

Schedule of Facility Costs

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

(July 16, 2026 (effective April 1, 2026))

Ministry of Health

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 111.90

First Transit

J804 - without blood pool images 18.70

J867 - with blood pool images 66.60

Cardioangiography

J806 - first pass for shunt detection, cardiac output and transit studies 110.45

Myocardial Perfusion Scintigraphy

J807 - resting, immediate post stress 252.70

J900 - application of PET for myocardial perfusion (maximum 1 per examination), to J807 50.55

J808 - delayed 93.05

J809 - application of SPECT to J807 or J808 add 50.55

J901 - application of Rubidium PET for cardiac perfusion (maximum 1 per examination), to J808 50.55

Payment rules:

1. J809 is limited to a maximum of 1 service with J807 per examination and a maximum of 2 services with J808 per examination.
2. J900 and J901 are only eligible for payment when performed for an indication listed as an approved "Routine PET Scan" on the PET Scans Ontario website on the date that the service was rendered. Please refer to the PET section of the Schedule of Benefits for more details
3. J900 and J901 are not eligible for payment when performed for an indication listed as evidence-building on the PET Scans Ontario website including PET Registry and/or PET Access Program indications.

Myocardial scintigraphy

J810 - acute infarction, injury, inflammation, infiltration 102.50

Myocardial wall motion

J811 - studies 110.45

J812 - repeat same day (to a maximum of three repeats) 55.90

J813 - studies with ejection fraction 156.95

J814 - repeat same day (to a maximum of three repeats) 55.90

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 152.95

NUCLEAR MEDICINE IN VIVO

ENDOCRINE SYSTEM

F

Oncological scintigraphy

J869	Theranostic scintigraphy	644.95
J872	Metastatic survey with I ¹³¹	279.40

Thyroid scintigraphy

J818	- with Tc ^{99m} or I ¹³¹	74.50
J871	- with I ¹²³	119.75

[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	33.25
J870	- repeat	17.00

Parathyroid scintigraphy

J820	Parathyroid scintigraphy	272.60
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Payment rules:

1. J820 is only eligible for payment for workup of hyperparathyroidism with biochemical evidence (e.g., elevated serum PTH) or inappropriately normal serum PTH and elevated normalized serum calcium or ionized calcium.
2. J820 is not eligible for payment for evaluation of an incidental nodule found on anatomic imaging (e.g. ultrasound, CT, MRI) in the absence of a biochemical abnormality.

NUCLEAR MEDICINE IN VIVO

GASTROINTESTINAL SYSTEM

F

Malabsorption test

J824	- with C ¹⁴ substrate	66.60
J873	- with whole body counting	159.90

Gastrointestinal

J825	- protein loss	95.70
J874	- blood loss using – Cr ⁵¹	71.90
J829	- transit.....	119.75

Calcium absorption

J826	- Ca ⁴⁵	71.90
J875	- Calcium ⁴⁷ absorption/excretion	293.90
J827	Oesophageal motility studies – one or more	138.05

Gastro-oesophageal

J876	- reflux.....	65.85
J877	- aspiration	46.60

Abdominal scintigraphy

J830	- Tc ^{99m} sulphur colloid or pertechnetate Tc ⁰⁴	101.05
J879	- LeVeen shunt patency	77.05

Miscellaneous

J831	Biliary scintigraphy	133.00
J832	Liver/spleen scintigraphy	93.05
J833	Salivary gland scintigraphy	111.75

NUCLEAR MEDICINE IN VIVO

GENITOURINARY SYSTEM

F

J834 Dynamic renal imaging 111.75

Computer assessed renal function

J835 - includes first transit 152.95

J880 - repeat after pharmacological intervention..... 52.10

J836 Static renal scintigraphy 38.65

J837 ERPF by blood sample method 46.60

J838 GFR by blood sample method 46.60

J839 Cystography for vesicoureteric reflux..... 140.00

Testicular and scrotal scintigraphy

J840 - includes first transit 95.70

NUCLEAR MEDICINE IN VIVO

HAEMATOPOIETIC SYSTEM

F

J841	Plasma volume	50.55
J843	Red cell volume	55.90
J847	Ferrokinetics – clearance, turnover, and utilization	465.70
J848	Red cell, white cell or platelet survival.....	119.20
J849	Red cell survival with serial surface counts	172.20

