



ONTARIO CHIROPRACTIC ASSOCIATION
ASSOCIATION CHIROPRACTIQUE DE L'ONTARIO

OCA Recommended Service Codes and Fee Schedule

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Preamble

Introduction

The OCA Recommended Service Codes and Fee Schedule (“The Fee Schedule”) has been prepared for chiropractors, patients and payers to provide for fair and reasonable billing for chiropractic services according to a clear and consistent model. The schedule is comprehensive, covering general and specialist chiropractic services.

The OCA has published The Fee Schedule since the early 1970s. The structure and content of the schedule has changed over the years to reflect the needs of practitioners, patients and payers. Recommended fees are adjusted periodically to reflect changes in the cost of rendering care and in the socio-economic circumstances of the day. The adjustments made to the guide over the past decade have been in line with general inflation.

This schedule replaces the 2008 schedule. The fee categories and codes remain unchanged. For 2009, fees have been increased by a total of 3.69%.

Chiropractors will appreciate that they do not necessarily offer all services scheduled, however, where provided services should be in accordance with the OCA’s Code of Ethics, Regulations of the College of Chiropractors of Ontario, Standards of Practice as established by the College of Chiropractors of Ontario, and/or Clinical Practice Guidelines established by the Glenora Conference or subsequent initiatives.

The Fee Schedule reflects services most commonly provided by chiropractors, but not necessarily all services. The omission of a specific service from the fee schedule does not imply that any such service cannot be rendered by the practitioner and/or that such service is not within the scope of practice of the practitioner.

Fees are Recommendations

The Fee Schedule is issued for information purposes only. Adoption of the fees recommended herein remains at the discretion of the practitioner. The Ontario Chiropractic Association does not have the authority to set fees for chiropractors.

Recommended fees represent the **full** fee for each service, inclusive of any partial or full insurance provisions. They are also the **recommended** fee for each service and should, therefore, be used by chiropractors as a guide to establish fees.

The OCA recognizes that chiropractic fees may vary across the province. As with other professional and health care professions a number of factors affect the establishment of a given fee for a given service. These include the cost to provide the service, regional and economic factors, and considerations of reasonable and customary practice for patient and practitioner.

The fee established by a chiropractic office for a given service should be charged to all patients who receive that particular service, and should be charged without reference to, for example, the existence of any third-party insurance under which the patient may be covered.

Delayed or neglected chiropractic care can lead to more serious, and harder to treat, chronic conditions. As private practitioners chiropractors have discretion to adjust charges, as appropriate, if this is deemed to be in the best interests of the patient or if a given treatment is less involved. Similarly, fees may be adjusted based on individual circumstances such as when treatment in particular circumstances requires specialized care or a greater time allocation.

According to Standards established by The College of Chiropractors of Ontario, patients must be informed of the cost of service before the service is performed regardless of the payer. Where the practitioner's fee is significantly at variance with the recommended fee, it is suggested that the patient and/or payer be informed of the reasons for the variance.

How Does the OCA Establish Recommended Fees?

Recommended fees are based on the OCA's opinion of the value of each service. To arrive at these values, consideration is given to many factors including, but not necessarily limited to:

- time requirements to prepare for and deliver the service;
- education and training requirements;
- intensity of cognitive and physical work required to deliver the service;
- level of skill required to deliver the service;
- level of risk associated with delivering the service; and
- cost associated with the provision of the service.

Because OHIP historically mandated chiropractic billing on a 'per visit' basis and not by service / intervention, the relative value used to derive recommended fees has been, and continues to be, based on the recommended cost of a common office visit.

A "common office visit" is defined as a visit consisting of spinal manipulation/adjustment. For 2009, this recommended fee (value) is \$35.39. Since fees are rounded to the nearest dollar, the recommended fee value for a common office visit for 2009 is \$35.00 (unchanged from 2008).

All other services (with the exception of those services provided on an hourly-rated basis) are assigned a relative value (weighting) based on this value. Relative value weighting is derived from an assessment of the average time required to treat an average patient by the typical practitioner in a typical practice in a typical town and the factors listed above. No changes have been made to weighting or relative values for 2009.

Recommended 2009 fees reflect a 3.69% adjustment for annualized inflation according to Statistics Canada's Consumer Price Index for Ontario (All Items), as reported for the month of September 2008.

Service Code Combinations: Allowance for Multiple Interventions

Assessment Services are always stand-alone interventions, or the first intervention performed during a patient encounter. Therapeutic interventions may be stand-alone interventions or may be provided in conjunction with assessment services or other therapeutic intervention(s) during the same patient encounter. In this case, a reduced fee is recommended for the second or subsequent services. Orthotic and x-ray services do not have discounted fees because of the specialized nature of these services.

Billing by Individual Service or by Encounter (By Visit or Session)

For administrative ease some chiropractors may choose to bill on a per visit basis. The Fee Schedule also accommodates this (see Service Code 2900). Where fees are established on a per visit basis (also called per session or per patient encounter), the fee should reflect the component interventions. To ensure patient understanding of the services performed, it is recommended that the components of the session be individually recorded on the invoice even if not priced individually.

