

# Billing in the ED



May 7, 2026

# Schedule of Benefits

## Physician Services Under the Health Insurance Act

- <https://www.ontario.ca/files/2026-03/moh-schedule-benefit-2026-03-27.pdf>



# Outline

- **Assessments**

- Everyday Assessments + Consults (“H-codes”)
- Handovers
- Critical Care (“G-codes”)
- Mental Health/Counselling/STD/Palliative (“K-codes”)
- Sedations/Assists
  
- +/- Special Visits (“SVPs”)

# Outline

- **Premiums**

- Procedures (E412/E413)
- Add-ons to G and K codes (H114/H113/H112)
- Trauma (E420)

- **Others**

- Admission/Holding Orders (H105)
- EUA (Z432)
- US Guided Procedures (J149C)
- MTO Reporting Form (K035)
- Phone consults (Critical K736/K737 and Regular K734/K735)
- E-assessments by phone

# Outline

- **Procedures** (presented by system)
  - Skin/Soft Tissue
  - Cardiovascular
  - Neuro
  - Respiratory
  - Optho
  - ENT
  - GI/Rectal
  - Ob/Gyn
  - Genitourinary
  - MSK/Fractures

# Assessments - H codes

- **Minor - H1x1**
  - History and exam of 1 part, system, or region
  - “I have a paper cut and need a tetanus shot”
- **Multisystem - H1x3**
  - History and exam of 2 or more parts, systems, or regions
- **Comprehensive - H1x2**
  - Full H&P (PMH/meds/fam hx/social hx) + workup (BW, imaging, +/-allied health consult) + attendance over many hours
- **Reassessment - H1x4**
  - Billable >2hrs after seeing patient if you order additional tests (i.e. further imaging, PO trial, ambulate pt etc.)
  - Cannot be billed if the r/a leads to an admission, discharge, or transfer of patient
  - Max of 2x H1x4 per physician per patient, and max 3 total per patient per day
    - i.e You see pt at 1200 & order u/s r/o appy, then r/a @ 1430 - u/s inconclusive so you order a CT = bill H1x4

# Assessments – H code specifics

Recent update

## Weekday Mon-Fri 0800-1700

- H101 – Minor
- H102 – Comprehensive
- H103 – Multi system
- H104 – Reassess

Recent update

## Weekday Eve **Mon-Thurs 1700-2400**

- H131 – Minor
- H132 – Comprehensive
- H133 – Multi system
- H134 – Reassess

## **Friday Evening 1700-2400**

## Sat/Sun/Holiday 0800-2400

- H151 – Minor
- H152 – Comprehensive
- H153 – Multi system
- H154 – Reassess

## Nights 0000-0800

- H121 – Minor
- H122 – Comprehensive
- H123 – Multi system
- H124 – Reassess

# Holidays

**Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, New Year's Day, December 25 through December 31 (inclusive) and,**

- a. if Christmas Day falls on a Saturday or Sunday, the Friday before Christmas Day;  
and
- b. if New Year's Day falls on a Saturday or Sunday, the Monday following New Year's Day;  
and
- c. if Canada Day falls on a Saturday or Sunday either the Friday before or the Monday following Canada Day, as determined at the choice of the physician.

**Examples** – December 25<sup>th</sup>, 2027 falls on a Saturday, therefore since December 25 – Jan 1<sup>st</sup> are already holiday days for billing, Friday December 24<sup>th</sup>, 2027 can be billed as a holiday (H1x5)

July 1<sup>st</sup>, 2028 falls on a Saturday, therefore **either** Friday June 30, 2028 **or** Monday July 3, 2028 can be billed as a holiday (H1x5) “as determined at the choice of the physician”.

# Assessments - Consults

- Billable for patients referred into the ED by a physician, NP, or sent from LTC/RH
- Include the referring MD/NP's billing number ,or name, on the order in Cerner
  - Billing number search tool → <https://ontariobillingnumber.com/>
- NOT billable when taking an in-department consult from a NP or colleague
  - **H055** – FRCPC (or US/UK trained)
  - **H065** – CCFP, CCFP (EM)

# Assessments - Handovers/Transfer of Care

- **From NP** = bill full assessment for what you do +/- procedures
- **From MD colleague** = ask what/how they billed on patient
  - G code? You can continue them (up to 3 docs can bill G codes/pt)
  - H code? Bill a lesser assessment and for anything else you do

# Critical Care – “G codes”, “G3” or “G5”

- **Time-based**
  - Consecutive or non-consecutive = total time spent for a patient’s care
  - 15-minute increments (*or part thereof, aka 1 minute*)
    - = Face to face at bedside + Reviewing labs/imaging + Discussing dispo plan with charge RN/consultants etc. etc. (all time spent involved in the care of the patient)
  - >2hrs = manual review (biller has to send in your note)
- Document start AND stop times
  - “Total time spent = >30 mins” is not a start and stop time
- Up to three (3) physicians per patient

# Critical Care – “G codes”, “G3” or “G5”

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same day as any code described as "life threatening critical care":

1. Assessment and ongoing monitoring of the patient's condition.
2. Intravenous lines.
3. Cutdowns.
4. Arterial and/or venous catheters.
5. Central venous pressure (CVP) lines.
6. Endotracheal intubation.
7. Tracheal toilet.
8. Blood gases.
9. Nasogastric intubation with/without anaesthesia with/without lavage.
10. Urinary catheters.
11. Pressure infusion sets and pharmacological agents.
12. Defibrillation.
13. Cardioversion.