Bone marrow scintigraphy

J881	- whole body	132.00
J882	- single site	98.50

WBC scintigraphy

J883	- whole body	423.15
J884	- single site	372.60

NUCLEAR MEDICINE IN VIVO

MUSCULOSKELETAL SYSTEM

F

Bone scintigraphy

J850	- general survey.....	120.40
J851	- single site	98.50

Gallium scintigraphy

J852	- general survey.....	206.25
J853	- single site	143.65

Application of Tomography (SPECT)

J819	- where each SPECT image represents a different organ or body area, to J852, maximum three images per examination.....add	50.55
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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 Tc ^{99m}	139.65
J885	- with In ¹¹¹	357.90
J886	- via shunt puncture.....	102.85
J858	Brain scintigraphy - except cerebral perfusion	105.00
J902	Brain scintigraphy - cerebral perfusion.....	105.00

Payment rules:

Only one of J858 or J902 are eligible for payment per patient, per study.

NUCLEAR MEDICINE IN VIVO

RESPIRATORY SYSTEM

		F
J859	Perfusion lung scintigraphy.....	99.80
J887	Ventilation lung scintigraphy	125.10
J860	Ventilation and perfusion (V/Q) scintigraphy - same day.....	199.65

NUCLEAR MEDICINE IN VIVO

MISCELLANEOUS

	F
J861 Radionuclide lymphangiogram	130.30
J862 Ocular tumour localization	87.80
J864 Tear duct scintigraphy.....	113.10
J865 Total body counting including dosimetry	218.25
J878 RBCs scintigraphy	166.30
Application of Tomography (SPECT), other than to J807, J808 or J852	
J866 - maximum one per Nuclear Medicine examinationadd	50.55

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

116.10

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 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 intravenous pyelogram (IVP).
21. Nephrotomography is covered by the listings for IVP 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

PREAMBLE

24. X-ray of the lumbar spine should not be routinely ordered or rendered for low backpain without suspected or known pathology.

[Commentary:

Examples of suspected or known pathology include infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.]

DIAGNOSTIC RADIOLOGY

HEAD AND NECK

F

Skull

X001	- four views	37.40
X009	- five or more views	46.60
X003	Sella turcica (when skull not examined)	18.65

Facial bones

X004	- three views	27.15
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Nose

X005	- two views	18.65
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Mandible

X006	- three views (unilateral or bilateral)	27.15
X012	- four or more views	37.40
X007	Temporomandibular joints – four views including open and closed mouth views	27.15

Mastoids

X010	- bilateral – six views	35.85
X011	Internal auditory meati (when skull not examined)	27.15

Note:

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

X016	Eye, for foreign body	18.60
X017	Eye, for localization, additional	19.15
X018	Optic foramina	21.10
X019	Salivary gland region	17.20

Neck for soft tissues

X020	- two views	17.20
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DIAGNOSTIC RADIOLOGY

SPINE AND PELVIS

F

Cervical spine

X025	- two or three views	32.45
X202	- four or five views	41.80
X203	- six or more views.....	50.45

Thoracic spine

X027	- two views	29.60
X204	- three or more.....	37.40

Lumbar or lumbosacral spine

X028	- two or three views	32.45
X205	- four or five views	41.80
X206	- six or more views.....	50.45

Entire spine (scoliosis series)

X032	- four views	66.95
	- orthoroentgenogram (3 foot film)	
X033	- single view.....	27.15
X031	- two or more views	37.10

Sacrum and/or coccyx

X034	- two views	29.95
X207	- three or more views	38.80

Sacro-iliac joints

X035	- Two or three views	27.15
X208	- four or more views.....	36.25

Pelvis and/or hip(s)

X036	- one view	18.65
X037	- two views (e.g. AP and frog view, both hips, or AP both hips plus lateral one hip).....	34.70
X038	- three or more views (e.g. pelvis and sacro-iliac joints, or AP both hips plus lateral each hip)	39.85