Delegation

Certain procedures, excluding “Controlled Acts” as set out by the Regulated Health Professions Act, may be performed by another individual under the direct supervision of a chiropractor. **Direct supervision** requires that during the performance of the procedure by the employee, the chiropractor be physically present in the office or clinic in which the service is rendered. This does not preclude the chiropractor from being otherwise occupied, but he/she must be in personal attendance to ensure that procedure(s) are being performed completely and that he/she must at times be immediately available to intervene in a procedure as required in the best interests of the patient.

Referral

A **referral** takes place when one chiropractor requests the services of another health care professional. The requested services may consist of an opinion (consultation), diagnostic tests and/or procedures, and /or treatment. In instances of a requested opinion or diagnostic tests and/or procedures, the initiating chiropractor retains management of the patient by continuing to treat the patient.

A **transferral** occurs when the responsibility for the care of the patient is temporarily or permanently transferred from the chiropractor to another health care professional.

Locum Tenens

A **locum tenens** exists where an employed chiropractor substitutes temporarily for an employing chiropractor in the employing chiropractor’s practice.

Clinical Services

Assessments

1200

The Clinical Assessments described below comprise the case assessment and management of patient interactions. Chiropractors are required by the Regulated Health Professions Act (1991), the Chiropractic Act (1991), the regulations under those acts, and the standards of practice, guidelines, and policies of the College of Chiropractors of Ontario to perform a diagnosis before initiating treatment.

Varying levels of examination, evaluation, conference with or concerning patients, and the administration of each case is included. The key determinant components of Assessment services include history, examination, review of documentation, and chiropractic decision making. Case management contributory factors are counselling, co-ordination of care and nature of the presenting problem. Management services and subsequent time requirements vary with the level of complexity of respective case determinant components and contributory factors.

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			Minimum	Maximum
1201	Initial or Primary (1 region)	For a new or established patient, shall comprise a full history of the presenting complaint, the review of any relevant documentation, a detailed inquiry concerning the complaint and detailed examination of the affected part, region or system (more particularly the neuromusculoskeletal system) as required to: (a) arrive at a diagnosis (functional or pathological); (b) complete an appropriate record of findings; (c) advise the patient on course of treatment; (d) where appropriate, refer the patient for other health care. The large majority of first assessments will be "Initial or Primary Assessments." Time requirement is generally 20-40 minutes.	\$78.00	\$133.00
1202	Extended (more than one region)	For a new or established patient, shall comprise an initial assessment, but in circumstances where this is extended to a detailed examination of more than one region or system, or where the complaint is of a complicated nature necessitating significantly more time and comprehensive examination to differentially diagnose the condition. Time required is generally 30-60 minutes.	\$131.00	\$262.00
1204	Minor (includes re-assessment)	For a new or established patient, shall comprise a brief history and examination of the affected part or region, an appropriate record, and advice to the patient. Examples: extremity trauma, such as a serious sprain where active chiropractic treatment is not a priority; re-evaluation to monitor progress. Time requirement is generally 5-15 minutes.	\$26.00	\$44.00

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			Minimum	Maximum
1207	Brief Assessment	For an established patient, a brief pre-treatment assessment to determine the appropriateness of planned interventions. Billed only as a stand alone service on a visit/session where clinical judgment results in planned treatment interventions not being provided, for example where an acute inflammation results in a decision not to provide active care on that visit.	\$15.00	N/A
1209	Assessment Services billed at Hourly Rate	Clinical services including assessment services may be billed on an hourly (time based) basis.	\$187.00	\$320.00

Clinical Services

Therapeutic Interventions

2000 The following therapeutic interventions may be provided at the same patient encounter as an assessment service, or at a subsequent patient encounter. They may be provided as stand alone services or in combination as dictated by the clinical judgement of the chiropractor. Each patient encounter includes an assessment function. In the case of a patient encounter for treatment (therapeutic intervention) this brief pre-treatment assessment to ensure that the planned treatment is still appropriate is not billed separately but is included in the intervention. Where multiple therapeutic interventions are provided on the same patient encounter this brief assessment need only be performed once, so the second and subsequent therapeutic interventions are billed at a reduced rate. If the chiropractor concludes from this brief pre-treatment assessment that no therapeutic intervention is appropriate, the encounter is billed as a Brief Assessment (Service Code 1207).

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			As a stand alone service	As second or subsequent intervention on same visit/session
2100	Manual Care			
2101	Adjustment/manipulation, spinal; one or more regions	A specific adjustment/manipulation procedure, directed to a spinal or intervertebral joint is a manoeuvre during which the joint is moved within its anatomical range of motion using a fast, low amplitude thrust.	\$35.00	\$20.00
2110	Adjustment/manipulation, non-spinal; one or more joints	A specific adjustment/manipulation procedure, directed to a non-spinal joint, is a manoeuvre during which the joint is moved within its anatomical range of motion using a fast, low amplitude thrust.	\$30.00	\$15.00
2210	Joint mobilization spinal, non-spinal; one or more regions	Passive rhythmical oscillations performed within or at the limit of normal physiological range of movement, characterized by a non-thrust increase in passive joint play.	\$30.00	\$15.00
2201	Supportive Myofascial Therapy	Brief application of myofascial therapy in support of manipulation and/or mobilization. Various manual therapeutic procedures which are applied to the elastocollagenous tissues in order to restore normal flexibility and tone; may include manual traction, ischemic compression, trigger point therapy, massage, post-facilitation stretch, proprioceptive neuromuscular facilitation, post-isometric relaxation, reciprocal inhibition, and patient production of voluntary muscle contraction against manual passive resistance etc. Cannot be billed in conjunction with 2203, Comprehensive Myofascial Therapy. Time requirement is generally less than 10 minutes.	N/A	\$13.00