← This is billable with G3, not with G5

# **G5 – “life threatening critical care ”**

- **Critically ill, or**
- **Critically injured patient, causing**
- **Vital organ system failure**
  - *as a result of which imminent life-threatening deterioration in the patient's condition is highly probable*
  - Includes but is not limited to: CNS failure, circulatory failure, shock, renal, hepatic, metabolic and or respiratory failure

# G5 - “life threatening critical care ”

Amount payable per physician per patient for the first three physicians:

- G521 - first  $\frac{1}{4}$  hour (or part thereof) .....
- G523 - second  $\frac{1}{4}$  hour (or part thereof).....
- G522 - after first  $\frac{1}{2}$  hour, per  $\frac{1}{4}$  hour (or part thereof) .....
- G391 Amount payable per physician per patient for the fourth and subsequent physicians (per  $\frac{1}{4}$  hour or part thereof).....

# G3 – “other critical care”

- Where there is a potential threat to life or limb of such a type that without resuscitation efforts by the physician, there is a high probability the patient will suffer loss of limb or require life threatening critical care.

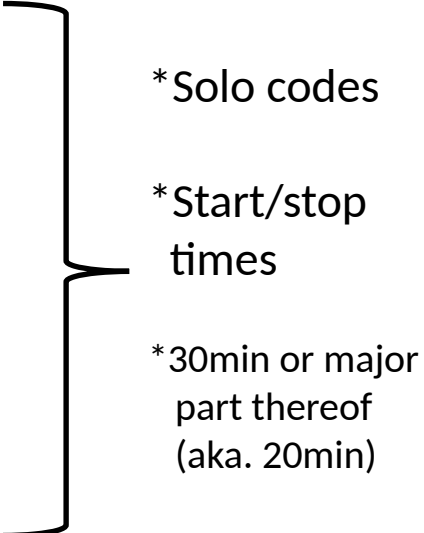
Amount payable per physician per patient for the first three physicians:

G395 - first ¼ hour (or part thereof) .....

G391 - after first ¼ hour per ¼ hour (or part thereof) .....

# Assessments - MH + Counselling

## “K-codes”

- **K623** – Form 1
    - **\*\*** Add G-codes if dealing with OD/toxidrome
  - **K005** – Mental Health Counselling
  - **K028** – STI mgmt./counsel or blood-borne exposure (needle-stick)
  - **K013** – Counselling “individual-care”
  - **K023** – Palliative care support
    - “for providing pain and symptom management, emotional support and counselling to patients receiving *palliative care*.”
- 
- \*Solo codes
- \*Start/stop times
- \*30min or major part thereof (aka. 20min)

# Procedural Sedations

- “I signed you up for a sedation in room 6”



# Procedural Sedations - xxxxC

- **Time + unit based**

- Document start and stop times
- Used for:
  - Fracture reductions, cardioversion, suturing
  - Exams under anaesthesia – foley, pelvic, peds LP, imaging (CT)

- **Premiums + Add-ons**

- Time premiums = E400C or E401C
- ASA III, IV, V
- Position modifier = Sitting >60°, Prone
- BMI > 40
- Age

# Procedural Sedations – Billing Units

- **Base units = 6**
  - Paid up front

Asst	Surg	Anae
6	136.35	6

- **Time units = 1 unit for each 15 min, or part thereof (2 unit/15min for 1-1.5hr, 3u/15min >1.5hr)**
  - 20 min = 2 units
  - 32 min = 3 units
  - 65 min = 6 units

Time units are calculated on the basis of time spent by the anaesthesiologist and commence when the anaesthesiologist is first in attendance with the patient in the OR for the purpose of initiating anaesthesia and end when the anaesthesiologist is no longer in attendance (when the patient may safely be placed under customary post-operative supervision). Time units are calculated for each 15 minutes or part thereof.

# Procedural Sedations – How to bill

- 1.) Add a “C” to the end of the procedure code
  - Colle’s # = F046 = **F046C**
  - Cardioversion = Z437 = **Z437C**
  
- 2.) Add up total units
  - Base + Time units = **enter this as “quantity” in Cerner order**
  - F046C x 25min = **F046C x 8**

# Procedural Sedations – How to bill

- 3.) Add a time premium (if applicable)
  - **E400C = +50%**
    - Weekday evening 1700-0000
    - Weekend/Holiday daytime 0700-0000
  - **E401C = +75%**
    - Nights 0000-0700

# Procedural Sedations – How to bill

- 4.) Additional modifiers

- **BMI > 40** = E010C (+2u)
- **Prone** = E011C (+4u)
- **Sitting >60°** = E024C (+4u)
  
