GENERAL SURGERY (03)

GENERAL LISTINGS

A035	Consultation	90.30
A935	Special surgical consultation (see General Preamble GP19).	160.00
A036	Repeat consultation	60.00
A033	Specific assessment	44.40
A034	Partial assessment	26.85

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP76.

C035	Consultation	90.30
C935	Special surgical consultation (see General Preamble GP19).	160.00
C036	Repeat consultation	60.00
C033	Specific assessment	44.40
C034	Specific re-assessment	28.90

Subsequent visits

C032	- first five weeks	per visit	31.00
C037	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C039	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	61.15
C123	- second day following the hospital assessment	61.15
C124	- day of discharge	61.15

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	61.15
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	61.15

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	31.00
C038	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP50)	per visit	31.00

C. Subsequent visit by the Most Responsible Physician (MRP)

Subsequent visit by the MRP – day following the hospital admission assessment (C122)

Definition:

Subsequent visit by the *MRP* - day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Subsequent visit by the MRP – second day following the hospital admission assessment (C123)

Definition:

Subsequent visit by the *MRP* - second day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Payment rules:

1. C122, C123 are limited to a maximum of one each per hospital admission.

   [Commentary:
   C122, C123 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be payable at a lesser visit fee.]

2. C122, C123 are *not eligible for payment*:
   - **a.** when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* - day of discharge);
   - **b.** for a patient admitted for obstetrical delivery or *newborn* care; or
   - **c.** for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

3. C122, C123 are not payable for a subsequent visit rendered by a surgeon to a hospital in-patient following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

4. When a patient is transferred to another physician within the same hospital during either of these days, C122 or C123 are only payable to the physician who was the *MRP* for the majority of the day.

5. When a patient is transferred to another physician at a different hospital, the day of transfer shall be deemed for payment purposes to be the day of admission.

6. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For first and second subsequent visits by the *MRP* following transfer from an Intensive Care Area (C142, C143), see General Preamble page GP46.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Subsequent visit by the MRP - day of discharge (C124)

Definition/Required elements of service:

Subsequent visit by the *MRP* – day of discharge is payable to the physician identified as the *MRP* for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

The discharge summary must include as a minimum the following information:

- **a.** reason for admission;
- **b.** procedures performed during the hospitalization;
- **c.** discharge diagnosis; and
- **d.** medications on discharge.

Payment rules:

1. C124 is only payable to the *MRP* and limited to one service per hospital admission.

2. C124 is *not eligible for payment* under any of the following circumstances:

- **a.** The patient was discharged within 48 hours of admission to hospital (calculated from the actual date of admission to hospital);
- **b.** The admission was for obstetrical delivery unless the mother required admission to an ICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **c.** The admission was for *newborn* care unless the *infant* was admitted to a NICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **d.** For transfers within the same hospital; or
- **e.** For discharges directly from a NICU or ICU where NICU or ICU critical care per diem services were rendered the same day.

[Commentary:

In the case of conflicting claims for this service, the physician to whom the patient has rostered (virtual or actual) may receive the payment for the service.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

D. First subsequent visit by the MRP following transfer from an Intensive Care Area

First subsequent visit by the MRP following transfer from an Intensive Care Area (C142)

Definition:

First subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Second subsequent visit by the MRP following transfer from an Intensive Care Area (C143)

Definition:

Second subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Payment rules:

1. C142, C143 are limited to a maximum of one each per hospital admission.

   [Commentary:
   1. C142, C143 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be eligible for payment at a lesser visit fee.
   2. C142 or C143 are *not eligible for payment* for visits rendered to patients who were in an Intensive Care Area only for monitoring purposes.]

2. C142, C143 are *not eligible for payment* to the same physician who rendered Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services prior to the patient's transfer.

3. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For Subsequent visit by the *MRP* – first and second day following the hospital admission assessment (C122, C123), see General Preamble page GP44.]

4. C142, C143 are *not eligible for payment*:
   - **a.** when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* – day of discharge), or
   - **b.** for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

5. C142, C143 are not payable for visits rendered by a surgeon to a hospital in-patient in the first two *week*s following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

6. When a patient is transferred to another physician within the same hospital, C142 or C143 are only payable to the physician who was the *MRP* for the majority of the day of the transfer.

E. Subsequent visit and palliative care visit by the MRP premium

E083 Subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982..... add 30%

E084 Saturday, Sunday or *Holiday* subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982.....Add 45%

Payment rules:

1. E084 is *only eligible for payment* for subsequent visits provided on Saturdays, Sundays and *holidays*.

2. Only one of E083 or E084 is *eligible for payment* per patient per *day*.

3. E084 is *only eligible for payment* when the MRP is from one of the following specialties: 00 (Family Practice and Practice in General), 02 (Dermatology), 07 (Geriatrics), 12 (Emergency Medicine), 13 (Internal Medicine),15 (Endocrinology & Metabolism), 16 (Nephrology), 18 (Neurology), 19 (Psychiatry), 22 (Genetics), 26 (Paediatrics), 28 (Pathology), 31 (Physical Medicine), 34 (Radiation Oncology), 41 (Gastroenterology), 44 (Medical Oncology), 46 (Infectious Disease), 47 (Respiratory Disease), 48 (Rheumatology), 60 (Cardiology), 61 (Haematology), 62 (Clinical Immunology).

4. E083 or E084 are *only eligible for payment*:

- **a.** if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or
- **b.** where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

5. E083 or E084 are *not eligible for payment* for *palliative care* visits to patients in designated *palliative care* beds in Long-Term Care Institutions.

6. E083 or E084 are not applicable to any other service or premium.

[Commentary:

1. E083 or E084 are *only eligible for payment* with subsequent visits and *palliative care* visits rendered by the *MRP*.

2. Examples of subsequent visits eligible for payment with E083 or E084 are C002, C007, C009, C132, C137, C139, C032, C037 or C039.

3. E083 or E084 are *not eligible for payment* with C121 additional visits for intercurrent illness.]

F. Concurrent Care

Definition/Required elements of service:

Concurrent care is any routine assessment rendered in hospital by the consultant following the consultant's first major assessment of the patient when the family physician remains the *most responsible physician* but the latter requests continued directive care by the consultant.

Payment rules:

Claims for concurrent care are limited to 4 per *week* during the first *week* of concurrent care, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

G. Supportive Care

Definition:

Supportive care is any routine visit rendered in hospital by the family physician who is not actively treating the case where:

- **a.** the patient is under the care of another physician;
- **b.** the supportive care is rendered at the request of the patient or family; and
- **c.** the care is provided for purposes of liaison or reassurance.

Payment rules:

Claims for supportive care are limited to 4 per *week* during the first *week* of supportive care, determined from the date of the first supportive visit, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.