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			As a stand alone service	As second or subsequent intervention on same visit/session
2203	Comprehensive Myofascial Therapy (per hour)	Therapeutic procedures which are applied to the elastocollagenous tissues in order to restore normal flexibility and tone; may include manual traction, ischemic compression, trigger point therapy, massage, post-facilitation stretch, proprioceptive neuromuscular facilitation, post-isometric relaxation, reciprocal inhibition, and patient production of voluntary muscle contraction against manual passive resistance, etc. Cannot be billed in conjunction with 2201, Supportive Myofascial Therapy. (Bill at hourly rate; Service Code 1420.	Bill at hourly rate	N/A
2200 - 2400	Physiological Modalities			
2205	Ultrasound	Inaudible acoustic vibrations of high frequency that may produce either thermal or non-thermal physiological effects.	\$28.00	\$13.00
2206	Electrical Current Therapy	Includes the use of any electrical modality for iontophoresis, muscle stimulation, galvanic currents, Russian Faradic currents, combination therapy (linkage of the electrical current with concurrent application of ultrasound) and micro-current applications where the therapist utilizes a moving electrode over the treatment area.	\$28.00	\$13.00
2208	Acupuncture (including needle and electro acupuncture)	The technique of inserting thin needles through the skin at specific points on the body involving stimulation of anatomical locations. This may incorporate a variety of techniques including electrical stimulation of the needles.	\$46.00	\$31.00
2216	Hydrotherapy	Use of therapeutic equipment such as a Hubbard Tank (not a "hot tub") for the purpose of mobilizing a body part or parts to facilitate movement in a gravity-reduced environment. Time requirement is generally 15 minutes or less.	\$25.00	\$10.00
2401	Heat or Cold Therapy	The application of heat in the form of heating pads, heat wraps, hot baths, warm gel packs, etc., or the application of cold using various methods including but not limited to the use of an ice bag, a cold pack, ice massage or fluids (such as ethyl chloride) that cool by evaporation.	\$23.00	\$8.00

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			As a stand alone service	As second or subsequent intervention on same visit/session
2403	Mechanical traction	Long-axis mechanical distraction (static or intermittent) of a body area to provide mobilization.	\$25.00	\$10.00
2406	Paraffin Bath Therapy	A method of delivering heat to an affected body part, often joints of the hand.	\$25.00	\$10.00
2407	Microwave Therapy	Exposure of body part or parts to a low frequency wave between 300 MHZ and 30,000 MHZ.	\$25.00	\$10.00
2408	Diathermy	Exposure of body part or parts to alternately generated electrical and magnetic fields with a frequency of 27 MHZ.	\$25.00	\$10.00
2409	Infrared therapy	Exposure of body part or parts to a device creating an infrared spectrum which provides superficial heating of tissues via radiant energy.	\$25.00	\$10.00
2411	Interferential Current Therapy	Electrotherapy to body part or parts utilizing two currents of differing frequency producing an interference pattern in the area treated.	\$25.00	\$10.00
2412	TENS	Transcutaneous electrical nerve stimulation by an alternating current with pulse widths from 20 - 100 microseconds and a frequency range of 50 - 200 HZ.	\$23.00	\$8.00
2413	Laser Therapy	Phototherapy involving the application of low power light. Including Low Level Laser Therapy (LLLT) and Light Emitting Diode Therapy (LEDT). 20 Minutes.	\$35.00	\$20.00
2414	Pen laser	The application of the light therapy in a small handheld unit.	\$28.00	\$13.00
2500	Rehabilitation			
2501	Exercise - Brief Instruction for self-directed exercise	Instruction of proper exercise technique(s) and an appropriate program to an individual patient for one or more body areas for patient use in a self-directed, unsupervised manner. This may be provided in-office depending on the nature of the program and the equipment available to the provider. Time requirement is generally less than 15 minutes.	\$25.00	\$10.00
2502	Exercise - In office constant supervised (one-on-one)	Designed for and provided to an individual patient under constant supervision and administered by suitably qualified individuals such as the chiropractor, an occupational therapist and/or a kinesiologist in order to prevent improper technique and further injury. Includes comprehensive instruction for a self-directed program. Per 30 minutes. Example, for 60 minutes bill one "stand alone" and one "subsequent" fee.	\$60.00	\$45.00