- **ASA III** = E022C (+2u)
- **ASA IV** = E017C (+10u)
- **ASA V** = E016C (+20u)

E021C	premature <i>newborn</i> less than 37 weeks gestational age	9 units
E014C	<i>newborn</i> to 28 days	5 units
E009C	<i>infant</i> from 29 days to 1 year of age	4 units
E019C	<i>infant or child</i> from 1 year to 8 years of age inclusive	2 units
E007C	<i>adult</i> aged from 70 to 79 years, inclusive	1 unit
E018C	<i>adult</i> aged 80 years and older	3 units

# Procedural Sedations – Exam Under Anaes.

- 1.) Billed when there is no procedure code to attach a -C to, or
- 2.) MRP is billing **Z432** (exam under anesthesia)
- **E023C**
  - Billed the exact same as described previously with modifiers
  - Base units = 6
    - Splinting (if not closed reduction)
    - Pelvic +/- removal vaginal FB
    - Foley insertion
    - Pediatric CT scan
    - Laceration codes that do not have “anae” base units

# Procedural Sedations – When you're alone

- SOB page GP100
- Wording suggests you can bill for procedure and sedation so long as it is “deep sedation”
- If unsure, bill for the sedation only.

For the purposes of anaesthesia services the following definitions apply:

1. Procedural Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
2. Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
3. *General Anaesthesia* is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

## **ANAESTHESIA ADMINISTERED BY SAME PHYSICIAN PERFORMING A PROCEDURE**

1. Except as described in paragraph 2, 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*.

# Assisting – xxxB

- Billed similar to sedations – time and unit based
- Add a “B” to the end of the procedure code
  - Colle’s # = F046 = **F046C**
- For helping with counter traction, holding etc.
  
- Add time premiums
  - **E400B** – weekday 1700-0000, weekend/holiday 0700-0000
  - **E401B** – overnight 0000-0700
  
- **Note** – for some procedures, not all
  - Most fractures, lacs, abscesses
  - If unsure, quick search the SOB

Asst	Surg	Anae
6	136.35	6

If this is listed, you can bill assist codes

# Assisting - How to bill

- **Colle's #** - 25 min, weekday evening
  - F046B x 8
  - + E400B
  
- **Radius + Ulna #** - 20min, overnight
  - F025B x 8
  - +E401B

# Special Visit Premiums – SVPs

- Billed when you come into work at a time that you are not otherwise scheduled to be working:
  - Before the start of your assigned shift
  - Last minute pick-ups – surge call, sick MD/family emergency
  - You are on-call and are called in
- **Cannot be billed** if you are already physically in the hospital
- **Use A-codes** in place of H-codes (G-codes and K-codes are ok)
- Everything else is the same (procedures , premiums etc)

# Special Visit Premiums – A-codes

- Instead of H-codes (H1xx), use A-codes (Axxx) for assessments

- H1x1 = A001

- H1x3 = A007

- H1x2 = A003

- H065/55 = A005 (Full consult)  
A905 (Limited consult)

# Special Visit Premiums – SVPs

For the purpose of special visit premiums under the heading "Emergency Department Physician", "Emergency Department Physician" means a physician:

- a. who on a day when the physician is scheduled to work in a hospital emergency department specifically for the purpose of rendering services to patients who attend the emergency department for physician services,
  - i. is requested by the emergency department to attend at a time when the physician is not otherwise scheduled to work in the emergency department; and
  - ii. who is not at the hospital at the time the emergency department request for attendance is made; or
- b. is on-call on a scheduled basis specifically to be available to a hospital emergency department to render services to patients who attend the emergency department for physician services and who is not at the hospital at the time the emergency department request for attendance is made.

# Special Visit Premiums – Documenting

- Document the following for each chart you're billing SVPs:
  - 1.) The time of the request to the attend the ED
  - 2.) The specific situation requiring your attendance

*“Called in early at 0500 due to high patient volume and wait times”*

# Special Visit Premiums – Codes and Billing

	<b>Weekday Daytime</b> 0700-1700	<b>Weekday Evening</b> 1700-0000	<b>Weekend/Holiday</b> 0700-0000	<b>Nights</b> 0000-0700
Travel Premium	H960	H962	H963	H964
First Patient	H980	H984	H988	H986
Additional Patients	H981 (max 4)	H985 (max 4)	H989 (max 9)	H987 (unlimited)

# Special Visit Premiums – How To

- 1.) 0700 shift, you start at 0600 and see 10 patients before 0700:

- 1<sup>st</sup>
  - H964 (travel) + H986 (1<sup>st</sup>) + A007 (abdo pain)
- 2<sup>nd</sup>
  - H987 (additional) + G395 + G391 + H112 + H105 (urosepsis)
- 3<sup>rd</sup>
  - H987 + A007 + F027 + E413 (distal rad buckle #)
- 4<sup>th</sup>
  - H987 + K623 (F1) + G395 + G391 + H112 (Tylenol OD)
- 5<sup>th</sup> – 10<sup>th</sup>
  - H987 + A/G/K +/- procedure +/- premiums +/- H105