DIAGNOSTIC RADIOLOGY

UPPER EXTREMITIES

F

Clavicle

X045	- two views	18.65
X209	- three or more views	28.65

Acromioclavicular joints (bilateral) with or without weighted distraction

X046	- two views	27.15
X210	- three or more views	37.00

Sternoclavicular joints (bilateral)

X047	- two or three views	22.45
X211	- four or more views	32.00

Shoulder

X048	- two views	22.45
X212	- three or more views	32.00

Scapula

X049	- two views	22.45
X213	- three or more views	32.25

Humerus including one joint

X050	- two views	18.65
X214	- three or more views	28.40

Elbow

X051	- two views	18.65
X215	- three or four views	28.65
X216	- five or more views	38.60

Forearm including one joint

X052	- two views	18.65
X217	- three or more views	28.65

Wrist

X053	- two or three views	18.65
X218	- four or more views	28.65

Hand

X054	- two or three views	18.65
X219	- four or more views	28.65

Wrist and hand

X055	- two or three views	27.15
X220	- four or more views	34.60

Finger or thumb

X056	- two views	14.35
X221	- three or more views	18.65

DIAGNOSTIC RADIOLOGY

LOWER EXTREMITIES

F

Hip (unilateral)

X060 - two or more views 29.75

Femur including one joint

X063 - two views 18.65

X223 - three or more views 27.75

Knee including patella

X065 - two views 18.65

X224 - three or four views 28.65

X225 - five or more views 38.60

Tibia and fibula including one joint

X066 - two views 18.65

X226 - three or more views 28.65

Ankle

X067 - two or three views 18.65

X227 - four or more views 28.65

Calcaneus

X068 - two views 18.65

X228 - three or more views 28.65

Foot

X069 - two or three views 18.65

X229 - four or more views 28.65

Toe

X072 - two views 14.35

X230 - three or more views 18.65

X064 Leg length studies (orthoroentgenogram)..... 27.15

DIAGNOSTIC RADIOLOGY

SKELETAL SURVEYS

F

Skeletal survey for bone age

X057	- single film	18.65
X058	- two or more films or views	27.15

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

X080	- single view	9.30
X081	- each additional film or view	9.30

DIAGNOSTIC RADIOLOGY

CHEST AND ABDOMEN

F

Chest

X090	- single view	18.65
X091	- two views	27.40
X092	- three or more views	35.25

Note:

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

Ribs

X039	- two or more views	22.45
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Sternum

X040	- two or more views	22.45
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Thoracic inlet

X096	- two or more views	18.65
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Abdomen

X100	- single view	18.65
X101	- two or more views	28.50

DIAGNOSTIC RADIOLOGY

GASTROINTESTINAL TRACT

F

Palatopharyngeal analysis

X105 - cine or videotape 36.90

Pharynx and oesophagus

X106 - cine or videotape 36.90

X107 Oesophagus when X103, X104, X108 or X109 not claimed..... 33.35

Oesophagus, stomach and duodenum

X108 - including survey film, if taken 57.95

X104 - double contrast, including survey film, if taken 60.70

X103 - double contrast, including survey film, if taken, and small bowel 76.20

X110 Hypotonic duodenogram..... 49.25

X109 Oesophagus, stomach and small bowel 73.90

Small bowel only

X111 - when only examination performed during patient's visit..... 33.05

Colon

X112 - barium enema including survey film, if taken 60.55

X113 - air contrast, primary or secondary, including survey films, if taken 76.65

Gallbladder

X114 - one or multiple day examinations 37.45

X120 - one or multiple day examinations with preliminary plain film..... 49.80

X116 T-tube cholangiogram 27.15

X123 Operative pancreatogram or ERCP..... 27.15

DIAGNOSTIC RADIOLOGY

GENITOURINARY TRACT

	F
X129 Retrograde pyelogram, unilateral or bilateral.....	27.15
X130 Intravenous pyelogram including preliminary film.....	62.05
X137 Cystogram (catheter).....	29.85
X135 Cystourethrogram, stress or voiding (catheter)	34.35
X131 Cystourethrogram (non-catheter)	7.20
X191 Intestinal conduit examination or nephrostogram	27.15
X138 Percutaneous antegrade pyelogram.....	27.15
X139 Percutaneous nephrostogram	27.15
X134 Retrograde urethrogram	22.45
X136 Vasogram.....	22.45
X141 Cavernosography	25.85

DIAGNOSTIC RADIOLOGY

OBSTETRICS AND GYNAECOLOGY

F

X147 Hysterosalpingogram.....