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			As a stand alone service	As second or subsequent intervention on same visit/session
2503	Exercise - In office intermittent supervision or group	For patients performing prescribed therapeutic exercises in the chiropractor's facility where supervision is intermittent, for example when part of a group session or working semi-independently. Per 30 minutes.	\$50.00	\$35.00
2504	Neuromuscular (functional) Retraining	Includes one-on-one procedures developing patient neuromuscular co-ordination through repetitive activity movements under a variety of mechanical conditions to pattern the motor system for particular activities. Time requirement is generally less than 15 minutes.	\$34.00	N/A
2505	Work Conditioning (per hour)	Program designed for an individual patient targeting daily living activities as well as constituent components of work-related activities. (Bill at hourly rate; fee code 2950.)	Bill at hourly rate	N/A
2506	Aquatherapy	Supervised exercise in the gravity reduced environment of a pool. Per hour.	\$78.00	N/A
2510	Gait training	Re-education of appropriate gait pattern after serious lower limb/pelvic injury (not to be used in conjunction with orthotic prescription.) Time requirement is generally less than 15 minutes.	\$34.00	N/A
2525	Work Hardening (per hour)	Service provided in conjunction with an appropriate job task analysis. The patient engages in activities of work, with or without modifications, in a transitional environment or in a specialized clinical environment offering similar or identical essential tasks as required to reach a level of work-specific conditioning to return to employment. (Bill at hourly rate; fee code 2950.)	Bill at hourly rate	N/A
2540	Environmental analysis; Job site Assessment (per hour)	On-site analysis of work activity and work environment, and preparation of a required report; provided for a patient, supervisor or manager with regard to appropriateness of the work function as it applies to the health of the patient(s) or employee(s). This may include a definition of the occupation(s), including references to essential physical demands, frequency of occurrence and job strength ratings, utilizing accepted national databases such as the D.O.T. (U.S.) or N.O.C. (Canada) where appropriate. Ergonomic/environmental factors may also be itemized with recommendations regarding concerns/deficiencies. (Bill at hourly rate; fee code 1209.)	Bill at hourly rate	N/A

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			As a stand alone service	As second or subsequent intervention on same visit/session
2542	Environmental Analysis; Home (per hour)	An evaluation, and preparation of a required report, of the patient's home to compile an inventory of activities of daily living including: self-care i.e. bathing, dressing, grooming, toileting, eating; household duties i.e. meal preparation, clean-up, laundry, ironing, bed - making, light and heavy cleaning, shopping, and driving; caregiving responsibilities; and outdoor maintenance activities. Evaluation and report is made with respect to barriers to recovery and/or the need for assistance in performing essential components of these tasks. (Bill at hourly rate; fee code 1209.)	Bill at hourly rate	N/A
2543	Environmental Analysis; Work Space (Ergonomic) Assessment (per hour)	Analysis and preparation of a required report of an individual's work space to assess ergonomic issues as they related to seating, work surfaces, equipment and body positioning with recommendations to improve deficient areas and education regarding reduction of postural fatigue. (Bill at hourly rate; fee code 1209.)	Bill at hourly rate	N/A
2550	Functional Capacity/ Functional Abilities Evaluation (per hour)	The evaluation of physical capacity for the purpose of determining tolerances for the performance of home and/or work related tasks. The evaluation of lifting capacity is a key ingredient of most FCE's, which can be assessed on a static and/or dynamic basis and should include measures of consistency of effort. Testing may include: aerobic, anaerobic and metabolic capacity analysis; while strength testing can be isometric, isotonic or isokinetic. The preparation of a detailed report should include a synopsis of the client's consistency of effort, synopsis of pertinent work and/or home tasks and a battery of tests that focus on tolerances for those tasks. Correlation with other aptitudes to determine job match may also be included. (Bill at hourly rate; fee code 1209).	Bill at hourly rate	N/A

2900 Sessional (Per/Visit) and Time Based Fees				
OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			Minimum	Maximum
2900	Per Visit (Session) Fees Treatment Session	Used when a practitioner elects to bill for treatment by the visit/session/patient encounter rather than by the specific service or intervention. The session components should be identified. Fees may vary between practitioners and between patients depending on the specific nature of the interventions used, time requirements, etc.	\$33.00	\$54.00
2950	Therapeutic Intervention (per hour)	Clinical services including therapeutic interventions may be billed on an hourly (time based) basis.	\$187.00	\$320.00

Orthotics				
2200	There are currently three popular procedures - foam impression, plaster casting and electronic sensor pad - which result in the creation of in-shoe orthotics. Each of these requires two components; the professional service (including assessment, fitting, and any necessary adjustment of the orthotic device); and the product cost.			
OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			As a stand alone service	As second or subsequent intervention on same visit/session
2240	Orthotics Professional Services	Includes all professional services relating directly to the provision of custom in-shoe orthotics including the assessment, casting, fitting, and follow up assessment. If following the assessment the chiropractor determines that custom orthotics are not necessary, the assessment will be billed as a Minor Assessment (OCA Fee Code 1204).	\$284.00	N/A
	Product Cost	Products are provided at cost plus a reasonable handling charge.		

Diagnostic Radiography

The professional component, performed by the chiropractor, consists of interpretation of the results including the preparation of a written report.

The technical component consists of provision of the premises, clinical supplies, equipment, and personnel, preparation of the patient, performance or supervision of the performance of the procedure, and maintenance of appropriate records.

For a given radiological study, a chiropractor may provide the professional component, the technical component, or both. A chiropractor taking and interpreting his own films, or taking and interpreting films requested by another practitioner will bill for both the technical and professional components. A chiropractor taking but not interpreting films requested by another practitioner will bill only the technical component. A chiropractor interpreting films taken at his/her request at another location will bill only the professional component.