**Nights**  
0000-0700

Travel Premium      H964

First Patient      H986

Additional Patients      H987  
(unlimited)

# Special Visit Premiums – Admitted patients

- Billable when a patient is admitted but in ED
  - Admitted, waiting for bed
- When you consult on an admit in hospital
  - Ex.) Suturing a patient in EAU
  - Ex.) Epistaxis on the ward, patient brought to ED for you to insert rapid rhino
- Paid @ 100% (outside of AFA)
  - You can submit yourself (MdBilling etc.) or email info to billers

# Special Visit Premiums – Admitted patients

	<b>Weekday Daytime</b> 0700-1700	<b>Weekday Evening</b> 1700-0000	<b>Weekend/Holiday</b> 0700-0000	<b>Nights</b> 0000-0700
Travel Premium	C960	C962	C963	C964
First Patient	C990	C994	C986	C996
Additional Patients	C991 (max 10)	C995 (max 10)	C987 (max 20)	C997 (unlimited)

# Special Visit Premiums - Admitted patients

- Patient in EAU broke a lightbulb and lacerated forearm, weekday eve
  - C994 (1<sup>st</sup> person seen weekday eve) - no travel prem, you are already there
  - A005 (consult note → remember, need referring MD billing number)
  - Z176 (suture <5cm)
  - E412 (+20% premium)
- Paid @ 100%

# Premium Codes – Procedure Premiums

- Any “surgical procedure” listed in the SOB
  - **E412 = +20%**
    - Weekday evening 1700-0000
    - Weekend/Holiday daytime 0700-0000
  - **E413 = +40%**
    - Nights 0000-0700

# Premium Codes – H114 / H113 / H112

- When you bill a G- or K-code (instead of H-code)
  - **H114**
    - Mon-Thurs evening 1700-0000
  - **H113**
    - Friday evening 1700-0000
    - Weekend/Holiday daytime 0800-0000
  - **H112**
    - Nights 0000-0800

# Premium Codes – Trauma Premium

- Added to:
  - G codes, procedure codes, anesthesia/assistant codes in trauma
- For day of trauma or within 24hrs after

**Document ISS score (with AIS breakdown) on chart:**

- $\geq 16$  yrs + ISS score  $> 15$
- $< 16$  yrs + ISS score  $> 12$

- **E420** = +50%

# Phone Calls – Criticall

- **K736** – Referring MD (you phone neurosurgery)
  - Max 2 per patient
- **K737** – Consulting MD (criticall calls you)
  - \*Need referring MD billing number

\*NO time requirement

## **Medical record requirements:**

CritiCall telephone consultation is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

- 1.the telephone consultation was arranged by CritiCall Ontario;
- 2.identification of the patient by name and health number;
- 3.identification of the referring **physician or nurse practitioner** and consultant physician;
- 4.the reason for the consultation; and
- 5.the opinion and recommendations of the consultant physician(s).

# Phone Calls – Consultant Advice

## Medical record requirements:

Physician to physician telephone consultation is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

1. patient's name and health number;
2. start and stop times of the discussion; **(10 min.)**
3. name of the referring physician or nurse practitioner and consultant physician;
4. reason for the consultation; and
5. the opinion and recommendations of the consultant physician.

- **K734** – Referring MD
- **K735** – Consulting MD
- **Document** start and stop times = 10 minutes minimum
  - Not billable if:
    - Care is transferred to another MD
    - To arrange a consultation/visit
    - To primarily discuss results of diagnostic investigations
    - When consultant see patient same day or next

