Ontario Medical Association

OMA-MSPC Fee Setting Process

Preliminary Comments

Economics, Policy & Research, June 3, 2022

Table of Contents

Preface

The Report from the OMA Medical Services Payment Committee (OMSPC) contains each Section/MIG's proposal followed by the MSPC's Decision, as well as the rationale for the MSPC's decision.

The Committee would like to acknowledge the efforts made by the OMA Constituencies (Sections, MIGs and Fora) to provide their submissions in a complete and timely manner. We would also thank the OMA staff whose support was essential to the work of the Committee.

OMA MSPC Members

- Dan Reilly, MD, Obstetrics & Gynaecology, Fergus, OMA Co-Chair
- Miguel Cortel-LeBlanc, MD, Emergency Medicine, Ottawa
- Kevin Smith, MD, Anaesthesiology, Toronto
- Neshmi Zaman, MD, General and Family Practice, Toronto

The Report is intended to be a first draft of the Schedule of Benefits changes that the OMSPC will pursue. It is anticipated that Sections and MIGs will review this report and provide feedback on the decisions it contains.

Introduction

While the Medical Services Payment Committee (MSPC) is a bilateral committee with equal representation from the OMA and Ministry of Health (MOH), the OMA-MSPC (OMSPC) undertook preparatory work to be ready for a multi-year process to modernization of the OHIP Schedule of Benefits that is anticipated to be established after a new Physician Services Agreement (PSA) has been reached or an Arbitration Award is handed down by the Kaplan Board of Arbitration.

Section, MIG and Forum Leaders were invited to make fee submissions by December 5, 2021 to address:

- The modernization of the Schedule of Benefits to reflect current medical practice;
- The gender pay gap within their Section; and
- Changes related to medical innovation/technological advances.

To support this work, two information/education sessions were held for section, MIG and forum executives to attend and ask questions. A recording of the sessions has been made available for those unable to attend. The sessions were held on,

1. Tuesday, September 21 (8:00 - 9:00 PM)
2. Thursday, September 30, 2021 (8:00 - 9:00 PM)

In addition, the OMA Economics, Policy and Research department conducted an intra-sectional fee relativity survey that was deployed in October 2021. Participants were asked to evaluate services commonly billed by their own Section based on their time and intensity. The results of this survey could then be used as part of the Section's, MIG's or Fora's fee submission to the OMA-MSPC.

All OMA constituency groups were invited to participate in the consultation process. The purpose of these meetings was to gather information, and to provide helpful feedback to the constituency groups

further develop their proposals prior to a future bi-lateral process. In total, 49 Sections MIGs and Fora met with the OMSPC to discuss fee submissions; sessions were held on the following six meeting dates:

January 31, 2022	**9:00am – 12:00pm & 1:00pm – 4:30pm**
February 1, 2022	**9:00am – 12:00pm & 1:00pm – 4:30pm**
February 24, 2022	**9:00am – 12:00pm & 1:00pm – 4:30pm**
February 25, 2022	**9:00am – 12:00pm & 1:00pm – 4:30pm**
March 10, 2022	**9:00am – 12:00pm & 1:00pm – 4:30pm**
March 11, 2022	**9:00am – 12:00pm & 1:00pm – 4:30pm**

See **Appendix I** for additional information on the approved OMA-MSPC fee proposal evaluation process for 2021/2022

Summary of Submissions

OMSPC comments on OMA Constituencies submissions fall into six broad categories that are summarized in Figures 1 and 2.

Figure 1. OMSPC Comments by Category

OMA Constituencies/Groups	**54**
Delete fee codes	33
New fee codes	201
Revisions	103
Revisions and New fee codes	1
Value changes	318
Value Changes and Revisions	42
TOTAL	**698**

Figure 2. OMSPC Comments by OMA Constituency

OMA Constituency	**Delete fee code**	**New fee code**	**Revision**	**Revision and New fee code**	**Value change**	**Value Change and Revision**	**TOTAL**
Addiction Medicine	1	1	0	0	2	0	**4**
Allergy & Clinical Immunology	0	0	1	0	2	0	**3**
Anaesthesiologists	3	2	0	0	0	1	**6**
Cannabinoid Medicine	0	5	0	0	2	0	**7**
Cardiac Surgery	0	8	3	0	1	0	**12**
Cardiology	0	2	4	0	1	0	**7**
Chronic Pain	0	1	2	0	10	0	**13**

OMA Constituency	Delete fee code	New fee code	Revision	Revision and New fee code	Value change	Value Change and Revision	TOTAL
Critical Care Medicine	0	20	5	0	3	0	**28**
Dermatology	0	1	0	0	0	0	**1**
Diagnostic Imaging	0	12	5	0	9	1	**27**
Emergency Medicine	0	1	3	0	21	0	**25**
Emergency Medicine (MG)	0	1	0	0	0	1	**2**
Endocrinology & Metabolism	0	0	0	0	9	0	**9**
Gastroenterology	2	1	0	0	0	0	**3**
Gastroenterology (MG)	0	0	1	0	0	0	**1**
General & Family Practice	0	3	1	0	28	0	**32**
General Surgery	0	9	9	0	0	0	**18**
General Thoracic Surgery	0	5	0	0	4	2	**11**
Genetics	5	1	0	0	2	0	**8**
Geriatric Medicine	0	0	3	0	4	0	**7**
Haematology & Medical Oncology	1	2	2	0	1	0	**6**
Hospital Medicine	2	5	4	0	4	11	**26**
Hyperbaric Medicine	0	1	0	0	0	0	**1**
Infectious Diseases	0	2	0	0	7	0	**9**
Internal Medicine	0	1	0	0	5	1	**7**
Laboratory Medicine	0	0	0	0	28	0	**28**
Long Term Care & Care of the Elderly	0	0	0	0	0	3	**3**
Nephrology	9	0	0	0	15	0	**24**
Neurodevelopmental Disorders	0	2	0	0	0	0	**2**
Neurology	1	11	1	0	1	0	**14**
Neurosurgery	0	10	0	0	1	0	**11**
Nuclear Medicine	7	12	15	0	0	5	**39**
Obstetrics & Gynaecology	0	15	2	0	89	8	**114**
Occupational & Environmental Medicine	0	12	0	0	0	0	**12**
Ophthalmology	2	11	4	0	3	4	**24**
Orthopaedic Surgery	0	15	0	0	1	0	**16**
Otolaryngology	0	4	1	0	1	0	**6**
Paediatrics	0	3	5	0	0	0	**8**
Paediatrics (MG)	0	0	1	0	0	0	**1**
Palliative Medicine	0	2	0	0	2	0	**4**

OMA Constituency	Delete fee code	New fee code	Revision	Revision and New fee code	Value change	Value Change and Revision	TOTAL
Physical Medicine & Rehab	0	1	4	0	2	0	**7**
Plastic Surgery	0	0	14	0	1	0	**15**
Primary Care Fee-for-Service	0	0	0	0	2	0	**2**
Primary Care Mental Health	0	0	2	0	13	0	**15**
Primary Care Solo Doctors	0	2	0	0	0	0	**2**
Psychiatry	0	3	3	0	1	0	**7**
Reproductive Biology	0	0	1	0	0	0	**1**
Respiratory Diseases	0	2	3	0	17	1	**23**
Rheumatology	0	3	0	0	13	1	**17**
Rural Medicine Forum	0	0	0	0	0	1	**1**
Sport and Exercise Medicine	0	0	0	0	9	1	**10**
Surgical Assistants	0	3	4	1	2	1	**11**
Urology	0	2	0	0	1	0	**3**
Vascular Surgery	0	4	0	0	1	0	**5**
Total	**33**	**201**	**103**	**1**	**318**	**42**	**698**

The following Constituencies did not make a formal submission to the OMA-MSPC:

Figure 3. OMA Constituencies that did not make a fee submission

Academic Medicine Forum
CHC and AHAC
Clinic Endoscopists
Clinical Hypnosis
College and University Student Health
Complementary and Integrative Medicine
Green is Health
Medical Students
Neuroradiology
Ontario Psychiatric Hospitals
Public Health Physicians
Radiation Oncology
Residents
Sleep Medicine