When either a technical or professional component of a fee is billed independently, the suffix “-T” or “-P” will be added to the service code, for example 5001-T or 5001-P.

5000 General Radiographic Services					
OCA Fee Code	OCA Fee Category	CCI code	01-Jan-09 Recommended Fee		
			Technical Component % of total fee:	Professional Component % of total fee:	Total Fee
			70%	30%	
5000	Neck, Spine, Trunk, and Pelvis				
	Cervical Spine:				
5001	two or fewer views	3.SC.10.CX.A	\$33.60	\$14.40	\$48.00
5002	three or four views	3.SC.10.CX.B	\$44.80	\$19.20	\$64.00
5003	five or six views	3.SC.10.CX.C	\$55.30	\$23.70	\$79.00
5004	more than six views	3.SC.10.CX.D	\$67.20	\$28.80	\$96.00
	Thoracic Spine:				
5011	two or fewer views	3.SC.10.CX.A	\$40.60	\$17.40	\$58.00
5012	three or four views	3.SC.10.TX.B	\$49.00	\$21.00	\$70.00
	Lumbar or Lumbosacral spine:				
5021	two or fewer views	3.SC.10.LB.A	\$39.20	\$16.80	\$56.00
5022	three or four views	3.SC.10.LB.B	\$48.30	\$20.70	\$69.00
5023	five or six views	3.SC.10.LB.C	\$57.40	\$24.60	\$82.00
5024	more than six views	3.SC.10.LB.D	\$67.20	\$28.80	\$96.00
5032	Entire Spine: survey study, two views (A-P and lateral)	3.S1.10.A	\$58.80	\$25.20	\$84.00
	Pelvis				
5041	two or fewer views	3.SQ.10.A	\$39.20	\$16.80	\$56.00
5042	three or four views	3.SQ.10.B	\$46.90	\$20.10	\$67.00
	Sacrum and coccyx:				
5051	two or fewer views	3.SF.10.A	\$39.20	\$16.80	\$56.00
5052	three or four views	3.SF.10.B	\$46.90	\$20.10	\$67.00

OCA Fee Code	OCA Fee Category	CCI code	01-Jan-09 Recommended Fee		
			Technical Component % of total fee:	Professional Component % of total fee:	Total Fee
			70%	30%	
	Sacro-iliac joints:				
5061	two or fewer views		\$39.20	\$16.80	\$56.00
5062	three or more views		\$46.90	\$20.10	\$67.00
	Ribs(*)				
5071	two or fewer views	3.SL.10.A	\$30.80	\$13.20	\$44.00
5072	three to four views	3.SL.10.B	\$39.20	\$16.80	\$56.00
	Clavicle(*)				
5081	two or fewer views	3.SM.10.A	\$30.80	\$13.20	\$44.00
5082	three or four views	3.SM.10.B	\$39.20	\$16.80	\$56.00
	Scapula(*)				
5091	two views	3.SN.10.A	\$30.80	\$13.20	\$44.00
5092	three or four views	3.SN.10.B	\$39.20	\$16.80	\$56.00
5100	Upper Extremity				
	Shoulder joint				
5101	two or fewer views	3.TA.10.A	\$30.80	\$13.20	\$44.00
5102	three or four views	3.TA.10.B	\$39.20	\$16.80	\$56.00
	Acromioclavicular or sternoclavicular joints(*)				
5111	two or fewer views	3.TB.10.A	\$39.20	\$16.80	\$56.00
5112	three or four views	3.TB.10.B	\$46.90	\$20.10	\$67.00
	Humerus				
5121	two or fewer views	3.TK.10	\$30.80	\$13.20	\$44.00
5122	three or more views	3.TK.10	\$39.20	\$16.80	\$56.00
	Elbow joint				
5131	two or fewer views	3.TM.10.A	\$22.40	\$9.60	\$32.00
5132	three or four views	3.TM.10.B	\$30.80	\$13.20	\$44.00
5133	five or six views	3.TM.10.C	\$39.20	\$16.80	\$56.00
	Radius and ulna				
5141	two or fewer views	3.TV.10.A	\$22.40	\$9.60	\$32.00
5142	three or four views	3.TV.10.B	\$30.80	\$13.20	\$44.00
	Wrist joint				
5151	two or fewer views	3.UB.10.A	\$22.40	\$9.60	\$32.00
5152	three or four views	3.UB.10.B	\$30.80	\$13.20	\$44.00
	Phalanx of hand(*)				
5161	two or fewer views	3.UJ.10.A	\$15.40	\$6.60	\$22.00
5162	three or four views	3.UJ.10.B	\$23.80	\$10.20	\$34.00
	Hand				
5171	two or fewer views	3.UL.10.A	\$22.40	\$9.60	\$32.00
5172	three or four views	3.UL.10.B	\$30.80	\$13.20	\$44.00