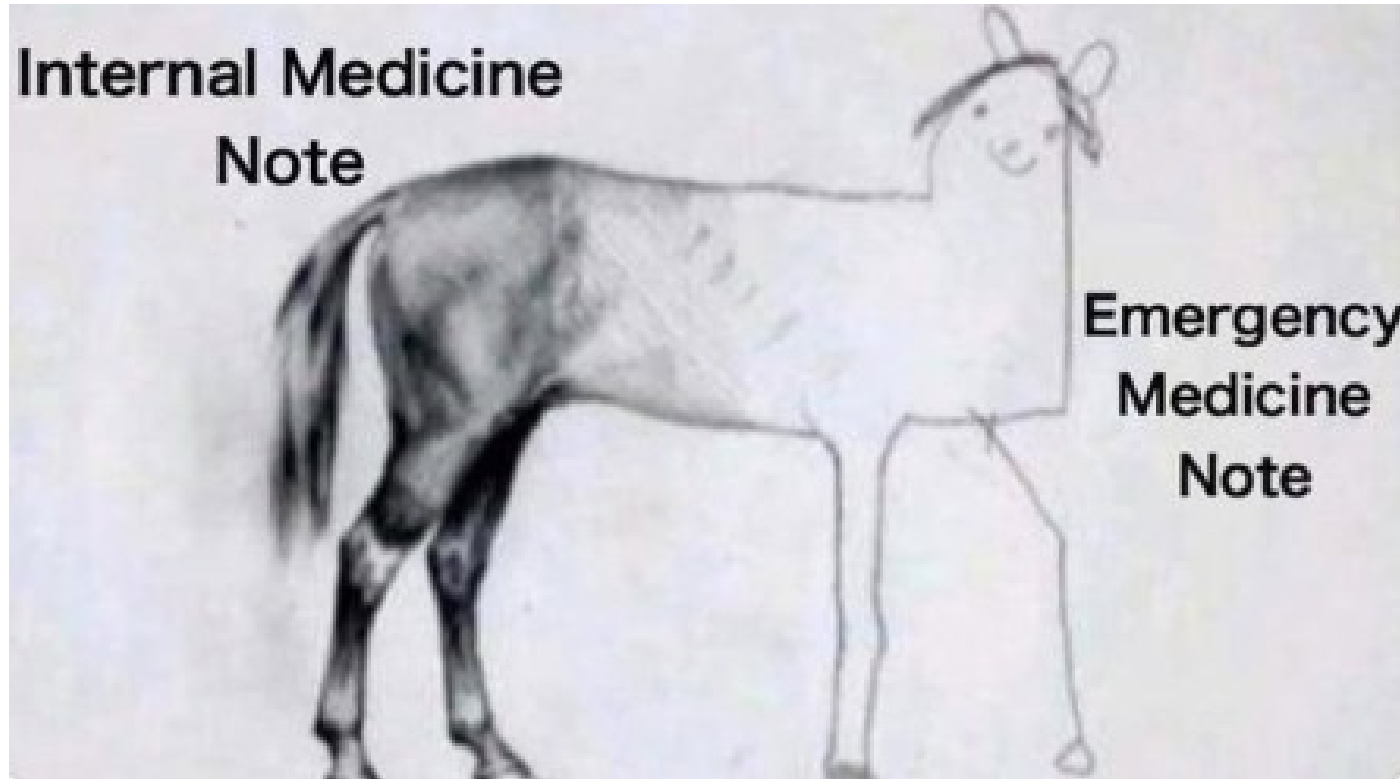
# Other Codes

- **H105**
  - Holding orders (admitted patients) – fluids, pain meds, abx, diet etc.
- **Z432**
  - Examination under anesthesia – if you have to do one
  - Sedation MD = **E023C**
- **J149C**
  - POCUS for aspiration/drainage procedures
- **K035**
  - Ministry of transport (MTO) reporting form
  - <https://forms.mgcs.gov.on.ca/en/dataset/023-5108>

# E-assessments - Calling patients

- Consider billing when you need to phone a patient (0900 callbacks)
- **A102**
  - Calling a patient you have NOT seen before
- **A001/A007 + K301** (indicates telephone assessment)
  - Calling a patient you HAVE SEEN within past 24 months
- Take info and email to billers
  - Patient name, HC #, date of service, codes

**Internal Medicine  
Note**



**Emergency  
Medicine  
Note**

# Procedures – By system

- Eligible for E412/E413 premium
- Use xxxC for sedation
  - Skin/Soft Tissue + Burns
  - Cardiovascular
  - Neuro
  - Respiratory
  - Optho
  - ENT
  - GI/Rectal
  - Ob/Gyn
  - Genitourinary
  - MSK/Fractures

# Skin/Soft Tissue

- **Z080** – Wound/ulcer debridement
  - 10 minutes (start/stop time)
  - If needing sutures, bill as a laceration
    - **Z081** – two
    - **Z082** – three
    - **Z083** – four or more
- **Z128** – Nail plate excision w/ anaesthesia
- **Z130** – Nail plate excision w/ destruction nail bed
- **Z113** – Skin biopsy
- **Z116** – Skin biopsy + sutures
- **Z122** – Lipoma/cyst (face or neck)
  - **Z145** – w/ sedation/assist
- **Z125** – Lipoma/cyst (body)
  - **Z149** – w/ sedation/assist

# Foreign Body Skin

- **Z114** – FB skin , local anaes
- **Z115** – with sedation (+assist)
  
- **R517** – FB excision (extends into muscle)