Guiding Principles

The OMA-MSPC developed a set of general principles on how the OMA Fee Setting process will be carried out in a fair and equitable manner. These general principles are described below:

- That Sections and MIGs consider as an initial starting point, the results of the 2021 fee relativity survey. The OMA-MSPC encourages Sections and MIGs to bring forward proposals that will address,
    - The modernization of the Schedule to reflect current medical practice;
    - The gender pay gap within their Section; and
    - Changes related to medical innovation/technological advances.
- Transparency: the OMA-MSPC will share information widely as the process moves along and provide draft recommendations for comment prior to finalizing any submissions.
- Inclusivity: the OMA-MSPC will host meetings with OMA Sections and MIGs. All proposals (e.g., proposals from OMA Sections, MIGs and OMA-MSPC recommendations) will be shared with the appropriate OMA Sections and MIGs for review and comment.
- Cost impact analysis will be based on OHIP Specialty. Although this document references consultations with OMA Sections and MIGs, the final cost impact analysis of recommendations will be based on OHIP Specialty. Please note that funding allocations will be determined by the results of negotiations between OMA's Negotiations Task Force and the Ministry.
- Fee relativity: it is expected that OMA Sections and MIGs will address disparities in fees for similar services and not create new disparities. This means that services that take similar time and are of similar work intensity are paid similar fees and that proposals do not create new inequities in the fee schedule. The OMA-MSPC will ensure that fee proposals are consistent with the relative value of services with similar work effort.
- Cross-over fees
    1. All OMA Sections and MIGs will be consulted about services that are billed by multiple OHIP Specialties.
    2. For services that are billed by multiple OMA Sections and MIGs, the OMA-MSPC encourages the OMA Sections and MIGs to work collaboratively in developing their proposals. In situations where an agreement cannot be reached, the opinions of all OMA Sections and MIGs affected by the change to a service will be considered, while making every effort to ensure that undervalued services are addressed fairly.
    3. Cost impact analysis of a fee proposal will be estimated proportionately among affected OHIP Specialties.
- The OMA-MSPC may make final recommendations on services that affect multiple OMA Sections, MIGs and multiple OHIP Specialties (e.g., special visit premiums).
- The OMA-MSPC will ensure OMA Sections and MIGs are made aware of proposals affecting their members and given an opportunity to provide feedback.
- Technical Fees will not be considered by OMA-MSPC as the Kaplan Board of Arbitration has established a separate process which is ongoing. At time of writing, this process has yet to be determined. Sections and MIGs will be contacted as this process is developed.
- In formulating its recommendation, the OMA-MSPC will determine whether public funding should be directed towards the medical service and will consider the strength of best available evidence for the comparative safety, effectiveness, and total cost of the medical services.

The OMA-MSPC will use the above principles when considering proposals and making final recommendations.

Proposals put forward by OMA Sections and MIGs that are not recommended may be resubmitted at a future date.

Evaluation of a Fee Proposal: Criteria Elements to Consider

The committee identified five key criteria elements to consider when evaluating a fee proposal: Time, Intensity, Relativity, Practice Expense and Add-on fees. Table 1 below describes each criteria element.

Table 1: Evaluation Criteria of a Fee Proposal*

Criteria Element	Description
Time	Physician total time taken (pre-, intra- and post-service) by a typical physician to provide the typical service.
Intensity	Intensity of the service provided (1) Knowledge and judgment (2) Communications and interpersonal skills (3) Technical skills (complexity of the service) (4) Risk and stress
Relativity	Fee relativity with comparable services.
Practice Expense	Measures practice overhead costs, such as, rent, staff compensations, medical supplies, and equipment needed to perform a service.
Add-on fees	Identification of add-on fees and premiums commonly billed with the base service.

*For the above criteria, the "*Averaging Principle*" is taken into consideration. The *Averaging Principle* is described as the evaluation of each fee such that the fee reflects the work provided by the typical physician for the typical case.

Next Steps

The proposed PSA underwent a ratification vote on March 27, 2022. Under the agreement, the OMA-MSPC will become the OMA-side of the bilateral Physician Payment Committee (PPC). The agreement contained specific timelines for implementation, requiring the current phase of fee-setting work of this new committee to be completed by October 1, 2022.

Constituency groups will continue to be engaged throughout the development process and will have opportunities to provide feedback. Feedback on the Committee comments in this report can be emailed to mspc@oma.org. Please note that all proposals and Committee comments below are in draft form.

OMA-MSPC Comments

1 Addiction Medicine

1.1 K682 Opioid Agonist Maintenance Program monthly management fee - intensive, per month
1.2 K683 Opioid Agonist Maintenance Program monthly management fee - maintenance, per month

The Section amended its submission subsequent to meeting with the OMA-MSPC, and upon review of the committee's initial draft report. The Section indicated that it would prefer moving forward with fee increases to K682 from $45.00 to $93.81 and K683 from $38.00 to $69.39.

The Section initially proposed the creation of a new Addiction Medicine Monthly Maintenance fee code to replace existing monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP) fee code K682, K683 and K684.

The additional funding request is for the following services:

a) Physicians covering multiple practices. Both urban and rural and being available daily, including after hours, weekends and holidays. (The notion that relapse and early recovery is unstable and has an unpredictable course and the need to pivot and meet the client's needs can only happen with telehealth)
b) Needing to start/restart clients in multiple sites on the same day
c) Rural settings that are always difficult to access. Small centres with fewer clients that firstly would not be able to get an in-person physician to fly in for in person care as it is not financially viable. This is the reason small rural centres for care will close if PSA not altered and would not seem fair for these patients living in smaller centres
d) Noncompliance to appointments and patients missing the special in person visit (e.g., Toronto based physician flying north for in person visit in Thunder Bay)
e) Doctors with small numbers of clients in many clinics scattered over a large geographic area.
f) Coordination of care for incarcerated clients transferring to and from jails
g) Group coverage, allowing physicians to be on call for a group and tending to a variety of needs inside and outside normal hours
h) Payment for high numbers of homeless and disenfranchised residents of Ontario who fail to maintain valid OHIP

The Section put forward the following in support of their request:

- Would act as a form of "capitation"
- Would provide programs and government with a more predictable funding model
- Would provide programs with objective, reliable and verifiable data on their treatment numbers. This will help physicians in advocating for stipends, sessional fees, OHT funding etc.
- Proposed funding model would support technical and clinical innovation
- Would provide a much needed source of stable income in cases of future lockdowns, pandemic quarantines etc.
- Would reduce OAMP billing outliers
- Would also reduce the gender pay gap
- Focusses funding on more important/ intensive/ time-consuming/ stressful aspects of care.

- The new requested revenue neutral amount for K682 is the existing $45 plus $34.61 or $79.81 (money for OTN telemedicine premiums). We are requesting an additional $14 per patient per month for the additional services described below which totals $93.81.
- The new requested revenue neutral amount for K683 is the existing $38 plus $17.39. which is $55.39 (money for OTN telemedicine premiums). We are requesting an additional $14 per patient per month for the additional services described below which totals $69.39
- Other similar management fees are as follows:
    - W010 Monthly management fee - $108.85
    - Chronic dialysis weekly team fee
      G860 Hospital haemodialysis - $127.20
      G861 Hospital peritoneal dialysis - $127.20
      G862 Hospital self-care haemodialysis or satellite haemodialysis -$127.20
      G863 Independent health facility haemodialysis - $127.20
      G864 Home peritoneal dialysis - $127.20
      G865 Home haemodialysis - $127.20
      (NOTE: Averaged across a common year, there are. 4.345 weeks per month. So this is the same as 127.20 x 4.345 = $552.68/ month)
    - G512 Palliative care case management fee - $67.75
      The service rendered for providing supervision of palliative care to a patient for a period of one week, commencing at midnight Sunday
      (NOTE: Averaged across a common year, there are. 4.345 weeks per month. So this is the same as 67.75 x 4.345 = $294.37/ month)

The Committee noted the following:

- The committee discussed whether the proposed wholescale changes may be beyond the current scope of this process (e.g., funding not related to schedule of benefits), and might be best addressed through alternate funding mechanisms (e.g., APP).
- OTN funding and payments are not part of OHIP, and therefore might not be transferable to support the new fee or fee increases to K682 and K683 on a cost neutral basis
- The Ministry of Health has agreed to work with the OMA to consider and, where appropriate address, situations where pre-existing, pre-pandemic virtual care practice patterns that were enabled by the Ontario Telemedicine Network (OTN) and supported access to and continuity of patient care, may have been unintentionally restricted under the 2021 PSA.
- It is unclear whether this review will be completed in time to be considered as part of the PPC's final recommendations to the PSC.