37.30

DIAGNOSTIC RADIOLOGY

FLUOROSCOPY – BY PHYSICIAN WITH OR WITHOUT SPOT FILMS

	F
X195 Chest	11.55
X196 Skeleton.....	11.55
X197 Abdomen	11.55
X189 Fluoroscopic control of clinical procedures done by another physician per ¼ hour	9.15

DIAGNOSTIC RADIOLOGY

SPECIAL EXAMINATIONS

F

Abdominal, thoracic, cervical or cranial angiogram by catheterization

Using single films

X179	- non-selective	37.00
X180	- selective (per vessel, to a maximum of 4)	48.65

Using film changer, cine or multiformat camera

X181	- non-selective	74.60
X182	- selective (per vessel, to a maximum of 4)	99.20
X140	- selective (5 or more vessels)	396.90

Carotid angiogram by direct puncture

X160	- unilateral	61.15
X161	- bilateral	98.30

Peripheral angiogram

X174	- unilateral	37.30
X175	- bilateral	49.25
X198	Splenoportogram	73.90
X199	Translumbar aortogram	73.90

Vertebral angiogram – direct puncture or retrograde brachial injection

X132	- unilateral	61.15
X133	- bilateral	99.95
X156	Arthrogram, tenogram or bursogram	32.80
X200	- with fluoroscopy and complete positioning throughout by physician ..	45.85

Bronchogram

X158	- unilateral	36.25
X159	- bilateral	48.00
X162	Cerebral stereotaxis	74.05
X122	Cholangiogram, percutaneous trans-hepatic	36.90

DIAGNOSTIC RADIOLOGY

BONE MINERAL DENSITY (BMD) MEASUREMENT

F

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

Bone Mineral Density (BMD) measurement by DXA is an insured service only when all the following conditions have been met:

1. the service is rendered for the assessment and management of osteoporosis or low bone mass;
2. when more than one site is measured, the sites include both the hip and spine. Where measurement of either is not technically feasible, the remaining site or other generally accepted site(s) should be measured.

[Commentary:

Examples where measurement of hip and/or spine would be considered not technically feasible include regional surgery (instrumentation, prosthesis), extreme obesity, or localized structural abnormalities, etc.]

Definition:

For the purpose of subsequent testing, patient risk is defined according to the threshold for osteoporosis pharmacotherapy in alignment with the Osteoporosis Canada 2023 Guideline. Levels of patient risk are defined as:

“high-risk patient” means a patient who meets any of the following thresholds for osteoporosis pharmacotherapy:

1. T-score ≤ -2.5 at one of the following sites: lumbar spine, femoral neck or total hip;
2. Previous hip or spine fracture, or ≥ 2 other fracture events; or
3. Estimated 10-year fracture risk $\geq 15\%$ using the fracture risk assessment tool (FRAX) or equivalent major osteoporotic fracture assessment tool.

“non-high-risk patient” means a patient who does not meet any of the above thresholds for osteoporosis pharmacotherapy.

Baseline Test (once per lifetime)

X145	- one site	53.55
X146	- two or more sites	69.05

Subsequent test - non-high-risk patient (once every 60 months or longer)

X142	- one site	53.55
X148	- two or more sites	69.05

Subsequent test - high-risk patient or therapy monitoring (once every 36 months)

X149	- one site	53.55
X155	- two or more sites	69.05

Additional test - patient specific risk factors (once every 12-36 months)

X237	- one site	53.55
X236	- two or more sites	69.05

Payment rules:

1. Patients are limited to one baseline test (X145 or X146) in their lifetime.

DIAGNOSTIC RADIOLOGY

BONE MINERAL DENSITY (BMD) MEASUREMENT

F

2. Subsequent test - non-high-risk patient (X142/X148) is limited to a maximum of one test rendered every 60 months following the baseline test (X145/X146) or any subsequent test (X142/X148/X149/X155) or any additional test (X236/X237).
3. (X149/X155) for a high-risk patient is limited to a maximum of one test every 36 months following the baseline test (X145/X146) or any subsequent test (X142/X148/X149/X155) or any additional test (X236/X237).
4. X149/X155 for therapy monitoring is limited to a maximum of
 - i. one test rendered not earlier than 36 months after initiating pharmacotherapy; and/or
 - ii. one test rendered not earlier than 36 months after stopping bisphosphonate therapy.
5. X149/X155 for therapy monitoring is *not eligible for payment* when rendered earlier than 36 months following X145/X146 or X142/X148 or X149/X155 or X236/X237.
6. X236/X237 for patient specific risk factors are *only eligible for payment* when the clinical circumstances require testing more frequently than once every 36 months. Patient specific risk factors include:
 - i. a risk factor for secondary osteoporosis consistent with Canadian clinical practice guidelines in place at the time of the service; or
 - ii. a new fragility fracture; or
 - iii. a risk factor for rapid bone loss.
7. X236/X237 are limited to a maximum of one test every 12 months following any other BMD services (X145/X146 or X142/X148 or X149/X155 or X236/X237).
8. Canadian clinical practice guidelines and the use of BMD testing is primarily focused on men and women over age 50, and do not specifically address pediatric or younger adult patients who may require testing. In patients under 50, BMD testing is not routine practice unless specific comorbidities are present, or unless fragility fractures have occurred. In these cases, BMD services are eligible for payment at the frequencies that are clinically appropriate using the same above fee codes (e.g. X142/X148, X149/X155 or X237/X236).

[Commentary:

1. The 2023 Clinical Practice Guideline for Management of Osteoporosis and Fracture Prevention in Canada can be found at <https://www.cmaj.ca/content/195/39/E1333> and <https://www.cmaj.ca/content/cmaj/suppl/2023/10/03/195.39.E1333.DC1/221647-guide-1-at.pdf>
2. The Canadian Association of Radiologists (CAR) 2024 Update: Practice Guideline on Bone Mineral Densitometry Reporting can be found at https://car.ca/wp-content/uploads/2025/05/CAR-Practice-Guideline-on-Bone-Mineral-Densitometry-Reporting_-2024-Update_2025.pdf
3. Documentation to support the frequency of testing must be made available to the ministry upon request.
4. Individuals with a 10-year fracture risk < 10% may require repeat BMD testing at 5-10 year intervals.]

DIAGNOSTIC RADIOLOGY

MISCELLANEOUS EXAMINATIONS

F

X151	Cordotomy, percutaneous.....	60.55
X163	Dacrocystogram.....	37.00

Discogram(s)

X164	- one or more levels	36.25
X167	Fistula or sinus.....	26.90
X169	Laminogram, planigram, tomogram.....	49.90
X170	Laryngogram.....	36.25
X171	Lymphangiogram	61.30
X192	Mammary ductography	31.35

Mammogram – Signs or Symptoms

[Commentary:

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

Dedicated equipment

X184	- unilateral	35.15
X185	- bilateral	46.50

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	35.15
X178	- bilateral	46.50

Payment rules:

X169 is not eligible for payment with X172, X178, X184, or X185.

X194	Additional coned views with or without magnification (limit of two per breast) per film	7.50
X201	Breast biopsy specimen x-ray, per specimen	7.50
X150	Mechanical evaluation of knee	31.85
X193	Microradiology of the hands.....	18.10
X173	Myelogram – spine and/or posterior fossa.....	43.70
X190	Pantomography	22.20
X154	Penis	19.95
X176	Sialogram.....	37.30
X177	Skin thickness measurement.....	19.50
X183	Ventriculogram.....	60.55
X166	Examination using portable machine “in home” add to first examination only	81.00

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	54.80
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Echography – ophthalmic (excluding vascular study)

J102	- quantitative, A-mode.....	26.00
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J103	- B-scan immersion.....	51.00
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J107	- B-scan contact.....	25.25
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J108	- biometry (Axial length – A-mode)	26.45
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Face and/or neck

J105	- excluding vascular study	54.95
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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	56.65
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Abdomen and Retroperitoneum

Abdominal scan

J135	- complete	56.65
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J128	- limited study (e.g. gallbladder only, aorta only or follow-up study)	37.30
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DIAGNOSTIC ULTRASOUND