# Abscesses/Hematoma

## Abscess/Hematoma I&D (local anae)

Z101 – One \$28.10

Z173 – Two

Z174 – Three or more

Z104 – Perianal

Z106 – Ischioirectal/pilonidal

Z103 – Palmar/plantar

Z140 – Breast abscess

Z714 – Vulva/Bartholin \$25.40

## Abscess/Hematoma (general anae)<sup>An</sup>

Z102 – one

Z172 <sup>7 BU</sup> – two or more

Z105 – perianal

Z107 – ischioirectal/pilonidal

Z108 – palmar/plantar

Z740 – breast abscess

Z715 <sup>As/An</sup> – Vulva/Bartholin GA

Z728 – Vag I&D cyst/absc/hema

\* Subungual hematoma

\* +J149C – if US guided drainage

# Lacerations

**Z176** –  $\leq$  5cm

**Z175** – 5.1 to 10cm

**Z179** – 10.1 to 15cm

**Z191** –  $>15.1$ cm

**Z154** – face, or layers, ligate bleeders

**Z177** – “

**Z190** – “

**Z192** – face only

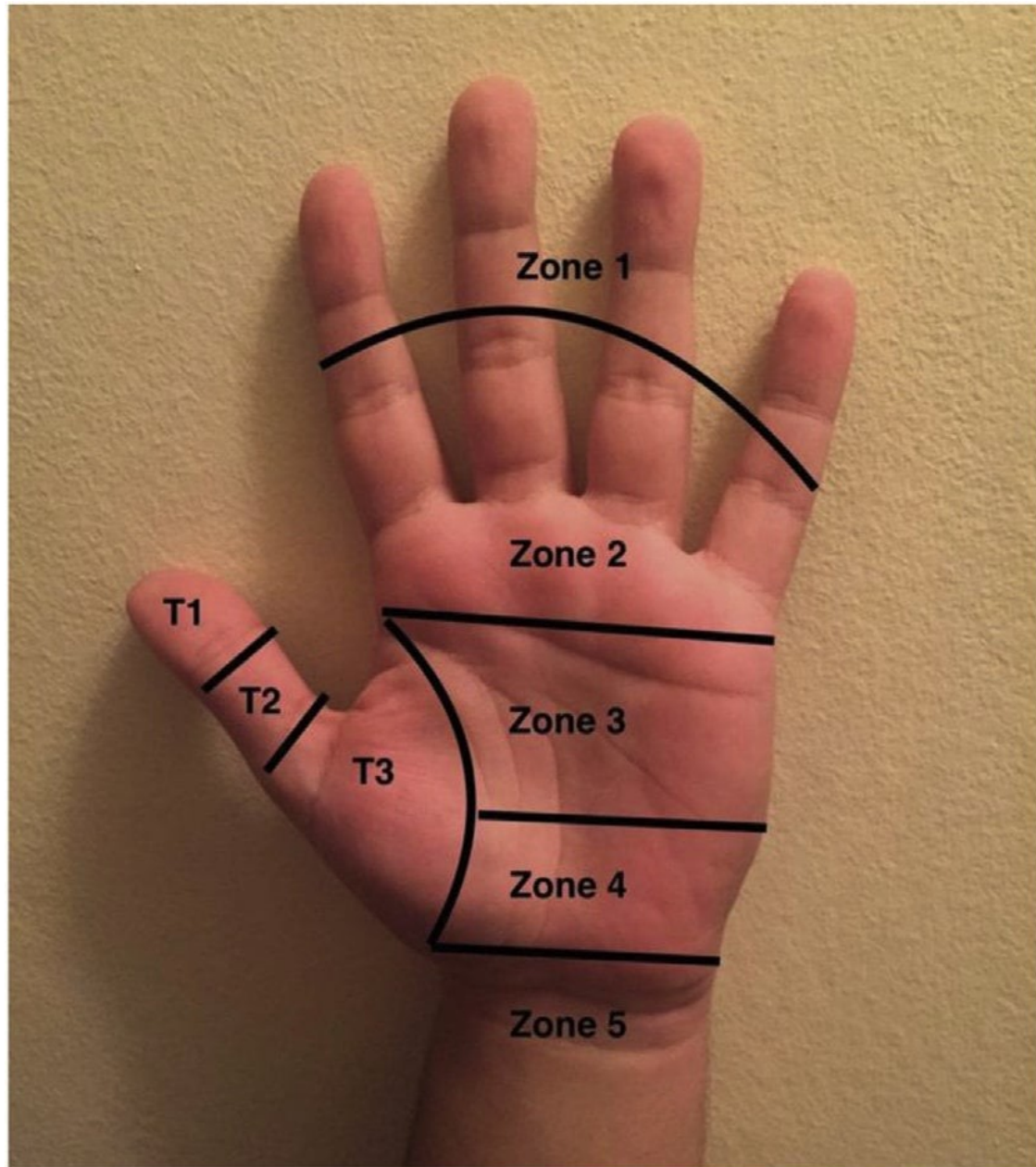
**Z187** – Complex lac face (align vermilion border, eyebrow/lid, pinna,  $\geq 3$  layer, bleeders)

**Z188** – Complex lac body ( $\geq 3$  layers [muscle sheath, subq, skin), ligate bleeders)

**Z189** – Zone 1 digit repair

Z187 + Z188 + Z189 = Start + Stop times, minimum 20min.

**R024** – Earlobe (no anae units)



# Burns - Debridement

- **R660** – Hand, per digit
  - **R661** – Dorsum or palm, per each
  - **R662** – Nose, cheek, lip, ear, forehead, scalp, neck, eyelid, per each
  - **R637** – Per %BSA debrided elsewhere
- 
- **R030** – Anaesthesia/Assist code for minor burn
  - **R038** – ‘’ for moderate burn

# Burns – SOB page M11

## Burns

### Note:

For burn care the following definitions apply:

Total Body Surface Area (TBSA) as calculated using the "rule of nines" or the Lund-Browder chart.

Young - a person 9 years of age and younger.

Adult - a person from 10 years up to, and including, 50 years of age.

Old - a person 51 years of age and older.