Committee Comments:

- The OMSPC is supportive in principle.
- Cost impact analysis will be required.
- The committee invites feedback from the SGFP.
- Final decision will be dependent upon PSC's review of unintended consequences of the 2021 PSA.

2 Allergy & Clinical Immunology

2.1 G208 - Provocation testing

The Section is proposing a fee increase to G208 from $16.85 to $50.00, by 196.7%.

The Section put forward the following in support of their request:

- G190 (Serial oral or parenteral provocation testing to a food, drug or other substance when the service is rendered in a hospital) compensates physicians for the identical procedure at $184.95.
- Originally, very low-risk procedures were performed in the outpatient setting and higher-risk procedures were performed in-hospital necessitating and this difference in risk was reflected in different codes, such as G190. However, because of the increased reliance on oral challenges as a gold standard, outpatient clinics are performing high-risk challenges routinely and as such should be compensated closer to the comparator of G190.
- G208 has increased minimally since its inception in 1992.
- While there is variability in the United States, oral challenges are compensated between $300-500 USD.
- In comparison to other provinces, Alberta values this procedure in an outpatient setting at $160.36 in addition to assessment and Nova Scotia compensates at $124, both of which are similar, although more generous, than our request.
- In addition, there is a gender disparity with females performing a significantly disproportionate number of G208 procedures, resulting in an overall reduction in net income compared to male physicians. For example, female allergist use this test relatively 35% more than a male physician when correcting for total billings. As well, 25% more female physicians actually bill this procedure code than males.
- The Intra-Sectional Relativity (ISR) survey results supports the proposed increase; this was ranked as the highest priority for our members. This is reflective of the significant burden this procedure places on an outpatient clinician. In addition, these parameters were judged to be similar to a formal consultation.

Committee Comments:

- The OMSPC is supportive in revising G190 to allow out of hospital claims for the following allergens: peanuts, tree nuts, milk and egg.

2.2 G197 - Skin testing - professional component, to a maximum of 50 per year, per test

The Section is proposing a fee increase to Increase G197 from $0.21 to $2.00, by 852.4%.

The Section put forward the following in support of their request:

- One of the greatest expenses in an allergy practice is the cost of our diagnostic supplies.
- Skin prick testing in office is fundamental to rapid and accurate diagnosis.
- When the fee structure for skin prick testing was developed 26 years ago, the cost of supplies was substantially lower than it is today.
- Despite the rapid rise in diagnostic extract costs, the fees for skin prick testing have only increased minimally; G197 paid $0.16 in 1992 and now is $0.21, and G209 (Skin testing technical component) paid $0.70 in 1992 and now pays 0.71. This gives a total cost of $0.86 in 1992 versus $0.92 in 2021.

- The burden of this procedure is reflective in the Intra-Sectional Relativity (ISR) survey results that suggested this is the second highest priority fee code (behind G208).
- Comparator codes include:
    - G199 (Venom allergy testing) which pays $40 per test (max 2).
    - G196 (Hypersensitivity skin test for validated drugs or agents excluding foods and inhalants which pays $17 per test (max 3).

The Committee noted the following:

- It is not clear to the committee why a technical fee was established for skin testing (G209) rather than a "tray fee", as the purpose of the fee is to defray supply costs rather than capital equipment and/or personnel (e.g., technician) to undertake the diagnostic procedure.

Committee Comments:

- The OMSPC supports in principle to increase G197.
- The OMSPC recommends the addition of evidence-based payment rules consistent with best practices and requests the Section's input in the development of these rules.
- The committee supports in principle to consider elimination of G209 and create a new tray fee (if within scope of the committee's mandate).

3 Anaesthesiology/ Ontario's Anaesthesiologists

3.1 A/Cxxx - Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service)

3.2 A/C215 Limited consultation for acute pain management in association with special visit to hospital in-patient

3.3 G222 Spinal or epidural injection of narcotic (duration of action more than 4 hours)

The Section requested modernization of acute pain services as follows,

1. Create a new code Axxx/Cxxx Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service), valued at $47.50.
2. Deletion of A/C215 Limited consultation for acute pain management in association with special visit to hospital in-patient - $47.50
3. Deletion of G222 Spinal or epidural injection of narcotic (duration of action more than 4 hours) - $55.00

The Section put forward the following in support of their request:

- The intent is to eliminate the concept of limited pain consult and replace it on a revenue neutral basis with a new Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service) fee code.
- This proposal is linked with a parallel proposal to delist G222 (spinal or epidural injection of narcotic) and redirect the savings to further enhance the new code and possibly other visits often used to support Acute Pain Services.
- A/Cxxx service would involve Complex post-operative/post-partum pain management is the service provided by an anaesthesiologist/FP-anaesthetist who assesses a patient and prepares a

post-operative/post-partum pain management treatment plan and assumes full analgesic care on behalf of the admitting service.

- Care may be provided by an individual anaesthesiologist/ FP-anaesthetist either individually or as part of a coordinated Anaesthesiologist/ FP-anaesthetist led Acute Pain Service.
- The service includes the initial pain-related assessment of the patient, provision and revision of pain orders and the provision of care related to the pain management plan whether in writing or by telephone for the whole calendar day on which it is claimed.
- The goal of this proposal is to modernize the Schedule of Benefits with regards to Acute Pain Services to reflect current reality and to better define what service is actually being provided.
- We anticipate that this proposal along with clearer, more modern rules will eliminate many of the bureaucratic difficulties encountered by our members and allow us to potentially build upon this Acute Pain Service concept, in the future, as needed.
- Our intention is to delist C215/A215 and replace it with this new code.
- The new service describes what is actually happening when C215/A215 is claimed and as such, should be completely revenue neutral.
- We cannot foresee any utilization changes associated with this redefinition.

Committee Comments

- OMSPC supports in principle.
- The committee requests the Section to provide an appropriate definition and payment rules to avoid potential abuse.

3.4 ExxxC Supervision of Anaesthesia Assistant(s) Providing Procedural Sedation For Cataract Surgery as part of an Anaesthesia Care Team

The Section requested a new code ExxxC Supervision of Anaesthesia Assistant(s) Providing Procedural Sedation For Cataract Surgery as part of an Anaesthesia Care Team (ACT) with 5 anaesthesia base units. The Section proposed the following criteria, payment rules and commentary:

ExxxC is payable only when the following criteria are met:

a. The anaesthesia service provided is for one or more of the following: E137, E138, E139, E140, E141, E143, E144, E145, E146, E147, E149
b. The Anaesthesia Assistant provides procedural sedation (see page GP100 for definition)
c. The sedation is ordered and supervised by an anaesthesiologist using a medical directive and/or patient specific orders
d. The hospital or out of hospital premises (OHP) where surgery occurs has policies and procedures in place governing the functioning of the Anaesthesia Care Team
e. The anaesthesiologist is immediately available to intervene when required
f. The anaesthesiologist may not directly provide any form of operative anaesthesia to any other patient(s) other than ExxxC but may perform other interruptible services that are billable to OHIP or comparable uninsured services
g. The supervising anaesthesiologist is either certified in anaesthesia by the RCPSC or holds a restricted certificate of registration in anaesthesia issued by the CPSO or is a FP anaesthetist with privileges to provide operative anaesthesia at a hospital
h. The Anaesthesia Assistant is a regulated healthcare practitioner currently registered in Ontario with either the College of Nurses of Ontario or the College of Respiratory Therapists

of Ontario who has completed the Anaesthesia Assistant program at an Ontario College, or its equivalent, and is credentialed as an anaesthesia assistant at the institution where the procedure takes place.