OCA Fee Code	OCA Fee Category	CCI code	01-Jan-09 Recommended Fee		
			Technical Component % of total fee:	Professional Component % of total fee:	Total Fee
			70%	30%	
5200	Lower Extremity				
	Hip joint				
5201	two or fewer views	3.VA.10.A	\$30.80	\$13.20	\$44.00
5202	three or four views	3.VA.10.B	\$39.20	\$16.80	\$56.00
	Femur				
5211	two or fewer views	3.VC.10.A	\$22.40	\$9.60	\$32.00
5212	three or more views	3.VC.10.B	\$30.80	\$13.20	\$44.00
	Knee joint				
5221	two or fewer views	3.VG.10.A	\$30.80	\$13.20	\$44.00
5222	three or four views	3.VG.10.B	\$39.20	\$16.80	\$56.00
5223	five or six views	3.VG.10.C	\$46.90	\$20.10	\$67.00
	Tibia and fibula				
5231	two or fewer views	3.VQ.10.A	\$22.40	\$9.60	\$32.00
5232	three or four views	3.VQ.10.B	\$30.80	\$13.20	\$44.00
	Ankle joint				
5241	two or fewer views	3.WA.10.A	\$30.80	\$13.20	\$44.00
5242	three or four views	3.WA.10.B	\$39.20	\$16.80	\$56.00
	Tarsal bones and intertarsal joints (*)				
5251	two or fewer views	3.WE.10 .A	\$30.80	\$13.20	\$44.00
5252	three or four views	3.WE.10 .B	\$39.20	\$16.80	\$56.00
	Phalanx of foot(*)				
5261	two or fewer views	3.WJ.10.A	\$30.80	\$13.20	\$44.00
5262	three or more views	3.WJ.10.B	\$39.20	\$16.80	\$56.00

Diagnostic Radiography

6000 Specialty Radiographic Services				
OCA Service Codes	Description	01-Jan-09 Recommended Fee		
		Technical Component % of total fee:	Professional Component % of total fee:	Total Recommended Fee
		70%	30%	
	Skull, radiographic examination:			
6001	less than four views	\$36.40	\$15.60	\$52.00
6002	four or more views	\$53.90	\$23.10	\$77.00
	Sinuses, radiographic examination			
6003	less than three views	\$23.80	\$10.20	\$34.00
6004	three or more views	\$32.90	\$14.10	\$47.00
	Chest, radiographic examination			
6005	two views	\$43.40	\$18.60	\$62.00
6006	three or more views	\$52.50	\$22.50	\$75.00
6103	CT Scan, Cervical Spine, with or without contrast media	N/A		
6104	CT Scan, Thoracic Spine, with or without contrast media	N/A	\$95.00	\$95.00
6105	CT Scan, Lumbar Spine, with or without contrast media	N/A	\$95.00	\$95.00
6106	CT Scan, Upper Extremity	N/A	\$95.00	\$95.00
6107	CT Scan, Lower Extremity	N/A	\$95.00	\$95.00
6199	Unlisted CT Scan	N/A	\$95.00	\$95.00
6203	MRI, Cervical Spine	N/A	\$95.00	\$95.00
6204	MRI, Thoracic Spine	N/A	\$95.00	\$95.00
6205	MRI, Lumbar Spine	N/A	\$95.00	\$95.00
6206	MRI, Upper Extremity	N/A	\$95.00	\$95.00
6207	MRI, Lower Extremity	N/A	\$95.00	\$95.00
6208	Unlisted MRI Service			
6401	Bone Age Study	\$44.10	\$18.90	\$63.00
6402	Bone Density Study	N/A	\$48.00	\$48.00
6403	Bone Length Study	\$56.70	\$24.30	\$81.00
6404	Bone scintigraphy, general survey	N/A	\$48.00	\$48.00
6405	Bone scintigraphy, single site	N/A	\$48.00	\$48.00
6407	Arthrogram, Tenogram, or Bursogram	N/A	\$48.00	\$48.00

Specialist Services

3000	Services from this category may be provided by a certified Fellow whose opinion or advice regarding evaluation and/or management of a patient or a specific problem is requested by another chiropractor or other appropriate outside agency. The following are recognized Colleges:			
	FCCS FCCSS(C) FCCO(C) FCCRS(C) FCCR	Fellow of the College of Chiropractic Sciences Fellow of the College of Chiropractic Sports Sciences (Canada) Fellow of the College of Chiropractic Orthopaedists (Canada) Fellow of the College of Chiropractic Rehabilitation Sciences (Canada) Fellow of the College of Chiropractic Radiologists		
OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			From	To
3001	FCCS Standard Consultation	Performance of a focused history and examination directed to a limited area or complaint which requires a straightforward or moderately complex chiropractic opinion and results in a brief report to the referring agent; the majority of consultations will be Standard Consultations.	\$142.00	\$241.00
3002	FCCS Complex Consultation	Performance of comprehensive history and examination, detailed review of existing documentation and/or radiographs which requires a highly complex chiropractic opinion and results in a summary report to the referring agent.	\$248.00	\$422.00
3003	FCCS Detailed Report	Preceded by a Complex Consultation, and would include specifics on the comprehensive history, examination, document and/or radiograph review, clinical impression, prognosis and recommendations.	\$442.00	\$751.00
3101	FCCSS(C) Standard Consultation	Performance of a focused history and examination directed to a limited area or complaint which requires a straightforward or moderately complex chiropractic opinion and results in a brief report to the referring agent; the majority of consultations will be Standard Consultations.	\$142.00	\$241.00
3102	FCCSS(C) Complex Consultation	Performance of comprehensive history and examination, detailed review of existing documentation and/or radiographs, requires a highly complex chiropractic opinion and results in a summary report to the referring agent.	\$248.00	\$422.00
3103	FCCSS(C) Detailed Report	Preceded by a Complex Consultation, and would include specifics on the comprehensive history, examination, document and/or radiograph review, clinical impression, prognosis and recommendations.	\$442.00	\$751.00