### Minor Burn

- a. less than 10% TBSA burn in *adult*
- b. less than 5% TBSA burn in young or old
- c. less than 2% TBSA full thickness burn - any age

### Moderate Burn

- a. 10 to 20 % TBSA burn in *adult*
- b. 5 to 10 % TBSA burn in young or old
- c. 2 to 5 % TBSA full thickness burn - any age
- d. the following regardless of TBSA or age of patient:
  - i. high-voltage injury
  - ii. suspected inhalation injury
  - iii. circumferential burn
  - iv. concomitant medical problem predisposing to infection (e.g. diabetes, sickle cell disease)

### Major Burn

- a. more than 20% TBSA burn in *adult*
- b. more than 10% TBSA burn in young or old
- c. more than 5% TBSA full-thickness burn - any age
- d. the following regardless of TBSA or age of patient:
  - i. high voltage burn
  - ii. known inhalation injury
  - iii. any deep partial and/or full thickness burn to face, eyes, ears, genitalia, hands, feet or joints
  - iv. significant associated injuries (e.g. fracture or major trauma)

# Cardio + Resp

- **Z437** – Electrical/chemical cardioversion, max 3x/pt (+ G395/G391)
  - If you shock twice in one setting to achieve NSR, typically billed as Z437 x 2
- **Z401** – Pericardiocentesis
- **M107** – Thoracotomy
  
- **Z341** – Chest tube insertion
- **Z363** – Chest tube removal (not billable same day as Z341)
- **Z326** – Trach tube change
- **Z332** – Thoracentesis
- **Z741** – Cricothyroidotomy

# Neurology

- **Z804** – Lumbar puncture (pays \$150 now, no u/s modifier anymore)
- **N120** – Burr hole (doubtful it would pay but if you do it, document and try)

# Ophthalmology

- **G435** – IOP (Tonopen) = \$5.10
- **Z847** – Cornea FB
- **Z848** – “, two
- **Z852** – “, w/ sedation
- **Z854** – Eyelid abscess, local
- **Z855** – “, sedation
- **E199** – Eyelid lac, full thickness
- **E198** – “, w/ lid margin
- **E235** – Lateral canthotomy (with lysis of inferior crus tendon)

# ENT

- **G420** – Syringing/curettage (remove wax unresponsive to tx or necessary to see TM – document either)
- **G403** – Epley maneuver for BPPV
  
- **Z915** – Foreign body ear
- **Z866** – “, with sedation
  
- **Z311** – Nasal foreign body
- **Z312** – “, with sedation
  
- **Z314** – Nasal cauterization
- **Z315** – Epistaxis anterior packing
- **Z316** – Epistaxis posterior packing
  
- **F136** – Nasal fracture, closed reduction
- **D062** – TMJ dislocation, closed reduction

# ENT

- **Z296** – Nasopharyngoscopy
- **Z292** – Direct laryngoscopy
- **Z322** – “, w/ FB removal
- **Z342** – Indirect laryngoscopy w/ FB removal
- **Z510** – Peritonsillar abscess I&D
- **E318** – Pinna hematoma, drain/pack
- **E317** – “, w/ sedation
- **Z301** – Nasal septum abscess/hematoma
- **Z506** – Oral abscess/hematoma
- **S066** – Post T&A bleed, cautery/suture
- **Z360** – Emergency rigid bronch for upper airway obstruction (not intubated, no G-codes)
- **Z327** – Flexible bronch
  - **+E623** – w/ removal of FB

# GI

- **Z590** – Paracentesis, diagnostic
- **Z591** – “, and therapeutic
- **Z545** – Incise thrombosed hemorrhoid
- **Z756** – Fecal disimpaction
- **Z541** – “, w/ sedation
- **Z538** – Hernia reduction<sup>except rectum</sup>
- **G356** – NG Tube
- **G349** – Blakemore tube
- **Z543** – Anoscopy
- **Z520** – G-tube change

# Ob/Gyn

- **P006** – Vaginal delivery
- **P009** – Attendance at L&D (assisting with delivery)
  - If gyne is present, they likely want the P006, you bill P009 + E411
- **P018** – C-section
  - **+E411** – Sole delivery premium = +100% (to any above)
- **S756** – Removal products of conception from cervix
- **H264** - ED pelvic exam with speculum (no procedure premium)

# Genitourinary

- **G900** – PVR measurement by MD
- **Z611** – Foley insertion by MD
- **Z608** – Manual declotting/irrigation of bladder
- **Z786** – Emergency management of priapism
  - Aspiration and irrigation of corpora cavernosa with intracavernosal vasoactive injection for priapism

**Emergent tx of paraphimosis:**

## **INCISION**

### **Slit of prepuce**

- S567** - newborn.....
- S568** - infant.....
- S569** - adult or child

# **MSK** – Casts/Corrective Splints

- Not billable with F-code for fracture
- **Z201** – Finger
- **Z202** – Hand
- **Z203** – Wrist/Forearm/Arm
- **Z199** – Foot
- **Z213** – Below knee
- **Z204** – Removal of plaster (>2 weeks after application)