Payment Rules:

1. Time units and anaesthesia extra units listed on GP97 are not eligible for payment with ExxxC

[Commentary

1. Local infiltration or topical anaesthesia used as an anaesthetic is not eligible for payment of an anaesthesia supervision code unless sedation is ordered to be held by the supervising anaesthesiologist for medical reasons which are documented in the medical record and the Anaesthesia Assistant remains with the patient to monitor and supervise their care.
2. Interruptible services could include provision of labour epidurals or consultations/visits.]

The Section put forward the following in support of their request:

- Anaesthesia Care Teams have been used for cataract anaesthesia in Ontario for the past 15 years.
- The MOH has funded these via APP contracts. The purpose of this proposal is to modernize the schedule of benefits and extend the model to FFS physicians.
- Surgical wait lists and anaesthesia human resource problems have been a challenge to the healthcare system for a number of years. The COVID-19 pandemic has exacerbated and brought renewed attention to them. One of the solutions put forward in 2006 by the bilateral Operative Anaesthesia Committee was the adoption of an Anaesthesia Care Team (ACT) model.
- Various versions have been and continue to be funded in hospitals across Ontario.
- Following the success of this rollout, many hospitals have self-funded expansions of their existing ACTS while many without funding have funded and started new ones.
- The first rollout of the ACT model was for procedural sedation for cataract surgery.
- These ACTs were and continue to be funded by APP contracts with the MOH that fund both the anaesthesiologist and the anaesthesia assistants.
- The anaesthesia fees for these contracts currently pay $110.35 per case with $77.35 going to the anaesthesiologist and $33.00 going to the hospital to fund the anaesthesia assistant. Given the success of this model as well as the pressing need to get as many anaesthesiologists as possible back to operating rooms while simultaneously supporting the cataract wait list initiatives, our Section proposes to modernize the SOB and bring this model to FFS physicians across the province. We are proposing a fee for an ACT for procedural sedation for cataract anaesthesia.
- This new fee code is to help formalize and enable the Anaesthesia Care Team (ACT) model.
- The MOH has already set the precedent for the model via all of the contracts that have been in place for the past 15 years.
- They have also established a baseline for the anaesthesiologist fee which is approximately the same as the OHIP fee for the service (5 units). As such, we expect that this proposal would be revenue neutral.
- We acknowledge that in cases where a shortage of anaesthesiologists has resulted in limited access to this service (or other services) and where an ACT model restores some of this access, additional cataract surgeries or other necessary services could be enabled. This is, after all, the primary purpose of an ACT.

- The comparator is the same service provided by APP contract.

Committee Comments:

- The OMSPC supports in principle.

3.5 P014C - introduction of catheter for labour analgesia including first dose

3.6 E111 Combined spinal-epidural for labour analgesia, to P014C add

The Section requested a simple relativity and modernization proposal as follows:

1. Deletion of E111 Combined spinal-epidural for labour analgesia, to P014C ($50.00) with saving reinvested into P014C.
2. An increase to P014C anaesthesia base units from 6 to 7 Anaesthesia units, and a descriptor revision as follows:

   P014C, introduction of a catheter for labour analgesia, including the first dose, <u>any combined spinal-epidural injections or dural puncture epidural techniques</u>

   (Revisions <u>underlined</u>)

The Section put forward the following in support of their request:

- Combined spinal epidural (CSE) for labour is an epidural technique whereby a spinal needle is passed through the epidural needle to allow a dural puncture and instillation of opioids and/or local anaesthetic directly into the intrathecal space prior to passing the epidural catheter into the epidural space.
- The principal advantage is a more rapid onset of analgesia and perhaps a better quality epidural block as a result of the dural puncture hole. A variation on the technique, dural puncture epidural, has the same steps, without instillation of spinal medication and is another option to potentially achieve an enhanced quality block.
- According to billing data from the OMA, this technique is used in approximately 30% of labour epidurals in Ontario.
- In our recent relativity survey, this code was identified by many members as something that should be addressed.
- The fee for introduction of an epidural is 6 anaesthetic units ($91.74). The fee for the spinal injection in labour (E111) is $50. This fee is only payable when the technique is used in labour. It is not payable when a dural puncture epidural is done instead and it is not payable when a CSE is done as part of an operative anaesthetic such as for caesarean section.
- It is the position of the Section that the fee is out of relativity and not broadly applicable to other instances where it is used and our members have flagged it as an area for us to address. While it remains a valuable technique that falls within standards of care, our Section would like to delist it and re-invest the funding in labour epidural insertion.
- We believe the dollar figures in question should allow us to add 1 unit to the value of P014 for all anaesthesiologists, the details would be worked out as part of a future implementation plan.

Committee Comments:

- The OMSPC supports in principle.

4 Cannabinoid Medicine

4.1 A9x7 - Focused practice assessment (FPA)

The MIG is requesting a new FPA code with a proposed fee equal to A007 Intermediate assessment at $36.85.

The MIG put forward the following in support of their request:

- FPA codes exist for other focused practice family physician.
- The service is equivalent to A007 Intermediate assessment and the FPA codes.
- Creation of new code would assist in track the physicians practicing cannabinoid medicine.

The Committee noted the following:

- Creating a new focus practice code will not resolve negation issues with patients enrolled to a primary care model. Implementing a focused practice code would be one of several steps that would need to occur to avoid negation.
- Providing a focus practice designation is outside of the committee's scope
- Determination of what fee codes are in or out of the various primary care model baskets is not an OHIP Schedule matter (relates to Primary Care contracts) and therefore is outside the committee's scope.
- In order to bill a focus practice assessment, the GP/FP physician is required to have additional training and/or experience in the particular focus practice area and should be prepared to provide documentation demonstrating this if requested by the Ministry. Additional information is needed in determining how this payment requirement is to be met.
- In response to the committee request for additional details on required training and/or experience, the following commentary was proposed:
    - Additional qualifications can be obtained through the Canadian Consortium for the Investigation of Cannabinoids, an accredited annual CME conference. Those already practicing in Cannabinoid Medicine should be 'grandfathered.'

Committee Comments:

- The OMSPC supports in principle.

4.2 A6xx - Cannabinoid medicine - Initial assessment

The MIG is requesting a new code for the initial assessment with a proposed fee of $144.75 where a physician spends a minimum of fifty (50) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

The MIG put forward the following in support of their request:

- A680 (Initial assessment – substance abuse) exists as the initial assessment code for substance abuse in addiction medicine.
- Initial cannabinoid assessments are just as unique and specific to our area of practice as it is in addiction medicine.
- The cannabinoid initial assessments are relatively similar to the initial assessment code for substance abuse in addiction medicine.

- Creation of new code would assist in track the physicians practicing cannabinoid medicine.
- A911 (Special family and general practice consultation) pays the same as A680 and are also time-based and comprehensive as above.
- Creating new codes will identify those practicing in Cannabinoid Medicine that can eventually lead to the creation of a designation. All other sections with designations have their own unique billing codes. The same time commitment would be required (50 mins) and the same criteria met as with other focused practice initial assessment codes. Addiction medicine is just an example.

The Committee noted the following:

- It is unclear whether this service is equivalent to the to the substance abuse fee code A680; however, the committee acknowledged that there is a minimum time requirement in order to bill.
- Creating a new code will not resolve negation issues with patients enrolled to a primary care model.

Committee Comments:

- The OMSPC supports in principle.

4.3 K6xx - Cannabinoid medicine - extended assessment

The MIG is requesting a new time-based fee for extended assessments with a proposed fee of $67.75 per unit (Unit means ½ hour or major part thereof).