PREGNANCY

Complete

J159	- on or after 16 weeks gestation (maximum one per normal pregnancy)	56.65
J160	- for high risk pregnancy or complications of pregnancy	56.65
J166	- multiple gestation, for each additional fetus, to J160add	48.10

Gestational age for Maternal Serum Screening Program

J157	- before 16 weeks gestation (maximum one per normal pregnancy) ...	37.30
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Limited

J158	- for high risk pregnancy or complications of pregnancy	37.30
J167	- fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158.....add	37.30

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)	45.30
J169	- multiple gestation, for each additional fetus, to J168add	38.50

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*	56.65
J138	Intracavitary ultrasound* (e.g. transrectal, transvaginal)	56.65

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	116.10
J476	Transvaginal sonohysterography – including Echovist contrast media for demonstration of tubal patency	270.50

Note:

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

J163	- limited study – for other than pregnancy	37.30
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Intracavitary ultrasound

J161	- limited – for other than pregnancy	37.30
J164	Follicle monitoring studies	28.30

[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	49.55
J201	- duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis	63.95

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	25.60
J202	- duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis, unilateral	33.10

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	8.60
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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.....	25.60
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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	25.60
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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.....	25.60
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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	23.65
J196	- with exercise and/or quantitative measurement, to J200.....add	9.30

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	7.95
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Penile Doppler Evaluation

J199	- Doppler scan	7.95
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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	28.00
J204	- when done in addition to Doppler studies	15.30

DIAGNOSTIC ULTRASOUND

MISCELLANEOUS

Echography for placement of radiation therapy fields

J180	- scan B-mode	40.80
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Extremities

J182	- per limb (excluding vascular study)	29.65
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Breast

J127	- scan B-mode (per breast)	27.55
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Scrotal

J183	- scan	54.95
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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)	54.95
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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.....	18.95
J307	- by body plethysmography.....	20.30

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)	60.35
J306	Airways resistance by plethysmography or estimated using oesophageal catheter.....	18.80
J303	Extra pulmonary airways resistance by plethysmography	18.80
J340	Maximum inspiratory and expiratory pressures	3.25
J310	Carbon monoxide diffusing capacity by single breath method.....	24.85
J308	Carbon dioxide ventilatory response.....	23.10

Stage I

J315	Graded exercise to maximum tolerance (exercise must include continuous heart rate, oximetry and ventilation at rest and at each workload)	72.50
E450	- J315 plus J301 or J304 before and/or after exercise	15.45
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	21.05

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)	104.50
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)	38.75
J319	Blood gas analysis – pH, PO_2 , PCO_2 , bicarbonate and base excess ...	13.10
J318	Arterialized venous blood sample collection (e.g. ear lobe).....	4.40
J320	A-a oxygen gradient requiring measurement of RQ by sampling mixed expired gas and using alveolar air equation	32.00
J331	Estimate of shunt (Qs/Qt) breathing pure oxygen.....	32.00
J313	Mixed venous PCO_2 , by the rebreathing method	13.10

Oxygen saturation

J323	- by oximetry at rest, with or without O_2	4.90
J332	- by oximetry at rest and exercise, or during sleep with or without O_2 .	20.40
J334	- J332 with at least two levels of supplemental O_2	35.50
J336	- with single blind assessment of exercise on room air and with supplemental oxygen.....	35.50

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	6.15
J333	Non-specific bronchial provocative test (histamine, methacholine, thermal challenge)	56.00
J335	Antigen challenge test.....	60.25

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

SLEEP STUDIES

PREAMBLE

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	107.65
J899	Sleep study between 1 and 4 hours	215.30
J990	Sleep study more than 4 hours.....	430.55

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.

SLEEP STUDIES

SLEEP STUDIES

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

J896 - diagnostic study 430.55

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;
 - 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

SLEEP STUDIES

SLEEP STUDIES

- 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 430.55

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 430.55

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.

SLEEP STUDIES

SLEEP STUDIES

[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

J893	Multiple sleep latency test	80.10
J894	Maintenance of wakefulness test	80.10

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 the inspecting body's quality and safety standards, the service is not eligible for payment.

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