on the peritoneal cavity, pelvis, retroperitoneum and hip or 45 for major surgery on the neck;

b. the surgery is rendered under *general anaesthesia* using either an open technique for the neck and hip, or an open or laparoscopic technique for the peritoneal cavity, pelvis, retroperitoneum; and

c. the principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, mediastinoscopy, thoracoscopy, cautery, ablation nor catheterization.

E676A	Morbidly obese patient, surgeon, to procedural fee(s).....add	25%
E676B	Morbidly obese patient, surgical assistant, to major procedure .....add	6 units

Note:

E676A/B is only payable with the following procedures:

D043	D046	D047	D052	E090	E499	E500	E589	E593	E626	E627	E655	E664	E673
E686	E697	E704	E706	E707	E708	E709	E711	E712	E713	E714	E718	E721	E722
E725	E728	E729	E731	E733	E734	E735	E736	E737	E738	E739	E743	E745	E748
E752	E754	E756	E757	E762	E764	E765	E766	E767	E768	E769	E771	E794	E796
E852	E853	E854	E855	E857	E860	E880	E882	E883	E884	E885	F098	F099	F100
F101	F135	M081	M082	M084	M090	M099	M100	P018	P041	P042	P050	P055	P056
P057	P058	P059	P060	R216	R241	R269	R330	R423	R439	R440	R443	R470	R481
R488	R491	R553	R569	R590	R627	R628	R639	R686	R783	R784	R785	R786	R800
R802	R803	R805	R806	R807	R811	R814	R815	R817	R823	R825	R826	R834	R839
R852	R855	R856	R858	R860	R861	R910	R877	R885	R905	R915	R932	R933	R934
R935	R936	R937	S114	S115	S116	S117	S118	S120	S121	S122	S123	S124	S125
S128	S129	S131	S132	S133	S134	S137	S138	S139	S140	S149	S150	S154	S157
S158	S159	S160	S162	S164	S165	S166	S167	S168	S169	S170	S171	S172	S173
S175	S176	S177	S180	S182	S183	S184	S185	S187	S188	S189	S191	S192	S193
S194	S195	S196	S197	S199	S204	S205	S206	S213	S214	S215	S217	S218	S222
S227	S265	S266	S267	S269	S270	S271	S274	S275	S276	S278	S280	S281	S282
S285	S287	S291	S292	S294	S295	S297	S298	S299	S300	S301	S302	S303	S304
S305	S306	S307	S308	S309	S310	S311	S312	S313	S314	S315	S318	S319	S321
S323	S325	S329	S332	S340	S342	S343	S344	S345	S402	S403	S405	S408	S410
S411	S412	S413	S415	S416	S420	S422	S423	S424	S427	S428	S430	S431	S432
S433	S434	S435	S436	S437	S438	S440	S441	S445	S446	S447	S448	S449	S450
S451	S452	S453	S454	S455	S457	S460	S461	S462	S465	S466	S467	S468	S471
S482	S483	S488	S490	S491	S512	S513	S546	S549	S561	S590	S647	S650	S651
S652	S653	S710	S714	S727	S728	S729	S731	S733	S735	S736	S738	S739	S740
S741	S743	S745	S747	S748	S750	S751	S757	S758	S759	S760	S761	S763	S764
S766	S775	S776	S778	S780	S781	S782	S784	S788	S789	S790	S792	S793	S795
S798	S799	S800	S813	Z526	Z552	Z553	Z564	Z569	Z577	Z594	Z737	Z738	

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Medical record requirements:
E676 is *only eligible for payment* when the BMI is recorded in the patient's permanent medical record.

[Commentary:
E676 is *not eligible for payment* if the surgery is rendered under local anaesthesia.]

25. Lysis of extensive intra-abdominal adhesions and/or scarring e.g. post radiation

E673 is payable to the surgeon in addition to the fee for the major intra-abdominal procedure only when lysis requires at least 60 minutes beyond the average duration of the major procedure. E673 less than 60 minutes in duration or rendered in conjunction with E718 is an insured service payable at nil.

#	E673	Lysis of extensive intra-abdominal adhesions	add	62.05

26. Payment for all surgical procedures includes payment for any intraoperative monitoring of the patient, if rendered.

27. Cancelled surgery – surgical services

a. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.

b. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the surgeon has scrubbed but is not required to do anything further, the service constitutes E006A and the amount payable is calculated by adding the time units to 6 basic units and multiplying by the surgical assistant's unit fee.

c. If the operation is cancelled after surgery has commenced but prior to its completion, the service is *eligible for payment* under independent consideration (R990).

[Commentary:
Submit claim for R990 by adding the time units to the listed procedural basic units and multiplying by the surgical assistant's unit fee and attach a copy of the operative report for review by a *medical consultant*.]

Note:
For the purpose of cancelled surgery, time units for the surgeon are calculated in the same way as time units for the surgical assistant (see General Preamble GP54).

28. Bariatric surgery

S120 (gastric bypass or partition), S189 (intestinal bypass) and S114 (sleeve gastrectomy) are insured services only when all of the following four criteria are satisfied:

1. Presence of morbid obesity that has persisted for at least the preceding 2 years, defined as:
  a. *Body mass index (BMI)* exceeding 40; or
  b. BMI greater than 35 in conjunction with any of the following severe co-morbidities:
    i. Coronary heart disease;
    ii. Diabetes mellitus;
    iii. Clinically significant obstructive sleep apnea (i.e. patient meets the criteria for treatment of obstructive sleep apnea); or
    iv. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

2. The patient's bone growth is completed (18 years of age or documentation of completion of bone growth);

3. The patient has attempted weight loss in the past without successful long-term weight reduction; and

4. The patient must be recommended for the surgery by a multidisciplinary team at a Regional Assessment and Treatment Centre in Ontario.

29. Transplant surgery

Claims submission instructions:

Transplant recipient: Submit claims using the transplant recipient's Ontario health insurance number only.

If the recipient is from out-of-province, submit claims using the recipient's provincial health insurance number.

Transplant donor: Submit claims using the transplant donor's Ontario health insurance number.

For a donor with a health insurance number from another province or for a donor from another country, submit claims using the Ontario recipient's health insurance number.

In circumstances where the donor is an Ontario resident but the health insurance number cannot be obtained despite reasonable efforts to do so, use the recipient's Ontario health insurance number.