The MIG put forward the following in support of their request:

- K680 (Substance abuse -extended assessment) exists as the substance abuse-extended assessment for addiction medicine.
- Cannabinoid medicine also needs an extended assessment code for the same reasons.
- Cannabinoid medicine patients share some of the same needs and are just as unique and specific as those in addiction medicine.
- Creation of new code would assist in track the physicians practicing cannabinoid medicine.
- Similar time based K-codes, such as K005 Primary mental health care, pay the same as K680 for doing similar work and spending the same time.
- Creating new codes will identify those practicing in Cannabinoid Medicine that can eventually lead to the creation of a designation. All other sections with designations have their own unique billing codes. The same time commitment would be required and the same criteria met as with other focused practice initial assessment codes. Addiction medicine is just an example.

The Committee noted the following:

- It is unclear whether this service is equivalent to the to the substance abuse fee code K680; however, the committee acknowledged that K680 is a time based code.
- It is unclear whether a new fee is needed, given the number of other time-based codes that could potentially be claimed (e.g., K005 Primary mental health care and K013 Counselling).
- Creating a new code will not resolve negation issues with patients enrolled to a primary care model.

Committee Comments:

- The OMSPC supports in principle.

4.4 Kxx1 - Cannabinoid medicine-periodic management fee – initial education, per visit

4.5 Kxx2 - Cannabinoid medicine-periodic management fee – follow-up education, per visit

The MIG is requesting two new Cannabinoid medicine periodic management fees modelled after the Opioid Agonist Maintenance Program (OAMP) fee codes K682 (intensive) and K683 (maintenance), as follows

1. Kxx1 Initial education - $45.00
2. Kxx2 Follow-up education - $38.00

The MIG put forward the following in support of their request:

- Opioid Agonist Maintenance Program monthly management fees exist for treatment of substance abuse; Cannabinoid medicine also needs a periodic maintenance fee code for the same reasons.
- Cannabinoid medicine patients share some of the same high needs and are even more complex and many of them palliative as those in addiction medicine.
- Creation of new code would assist in track the physicians practicing cannabinoid medicine.
- Kxx1 Initial Education fee should be allowed a maximum of one per year per patient to reflect the added time, education, support and staffing required in order to assist our patients with accessing their medical cannabis from their licensed producer which includes all registration and paperwork; education on the different strains being recommended by the physician; and dosing schedules of cannabis.
- Kxx2 Follow-up Education fee should be allowed a maximum of three per year per patient using the same rationale as for the Initial Education fee but it would be less “intense” and therefore should be paid at a lower rate.
- Again, we used the addiction medicine section as an equivalent comparison for the extra work their staff needs to support their patients similarly. Like in addiction medicine they would be billed by the MRP. Like in addiction medicine we manage our own patients.

The Committee noted the following

- Additional details are required on who would be eligible to bill these codes (e.g., how is MRP defined? Would it require any particular qualifications?).
- Additional supporting evidence is needed to justify the creation of a new fee and to support equivalence to monthly management of a patient in an Opioid Agonist Maintenance Program (in terms of time, intensity and work effort).

Committee Comments:

- The OMSPC supports in principle the MIG’s proposed new fee codes.
- The committee requests the MIG to provide detailed payment rules and commentary.

4.6 A911 - Special family and general practice consultation

4.7 A912 - Comprehensive family and general practice consultation

The MIG is requesting a fee a 4.2% increase to A911 ($144.75 to $150.83) and A912 ($217.15 to $226.27).

The MIG put forward the following in support of their request:

- The Section on General and Family Practice (SGFP) proposed a 4.2% raise to A005 Consultation, which is supported by the MIG.
- Intra-Sectional Relativity (ISR) survey results suggest an average of 38.7 mins per A005 consultation, which was, in part, the basis for the proposed increase.
- A911 is a time-based code of at least 50 mins, and using the same rationale for the A005 proposed increase, the MIG is requesting a equivalent percentage increase

Committee Comments:

- See Section on General and Family Practice

5 Cardiac Surgery

5.1 Rxxx Left atrial appendage occlusion/excision by suture or device

The Section is requesting a new fee code for open surgical left atrial appendage occlusion or excision. Proposed fee $755.80.

The Section put forward the following in support of their request:

- A new procedure that has been demonstrated as having similar impact on the prevention of stroke in the appropriate patients as a carotid endarterectomy.
- Recently submitted economic data shows huge improvement in discharge from hospital and massive improvement in patient outcome by 5 years.
- This should be compensated essentially the same as an atrial septal defect repair which is the simplest current cardiac procedure and will likely take similar time and effort.

Committee Comments:

- The OMSPC supports in principle.

5.2 Zxxx Sternal rewiring with or without special mechanical instrumentation

The Section is requesting a new fee code for sternal rewiring with or without special mechanical instrumentation valued at $500.

The Section put forward the following in support of their request:

- In rare cases after sternotomy dehiscence and or deep wound, infection can necessitate return to the operating room for removal of wires, wound debridement and complex re-closure of the sternal bone.
- These procedures are necessary as infection can lead to sepsis, death or at the least significantly reduced quality of life.

Committee Comments:

- The OMSPC supports in principle.

5.3 Jxxx Direct epiaortic ultrasound of ascending aorta

The Section is requesting a new fee code for direct epiaortic ultrasound of ascending aorta, valued at $100.

The Section put forward the following in support of their request:

- This procedure is a strong means to prevent stroke which remains a significant postoperative risk of cardiac surgery.
- When done in conjunction with digital evaluation, it has significant impact.
- This procedure is done under intraoperative sterile conditions and the "technician" is the physician.
- The results immediately impact the procedure.
- The entire process of preparing the device and the evaluation take at least 10 minutes of operative time at the very beginning of the most invasive operations and prolonged operations.

The Committee discussed the following issues:

- The proposed fee is out of relativity to comparable ultrasound service fees, such as H100 Emergency department investigative ultrasound at $19.65 and other vascular ultrasound codes (e.g., J190 and J201 Extra-cranial vessel assessment, above the aortic arch)
- The committee is of the opinion that it is most equivalent to H100 Emergency department investigative ultrasound at $19.65
- The Section's proposed fee is all-inclusive incorporating both the professional and technical components. Consideration of technical fees are not within the OMA-MSPC's scope.

Committee Comments:

- The OMSPC supports the in principle to create a new fee for direct epiaortic ultrasound of ascending aorta.
- The committee is of the opinion that the service is more in line with H100 Emergency department investigative ultrasound $19.65 and other vascular ultrasound codes (e.g., J190 and J201 Extra-cranial vessel assessment, above the aortic arch)
- Future allocations could be directed to this code if more fulsome evidence of time and intensity associated with the provision of this add-on warrants a higher value.

5.4 R735 Mitral replacement

The Section is requesting a fee increase to R735 from $960.35 to $1200.00.

The Section put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results supports the proposed increase.

Committee Comments:

- The OMSPC supports the Section's fee proposal in principle.

5.5 Jxxx Coronary doppler/transit flow time measurement

The Section is requesting a new fee code for coronary doppler/transit flow time measurement, valued at $100.00.

The Section put forward the following in support of their request:

- Intraoperative quality control measurement of graft function and patency has been shown to prevent early graft failure due to a host of easily manageable causes.
- Improvement in major adverse coronary events and mortality have been demonstrated and their use is supported by multiple international societal databases.
- This procedure is done under intraoperative sterile conditions and the "technician" is the physician.
- The results immediately impact the procedure.
- The entire process of preparing the device and the evaluation take at least 15 minutes of operative time at the very END of the most invasive operations and prolonged operations.
- Each coronary graft assessed represents a different study as well.
- The study could be performed for each graft up to five times for a coronary bypass.

The Committee discussed the following issues:

- The proposed fee is out of relativity to comparable ultrasound service fees, such as H100 Emergency department investigative ultrasound at $19.65 and other vascular ultrasound codes (e.g., J190 and J201 Extra-cranial vessel assessment, above the aortic arch)
- The committee is of the opinion that it is most equivalent to H100 Emergency department investigative ultrasound at $19.65
- The Section's proposed fee is all-inclusive incorporating both the professional and technical components. Consideration of technical fees are not within the OMA-MSPC's scope.