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee	
			From	To
3201	FCCO(C) Standard Consultation	Performance of a focused history and examination directed to a limited area or complaint, which requires a straightforward or moderately complex chiropractic opinion and results in a brief report to the referring agent; the majority of consultations will be Standard Consultations.	\$142.00	\$241.00
3202	FCCO(C) Complex Consultation	Performance of comprehensive history and examination, detailed review of existing documentation and/or radiographs, requires a highly complex chiropractic opinion and results in a summary report to the referring agent.	\$248.00	\$422.00
3203	FCCO(C) Detailed Report	Preceded by a Complex Consultation, and would include specifics on the comprehensive history, examination, document and/or radiograph review, clinical impression, prognosis and recommendations.	\$442.00	\$751.00
Specialists hourly rate				
3301	FCCRS(C) Standard Consultation	Performance of a focused history and examination directed to a limited area or complaint, which requires a straightforward or moderately complex chiropractic opinion and results in a brief report to the referring agent; the majority of consultations will be Standard Consultations.	\$142.00	\$241.00
3302	FCCRS(C) Complex Consultation	Performance of comprehensive history and examination, detailed review of existing documentation and/or radiographs, requires a highly complex chiropractic opinion and results in a summary report to the referring agent.	\$248.00	\$422.00
3303	FCCRS(C) Detailed Report	Preceded by a Complex Consultation, and would include specifics on the comprehensive history, examination, document and/or radiograph review, clinical impression, prognosis and recommendations.	\$442.00	\$751.00
3401	FCCR Consultation	Applies when radiographs made elsewhere are referred to a Fellow of the CCR for an opinion. Includes a written report, administrative and handling charges, per study or anatomical area.	\$53.00	\$90.00
Other	Other Unlisted Activity	Billed at hourly rate.	\$204.00	\$352.00

Specialized Diagnostic Testing

Dynamic Surface Electromyography

1500

Dynamic EMG's, such as flexion relaxation and mean/median frequency shift measures, utilizing surface applications of myoelectrical sensors to measure myoelectric volitional responses during muscle contraction, and includes reference testing and reports. Excluded are static EMG measurements where surface application of myoelectric sensors measure myoelectric volitional responses in a static state.

Testing and Reporting: Technical and professional components are based upon time where an eight (8) channel test requires approximately four times the preparation, interpretation and reporting required by a two (2) channel test. The technical component comprises 50-65% of the fee, and the professional component, 35-50%. Each test performed results in a corresponding report maintained in the patient's record.

Certification by an accredited CCE institution is required.

OCA Fee Code	OCA Service Category	Description	01-Jan-09 Recommended Fee
			As a stand alone service
1500		Dynamic Surface Electromyography	
		Flexion/Relaxation; Cervical Spine, Lumbar Spine	
1501		2 channels	\$95.00
1502		4 channels	\$126.00
1503		6 channels	\$158.00
1504		8 channels	\$190.00
		Range of Motion (6 ROM); Lumbar Spine, General Spine	
1521		2 channels	\$126.00
1522		4 channels	\$158.00
1523		6 channels	\$190.00
1524		8 channels	\$253.00
		Specialized Deltoid; 3 bundles, 9 graphs	
1533		6 channels	\$316.00
		Specialized Studies; 6 ROM 9 Graphs	
1543		6 channels	\$506.00

Photogrammetry

1601	Photogrammetry	Static, video or opto-electric imaging of posture and/or postural anomalies during specific dynamic tasks.	\$78.00
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Other Services

1300 - 1400			Definition	01-Jan-09 Recommended Fee
OCA Fee Code	CCI Code	OCA Service Category		
1301	7.SF.12	Consultation (patient, third party)	Opinion or advice regarding evaluation and/or management of a specific problem is requested by a patient, another chiropractor or other appropriate source. The request should be documented in the patient's record along with any advice and services described and/or recommended. This does not include the reporting of previously performed or ordered tests, assessments, or evaluations. This may be face-to-face or remotely delivered (telephone). Time requirement is generally per 15 minutes.	\$53.00
1303	7.SF.12	Planning	Includes planning for care, team conferencing, and other patient care planning activities. Time requirement is generally per 15 minutes.	\$31.00
1304	7.SF.15	Brokerage	Assisting with insurance claims, referrals, monitoring delegated or other third party services, etc. Time requirement is generally per 15 minutes.	\$31.00
1305	7SP.60	Education	Education provided as the sole intervention or one of the interventions on a patient encounter to enhance knowledge and skill that directly or indirectly assists the patient to understand, monitor and manage their situation / condition / impairment. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos but not the cost of these materials. Time requirement is generally per 15 minutes.	\$31.00
1310	7.SP.10.ZZ	Counselling	Therapeutic communication (i.e. discussion between service provider and service recipient), provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding a given situation/condition/impairment, which could alter attitudes and in turn change/modify behaviour. Such counselling sessions may be provided on a "one-to-one" or "one-to-many" basis. For example <ul style="list-style-type: none"> ● Nutritional counselling ● Exercise and physical fitness counselling 	\$32.00
1401		Out-of-hours supplement	Surcharge when chiropractor attends the office at the request of the patient outside of usual office hours.	\$53.00
1402		Home visit (or alternate out-of-clinic location) supplement	Surcharge when chiropractor travels to the patient's home or an alternate location for service delivery.	\$53.00