# MSK – Other

- **Z287** – I&D of bursa (anae 7u)
- **G370** – Knee joint or Olecranon bursa aspiration
- **G328** – Complex joint or bursa aspiration

# MSK – Hand/Carpals/Fingers

- **F004** – **Phalanx #**, rigid immobilization
  - **F005<sup>An</sup>** – **Phalanx #** , closed reduction
    - **+E558** - Each additional
  
  - **F008** – **Metacarpal #**, rigid immobilization
  - **F009<sup>An</sup>** – **Metacarpal #**, closed reduction
    - **+E504** – Each additional
  
  - **F006** – **Intrarticular # phalanx or metacarpal**, closed reduction
    - **+E503** – each additional
  
  - **F102** – **Carpal bone #**, rigid immobilization
  - **F016<sup>An</sup>** – **Carpal bone #**, closed reduction
  
  - **F018** – **Scaphoid #**, rigid immobilization
- **D001<sup>An</sup>** – **Phalanx dislocation, closed reduction**
    - **+E576** - Each additional
  
  - **D004<sup>An</sup>** – **MCP dislocation, closed reduction**
    - **+E577** – Each additional
  
  - **D007<sup>An</sup>** – **Carpal dislocation, closed reduction**
  
  - **R578<sup>As/An7</sup>** – **Extensor Tendon Repair**
    - **+E580** – each additional
  
  - **R629<sup>As/An</sup>** – **Revision of amputated finger tip**

# MSK – Wrist/Forearm/Elbow

- **F027** – **Distal radius**, rigid immobilization
- **F028** – “, closed reduction w/ local (hematoma block)
- **F046** – “, w/ sedation
  
- **F024** – **Radius & Ulna shaft**, rigid immobilization
- **F025** – “, closed reduction
  
- **F031** – **Radius or Ulna**, rigid immobilization
- **F032** – “, closed reduction
  
- **F029** – Epicondyle #, no reduction
- **F037** – “, closed reduction
  
- **F039** – Transcondylar #, no reduction
- **F040** – “, closed reduction
  
- **F034** – Olecranon #, rigid immobilization
- **F035** – “, closed reduction
  
- **D009** – Elbow dislocation, closed reduction
  
- **D012** – Radial head dislocation, closed reduction (Nursemaid’s elbow)

# MSK – Shoulder/Arm/Chest

- **F042** – **Humerus shaft**, no reduction
- **F043** – “, closed reduction
- **F053** – **Humerus neck**, no reduction
- **F054** – “, closed reduction
- **F050** – **Humerus neck + head dislocation**, no reduction
- **F051** – “ + “, closed reduction
- **F047** – **Humerus tuberosity**, no reduction
- **F048** – “, closed reduction
- **D015** – **Shoulder dislocation**, closed reduction
- **D016** – “, w/ sedation
- **D014** – **AC or SC joint**, no reduction
- **D025** – “, closed reduction w/ anae
- **F119** – **Scapula #**, no reduction

# **MSK – Pelvis/Hip/Femur**

- **D042** – Hip dislocation, closed reduction
- **F095** – Femur #, closed reduction in traction
- **F094** – “, infant/child

# MSK – Knee/Tib/Fib

- F085 – Patella #, no reduction
- D040 – Patella dislocation, closed reduction (no sedation)
- D031 – Patella dislocation, closed reduction **with sedation**
  
- D038 – Knee dislocation, closed reduction
  
- F078 – Tibia +/- Fibula #, rigid immobilization
- F079 – “, closed reduction
  
- F082 – Fibula #, rigid immobilization
- F083 – “, closed reduction

# MSK – Foot/Ankle

- **F074** – Ankle #, rigid immobilization
  - **F075** – “, closed reduction
  - **F104** – Ankle # + Tibial plafond burst
  - **D035** – Ankle dislocation, closed reduction
  
  - **F066** – Tarsal #, rigid immobilization
  - **F067** – “, closed reduction
  
  - **F061** – Metatarsal #,  $\geq 1$
  - **F062** – “, rigid immobilization
  - **F063** – “, closed reduction
  
  - **F070** – Calcaneus #, rigid immobilization
- **F056** – Phalanx #, rigid immobilization
    - **+E560** – each additional
  - **F058** – “, closed reduction
    - **+E561** – each additional
  
  - **D027** – Phalanx dislocation, closed reduction
    - **E578** – each additional
  
  - **F057** – Interphalangeal joint #, closed reduction
  - **D033** – Tarsal dislocation, closed reduction

# Other Codes

- Venipuncture
- Nerve blocks
- Trigger point injection
- IM injection (vaccines)
- Detention in ambulance

# Summary

- **H Codes** – H1xx, H0xx
  - Everyday use, handovers
- **G Codes** – G3/G5
  - Critical care
  - + H113, H114, H112 premiums
  - + K015 counselling family
  - + K736 criticall
- **Form 1** – K623
  - + G3/G5 codes if treating OD/toxidrome
  - + H113, H114, H112
- **MH/Counselling** –K005, K028, K013, K023
  - + H113, H114, H112

**Procedures** – + E412/E413, +J149C (u/s)  
**Admissions** – + H105