Committee Comments:

- The OMSPC supports the in principle to create a new fee for coronary doppler/transit flow time measurement billable per graft.
- The committee is of the opinion that the service is more in line with H100 Emergency department investigative ultrasound $19.65 and other vascular ultrasound codes (e.g., J190 and J201 Extra-cranial vessel assessment, above the aortic arch)
- Future allocations could be directed to this code if more fulsome evidence of time and intensity associated with the provision of this add-on warrants a higher value.

5.6 Zxxx Cell salvage/washing for intraoperative blood loss

The Section is requesting a new fee code for cell salvage/washing for intraoperative blood loss, valued at $85.00.

The Section put forward the following in support of their request:

- This technique has been recognized by multiple societies in an effort to minimize transfusion requirements and improve blood conservation.
- This would be payment for a supervisory role akin to that of any other device where blood washing is involved, such as cardiopulmonary bypass, dialysis or therapeutic plasma exchange.

- Direct work or effort is not necessary for every instance of this code being paid as the implication of the supervisory role is dealing with all aspects and problems of the procedure.

The Committee noted the following

- The procedures referenced require physical and/or cognitive work on the part of the physician billing the service.
- The committee does not have sufficient evidence of physical and/or cognitive work on the part of the surgeon associated with cell salvage, compared to the procedure being performed without cell salvage.
- On that basis, the committee maintains its position.

Committee Comments:

- The committee does not support the creation of a new fee for cell salvage/washing for intraoperative blood loss at this time, as insufficient evidence has been provided to justify in terms of the surgeon's time and work effort.

5.7 M134 Thoracotomy for post-operative haemorrhage or empyema

The Section requested a payment rule revision to M134, noting that it is routinely discounted or rejected when provided as a post-operative procedure.

The Section put forward the following in support of their request:

- This is a problematic code that is automatically rejected or billed paid at 85% as often occurs on same day as original operation.
- There is a need for a solution that prevents this automatic error which leads to significant payment delay.

Committee Comments:

- The committee recommends that the OHIP medical rules be modified such that M134 be paid at 100%
- Alternative, the code could be revised to Z code and thus avoiding the automatic computer rule discount.

5.8 Exx1 Minimally invasive approach

5.9 Exx2 off pump approach

The Section is requesting two new fee codes for a minimally invasive and off pump approaches, each valued at $500.00.

The Section put forward the following in support of their request:

- This is a minimally invasive, robotic and off pump procedures which requires specific extra training and expertise. It is often more time consuming and has well documented benefits to patient recovery and outcome.

Committee Comments:

- The OMSPC supports in principle.

5.10 G083 Haemodialysis - Continuous venovenous haemodialysis - initial and acute (for the first 3 services)

The Section is requesting a revision to the payment rules to allow G083 to be billed during cardiopulmonary bypass.

The Section put forward the following in support of their request:

- The procedure is performed and supervised by the surgeon.
- It increases operative time and risk and is often required to avoid death or institution of more intensive and costly therapy like extra corporeal membrane oxygenation.

The Committee discussed the following issues:

- The committee noted that G083 is a team fee and includes acute continuous venovenous haemodialysis for the first 3 services.
- It is unclear to the committee what service the surgeon is providing to be eligible to bill the service.
- The procedures referenced require physical and/or cognitive work on the part of the physician billing the service.
- The committee does not have sufficient evidence of physical and/or cognitive work on the part of the surgeon associated with cell salvage, compared to the procedure being performed without cell salvage.
- On that basis, the committee maintains its position.

Committee Comments:

- The committee does not support the proposed revision at this time, as insufficient evidence has been provided to justify in terms of the surgeon's time and work effort.

5.11 E682 Pump bypass - axillary artery graft for cardiopulmonary bypass, to E650, add

The Section is requesting a revision to E682 with the following descriptor and payment rule:

Proposed descriptor:

Cannulation or graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device.

Proposed payment rule:

To be paid as per current code for femoral, innominate, or axillary cannulation

The Section put forward the following in support of their request:

- This is standard practice with equivalent work in more complex patients that is paid as standard elsewhere.

Committee Comments:

- The OMSPC supports in principle.

5.12 Axxx Cardiac surgical consultation for regional service

The Section is requesting a new fee code for cardiac surgical consultation for regional service, valued at $90.30.

The Section put forward the following in support of their request:

- In complex tertiary care settings where a triage service is necessary, the patient is first evaluated by one team member in a complete way.
- Due to scheduling and hospital resource constraints etc., the operating surgeon may be another team member who before taking the patient for a complex surgical procedure must (morally, ethical and to uphold the standard of practice) then complete a full consultation themselves.
- The referral is essentially from the triage service.

Committee Comments:

- The OMSPC supports in principle.

6 Cardiology

6.1 Exxx Congestive Heart Failure Premium

The Section is requesting a new add-on premium for congestive heart failure (diagnostic code 428), paid at 50%, applicable to A603 Medical specific assessment, A604 Medical specific re-assessment, A601 Complex medical specific re-assessment and A608 Partial assessment.

The Section put forward the following in support of their request:

- Medical Specialists in many other areas are being paid a premium for seeing complex chronic disease patients in their area of expertise (E078 Chronic disease assessment premium – 50%).
- Cardiologists were able to bill E078 until April 1, 2015, when the Ministry unilaterally disallowed Cardiology (and three other specialties – Gastroenterology, Internal Medicine and Nephrology) from billing it.
- Cardiologists seeing complex patients with congestive heart failure should be paid a similar supplement in recognition of the additional time and complexity.
- Cardiologist providing these services are typically the lower billing Cardiologists, and as such would be address intra-sectional income relativity.

The Committee noted the following

- The Ministry's motives for disallowing Cardiology from billing E078 was, in part, an attempt to address specialty income relativity.
- The committee considered, as an alternative, whether creating a new assessment code for congestive heart failure that accounts for the increased complexity of these patients would meet the Section's needs; the Section indicated it would.

Committee Comments:

- The OMSPC supports in principle.

6.2 A603 Medical specific assessment

6.3 A604 Medical specific re-assessment

6.4 A601 Complex medical specific re-assessment

6.5 A608 Partial assessment

The Section is requesting that the 12% Internal Medicine Office Assessment Premium also be applied to their office assessment codes (A603 Medical specific assessment, A604 Medical specific re-assessment, A601 Complex medical specific re-assessment and A608 Partial assessment).

The Section put forward the following in support of their request:

- This created an inequitable situation whereby internal medicine specialists, who have less training, receive higher professional payments than Cardiologists, who see and treat patients with similar clinical syndromes.
- Extending the IM office assessment premium to cardiologists corrects the payment inequity created by the 2019/20 MSPC specialty allocation process that awarded this premium exclusively to Internal Medicine specialists.

The Committee noted the following:

- The 12% office assessment premium was awarded to the Internal Medicine in lieu of the loss of the Section's request to re-instate E078 Chronic Disease Assessment Premium, and not in lieu of an increase of the office assessment fees.

Committee Comments:

- The OMSPC supports in principle.

6.6 A605 Consultation

The Section is requesting a fee increase to A605 from $157.00 to $171.33.

The Section put forward the following in support of their request:

- Cognitive fees (consultations and assessments) in Cardiology are undervalued and have not been increased in many years.
- Increasing the A605 fee to $171.33 is consistent with the reimbursement formula already in use by the Ministry of Health through the Ontario eConsult Program.
- Based on the Intra-Sectional Relativity (ISR) survey results, the average service time to provide a Consultation service (A605) = 51.4 min
- Specialists providing services through the Ontario eConsult Program are paid an hourly rate of $200, pro-rated based on the length of time it takes to complete an eConsult.
- The Section on Cardiology's Consultation (A605) fee value change proposal is derived as follows:
- The average time to provide a consultation service is 51.4 minutes.
    - The Ontario eConsult Program's pro-rated hourly Consultation fee rate is $200.
    - The new Consultation service fee should be valued as follows:
    - 51.4/60 x 200 = 171.33.