OCA Fee Code	CCI Code	OCA Service Category	Definition	01-Jan-09 Recommended Fee
1403		Missed appointment	Appointments scheduled with the consent of the patient and not attended without reasonable notice being given may result in billing the patient equal to the value of the service scheduled. The chiropractor should use discretion and consider the circumstances surrounding the missed appointment.	

Documentation				
1407		Detailed narrative report	Detailed narrative report (legal, insurance, etc.) may be charged at an hourly rate (fee code 1420).	Bill at hourly rate
1408		Photocopy	Photocopy of patient files, clinical notes or other materials for patient or a third party.	\$35.00 for 1- 5 pages; \$1.25/page thereafter
1410	7.SJ.30.LB	Claim form; Auto Insurance or similar		\$92.00
1412	7.SJ.30	Form or Note: simple	Certificate completion requiring minimal input and signature by the chiropractor. Examples of certificates included are disability forms, institutional benefit program applications and handicap parking applications.	\$18.00
1415	7.SJ.30	Other documentation		Fees vary with complexity

Clinical Products				
		Clinical Products and Materials	Clinical Products (i.e. orthotics, splints) and materials (i.e. educational material) are provided at practitioner cost plus a reasonable handling charge.	

Hourly rate				
OCA Fee Code	OCA Service Category	Definition	01-Jan-09 Recommended Fee	
			Minimum	Maximum
1420	Other Professional Activity (per hour)	Professional activity including, for example preparation for and testifying as a witness, may be charged at an hourly rate. The hourly rate established by individual chiropractors will vary depending, for example, on specialized education and training, experience, geographical location, etc. Clinical Services may also be billed on an hourly basis (see fee 1209 and 2950).	\$187.00	\$320.00

Sample Visit Billings

Visit description		Services		Fees		
		Code	Service Description	First Treatment Intervention	Additional Treatment Interventions	Total
Example 1	A treatment visit on which the only intervention is spinal adjustment/manipulation.	2101	Spinal Adjustment / Manipulation	\$35.00		\$35.00
Example 2	A treatment visit on which the only intervention is ultrasound therapy.	2205	Ultrasound	\$28.00		\$28.00
Example 3	A treatment visit on which the patient receives both adjustment/manipulation and ultrasound therapy.	2101 2205	Spinal Adjustment / manipulation Ultrasound	\$35.00	\$13.00	\$48.00
Example 4	A treatment visit on which the patient receives adjustment/ manipulation, ultrasound therapy, and instruction for home exercises.	2101 2205 2501	Adjustment/ Manipulation Ultrasound Home Exercise Instruction	\$35.00	\$13.00 \$10.00	\$58.00
Example 5	A treatment visit in which the patient receives one hour of supervised rehabilitation exercise.	2502 2502	Exercise, supervised, first 30 minutes Exercise, supervised, subsequent 30 minutes	\$60.00	\$45.00	\$105.00
Example 6	An initial patient visit where the patient is assessed, and then treated on the same visit with spinal manipulation/ adjustment and supportive myofascial therapy.	1201 2101 2201	Initial Assessment Spinal Adjustment/ Manipulation Supportive Myofascial Therapy	\$78.00	\$20.00 \$13.00	\$111.00

Notes

1. Each patient interaction involves some degree of assessment. In previous Fee Schedules an *interactive assessment* was billed on each treatment visit. This has been removed as a separate service and the relative value of each treatment intervention when performed as a stand alone service has been adjusted to reflect this. Each treatment intervention now has a discounted price for those instances where it is provided as a second or subsequent intervention.

A new service, the "*Brief Assessment*" is a "pre-treatment assessment" but is only billed in circumstances where, based on the assessment of the patient at the time of intended treatment, the intended treatment on a planned session is not provided. It is priced the same as the discount applied to second and subsequent services.

2. X-ray service categorizations for General Radiology are those used by the CCI classification system. CCI is now used for Ontario Automobile Insurance billing purposes and is expected to be the standard adopted by other third party payers for electronic billing purposes.
3. Goods and products are to be provided at "cost plus a reasonable handling fee" without specifying mark up (%) or amount of the fee.
4. The recommended hourly rate, where it is applicable, is presented as a range.
5. All fees are calculated to the penny but rounded to the nearest full dollar.
6. Some rehabilitation assessments are now charged at an hourly rate rather than a fixed rate. This is because the time requirement can be variable.
7. Comprehensive Myofascial Therapy (Code 2203) is billed at an hourly rate to accommodate those practitioners who primarily provide these services. The time requirement is too variable to allow for a set fee.



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