Committee Comments:

- The OMSPC supports in principle.

6.7 Exxx Professional Practice Expense Recovery Fee for Out-Of-Hospital Ambulatory Care

The Section is requesting an add-on fee of $40.00 to consultations and assessments provided in an out-of-hospital ambulatory care setting.

The Section put forward the following in support of their request:

- The vast majority of ambulatory cardiac care in this province is now provided in outpatient settings that are not attached to, and are independent of, hospitals. There is no funding for this outpatient infrastructure except for professional fees.
- The professional fees paid to physicians in public practice for consultations and assessments delivered in outpatient settings have historically included all expenses of the practice, such as the cost of administrative, allied health, and clerical personnel, rent, office maintenance, computers, furniture, office supplies, EMR, telephone and other expenses. These costs have risen at a much more rapid pace than any increases in the professional fees, reducing the net income for some services to close to zero.
- Technical fees have risen only marginally in recent years and do not cover the full operating costs of an outpatient office.
- Outpatient service providers do not have access to same funding as hospitals to cover basic operating costs. A more level funding/reimbursement playing field is required to ensure that community-based outpatient services remain accessible throughout Ontario.
- We propose a new fee code as an add-on to all professional services delivered in outpatient settings that would rectify this inequity and support the continued provision of quality care in ambulatory settings. These fees should cover:
- 1. Administrative costs. Applicable to all “in person” and virtual visits. These will include administrative costs of scheduling visits and follow up and maintaining/updating the EMR.
- 2. Facility costs. Applicable to “in person” visits. This will include the rental and maintenance of facilities, receptionist staff, and leasing of the equipment needed in an outpatient clinic.
- 3. Infection control costs. Applicable to all “in person” visits done during the current and future outbreaks. These will include additional space, medical staff, cleaning staff and all required PPE.

The Committee noted the following:

- Other Sections have requested similar out-of-hospital add-on fees to assist in covering office overhead expenses.
- Consultation and visit fees were initially intended to compensate for providing premises, equipment, supplies, and personnel for the specific elements of the service.
- Technical fees associated with diagnostic services rendered outside hospital (e.g., echocardiography, stress testing, etc.) are in place to cover additional cost associated with providing these services; consideration of technical fees are outside the scope of the committee.
- An alternative option could be increasing office-based consultation and visit fees (e.g., “A” prefix codes).
- The Section on Cardiac Surgery supports the proposal with an increase in value for their specialty.

Committee Comments:

- The OMSPC supports in principle.

7 Chronic Pain

7.1 Exxx Tray Fee for Nerve Blocks

The Section is requesting a new tray fee for Nerve Blocks, paid at $11.15.

The Section put forward the following in support of their request:

- Given necessary requirement for nerve blocks including provision of supplies, this code would help reimburse physicians with the cost of this

The Committee discussed the following issues:

- Would require additional information to justify request in terms of cost incurred for supplies used to perform nerve block services

Committee Comments:

- The OMSPC supports in principle to creating a new tray fee for nerve blocks pending requested information.

7.2 G228 Nerve Blocks - Obturator nerve - Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves

7.3 G231 Nerve Blocks - Somatic or peripheral nerves not specifically listed - one nerve or site

7.4 G238 Nerve Blocks - Somatic or peripheral nerves not specifically listed - Transverse scapular nerve

7.5 G264 Nerve Blocks - Occipital nerve - first block per day (maximum 1 per day to a maximum of 16 first blocks per calendar year)

7.6 G370 Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath

7.7 N556 Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy - first site

7.8 E396 Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy - each additional site to N556

The Section requested the following fee changes and payment rules to selected nerve block fee codes and G370:

FC	Descriptor	Current	Proposed	$ increase	% Increase	Details
G228	Nerve Blocks - Obturator nerve - Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves	$34.10	$88.10	$54.00	158.4%	
G231	Nerve Blocks - Somatic or peripheral nerves not specifically listed - one nerve or site	$34.10	$88.10	$54.00	158.4%	

G238	Nerve Blocks - Somatic or peripheral nerves not specifically listed - Transverse scapular nerve	$34.10	$88.10	$54.00	158.4%	
G264	Nerve Blocks - Occipital nerve - first block per day (maximum 1 per day to a maximum of 16 first blocks per calendar year)	$34.10	$88.10	$54.00	158.4%	
G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	$20.25	$34.10	$13.85	68.4%	
N556	Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy - first site	$142.80	$71.40	-$71.40	-50.0%	a limit of 6 per 12 month period should be imposed for a combination of N556 and E396
E396	Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy - each additional site to N556	$71.40	$71.40	$0.00	0.0%	a limit of 6 per 12 month period should be imposed for a combination of N556 and E396

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

7.9 G917 Percutaneous diagnostic selective nerve root block with fluoroscopic guidance, with or without contrast

The Section is requesting a fee decrease to G917 from $160.00 to $80.00.

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that these fees are overvalued

The Committee discussed the following issues:

- The Section on Anaesthesiology indicated that they disagree with the proposed decrease and are of the opinion that the fee is appropriately valued.
- The Section on Anaesthesiology pointed out that they are the primary biller of G917, and therefore should have greater say over proposed fee changes.
- The committee conducted a comparative utilization analysis between Anaesthesiologists and other physician groups and found that Anaesthesiology bills a significantly greater proportion.

Committee Comments:

- The OMSPC does not support the proposed fee decreases.

7.10 G117 Epidural and spinal injections - Percutaneous epidural injections - Thoracic
7.11 G119 Epidural and spinal injections - Percutaneous epidural injections - Cervical
7.12 G246 Epidural and spinal injections - Percutaneous epidural injections - Lumbar

The Section is requesting the following fee decreases to percutaneous epidural injections

Fee Code	Descriptor	Current	Proposed	$ Decrease	% Decrease
G117	Epidural and spinal injections - Percutaneous epidural injections - Thoracic	$170.00	$130.00	-$40.00	-23.5%
G119	Epidural and spinal injections - Percutaneous epidural injections - Cervical	$190.00	$160.00	-$30.00	-15.8%
G246	Epidural and spinal injections - Percutaneous epidural injections - Lumbar	$150.00	$100.00	-$50.00	-33.3%

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that these fees are overvalued
- The fees are overvalued in comparison to analogous acute pain management codes:
    - G117 (CHRONIC thoracic epidural-$170) versus G118 (ACUTE thoracic epidural-$130)
    - G119 (CHRONIC cervical epidural-$190) versus G062 (ACUTE cervical epidural-$160)
    - G246 (CHRONIC lumbar epidural-$150) versus G125 (ACUTE caudal/lumbar epidural-$100)

The Committee discussed the following issues:

- The committee requested the Section on Anaesthesiology's feedback on the proposed fee decrease. The Section indicated,
    - They disagree with the proposed decreases and are of the opinion that the fees are appropriately valued
    - In comparison to the neuraxial epidurals with catheter (G118, G062 and G125), they are,
        - More difficult to perform
        - Require more time to complete
        - Require special training to perform
        - Mostly (soon to be all by CPSO mandate) done under fluoroscopic guidance, in patients with difficult anatomy
    - Anaesthesiology is the primary biller of the said codes, and therefore should have greater say over proposed fee changes
    - Vast majority of savings generated would fall to their Section to re-invest
- The committee conducted a comparative utilization analysis between Anaesthesiologists and other physician groups on fee codes G117, G119 and G246 and found that Anaesthesiology bills a significantly greater proportion.

Committee Comments:

- The OMSPC does not support the proposed fee decreases.

8 Critical Care Medicine

8.1 Axxx CCM Consult
8.2 Axxx CCM Consult (Pt ≤16 yr)
8.3 Axxx CCM Repeat Consult
8.4 Axxx CCM Specific Assessment
8.5 Axxx CCM Specific Re-Assessment
8.6 Axxx -CM Complex Specific Re-Assessment
8.7 Axxx CCM Partial Assessment
8.8 Axxx Comprehensive CCM Consultation (≥75 mins)

The Section is requesting a new consultation and visits menu of fees for Critical Care Medicine (CCM) be established equal to the that of Infectious Diseases, as follows:

FC	Descriptor	2021 Proposed
Axxx	CCM Consultation	$178.65
Axxx	CCM Consultation (Pt ≤16 yr)	$165.50
Axxx	CCM Repeat Consultation	$105.25
Axxx	CCM Specific Assessment	$90.85
Axxx	CCM Specific Re-Assessment	$69.70
Axxx	CCM Complex Specific Re-Assessment	$80.70
Axxx	CCM Partial Assessment	$43.30
Axxx	CCM Comprehensive Consultation (≥75 mins)	$300.70

The Section put forward the following in support of their request:

- There are no Critical Care Medicine (CCM) specific consult or assessment fee codes in the Schedule of Benefits
- CCM is an FRCPC accredited two-year Fellowship in addition to a Base Specialty (Internal Medicine, Surgery, Anesthesia and Emergency Medicine)
- CCM specialists must submit their billings according to their base specialty. This leads to significant differences in remuneration for provision of the same service with the same level of expertise.
- The Section has equated these new fee codes against Infectious Diseases (ID) for the following reasons
    - CCM is a sub-specialty requiring two years of additional training after completion of a primary base specialty (≥ 5 years post-graduate training)
    - CCM physicians bring a high level of expertise to the bedside, often with the added pressures of having to urgently resuscitate the patient whilst simultaneously performing an assessment and ordering further investigations.
    - CCM consults are often life-and-death situations with all the attendant stress that such situations entail.

- The level of training, expertise and responsibility required of a CCM consult or assessment is at least as great as that of a similar Infectious Disease service.
- Some CCM specialists are also ID specialists. If the CCM fee codes are not commensurate with the ID fee codes then the ID specialists will not use the CCM fee codes.

Committee Comments:

- The OMSPC supports in principle the Section's request to create new consultation and visit fees for Critical Care Medicine.

8.9 Gxxx Day 1 Comprehensive CCM per-diem
8.10 Gxxx Days 2-30 Comprehensive CCM per-diem
8.11 Gxxx Days >30 Comprehensive CCM per-diem
8.12 Gxxx Day 1 CCM per-diem
8.13 Gxxx Days 2-30 CCM per-diem
8.14 Gxxx Days >30 CCM per-diem

The Section is requesting new critical care per diem fees modelled after the critical and comprehensive care per diem fees (G400, G401, G402, G557, G558 and G559) that would be restricted to Critical Care Medicine (CCM) specialists as follows:

Fee Code	New FC	Descriptor	Current	Proposed	$ increase	% Increase
G557	Gxxx	Day 1 Comprehensive	$374.35	$516.70	$142.35	38.0%
G558	Gxxx	Days 2-30 Comprehensive	$223.50	$308.49	$84.99	38.0%
G559	Gxxx	Days >30 Comprehensive	$113.00	$155.97	$42.97	38.0%
G400	Gxxx	Day 1 Critical care	$223.10	$381.90	$158.80	71.2%
G401	Gxxx	Days 2-30 Critical care	$146.45	$250.69	$104.24	71.2%
G402	Gxxx	Days >30 Critical care	$58.60	$100.31	$41.71	71.2%

The Section put forward the following in support of their request:

- The current set of per-diem fees are significantly undervalued.
- This is especially evident in the Day 1 per-diems (G440, G557) that include a consult plus all resuscitative efforts and care for the remainder of that first day.
- As the Schedule of Benefits (SOB) currently stands, any IM specialist can bill an "unbundled" set of fee codes that amount to a much higher sum than the Day 1 per-diems.
- Critical Care per-diem fees have "stagnated" in that they have not increased at the same rate as other comparable fee codes (e.g., in comparison to A135 Internal Medicine consultation).
- Critically ill patients are often as much or more work on Days 2-30 yet the per-diem is significantly less than on Day 1.
- The current Days 2-30 fees of $223.50 or $146.45 are inadequate compensation for the burden of services delivered.
- Patients in the ICU >Day 30 are in a different phase of their illness yet can be as much or more work than patients in the early phase of their critical illness.
- The current >Day 30 fees of $113.00 or $58.60 are similarly inadequate.

The Committee noted the following:

- The committee was persuaded by the Section that the critical and comprehensive care per diem fees (G400, G401, G402, G557, G558 and G559) are under valued
- The committee considered the notion of:
    - delisting the critical and comprehensive care per diem fees (bill piecemeal for services rendered);
    - creating new critical care menu of fees per diem fees that vary in value based on complexity (e.g., have three levels of day 1 to reflect level of complexity);
    - redefining and lowering the per diem fees in order to allow co-billing specific services (e.g., bill a new time-based code in addition to the per diem fee and/or other fee codes).
- The committee agreed with the Section that these other fee payment models would require further study and analysis.
- The Sections on Anaesthesiology and Internal Medicine expressed concern regarding the proposed increases in terms of intra- and inter-sectional relativity and the impact on their funding allocations.
- The Section on Respiratory Diseases expressed significant concerns on creating a listing of critical care per diem fees restricted to critical care medicine specialists, noting numerous other physicians and specialties provide critical care services in critical care units across the province both urban and remote critical care units, step-up units and step-down units that are not staffed by critical care medicine specialists.
- The committee noted that given the various types of intensive care units (ICU), a review of how critical care is reimbursed should be undertaken to establish an appropriate fee listing. ICU attributes that could be taken into considered as part of the review include,
    - Size of ICU (small versus large)
    - Type of ICU (cardiac, neurosurgery, general)
    - Physician resources (coverage, full time/part time)
    - Patient volume
    - Open versus closed units (closed units have dedicated physicians looking after patients)

Committee Comments:

- The OMSPC supports in principle increasing the critical and comprehensive care per diem fees (G400, G401, G402, G557, G558 and G559) rather than creating a new set of critical care per diem fees restricted to CCM specialists at this time.
- A review of how critical care is reimbursed should be undertaken to establish an appropriate fee listing. This could be accomplished by establishing a working group involving the applicable Sections.
- Subsequent to a discussion between the committee Chair and Section Executive, the committee will reconsider the Section's request to create new critical and comprehensive care per diem fees (G400, G401, G402, G557, G558 and G559) that would be restricted to Critical Care Medicine (CCM) specialists (e.g., physicians with OHIP Specialty code "11").

8.15 Special Visit Premiums - Evening & Weekend

The Section is requesting that the person seen Special Visit Premiums (SVP) for evenings and weekends (K998, K999, C986, C987, K/C994, K/C995) be eligible for payment with Critical Care per diem fees.

The Section put forward the following in support of their request:

- Intensive Care is a 24/7 specialty
- We are frequently called back to see our patients at unsocial hours and must see each patient on both evening and weekend days.
- There is no provision in the Schedule for Special Visit Premiums or Weekend Modifiers to be applied to Critical Care per diem fees.
- Thus, we are not compensated for seeing patients on weekends or evenings, even though all other specialists receive these premiums for work at unsocial hours.

The Committee noted the following:

- The payment rule disallowing SVPs from being billed with critical care per diem fees have been around for decades and it is unclear whether allowance was considered when SVPs were updated in 2009.
- SVPs are not eligible for payment with routine elective rounds and limits are in place for Emergency Department Physician.

Committee Comments:

- The OMSPC supports in principle the Section's request to allow the person seen Special Visit Premiums (SVP) for evenings and weekends (K998, K999, C986, C987, K/C994, K/C995) be eligible for payment with Critical Care per diem fees

8.16 G521 Life Threatening Critical Care -First 15 minutes
8.17 G523 Life Threatening Critical Care - Second 15 minutes
8.18 G522 Life Threatening Critical Care - Subsequent 15 minute blocks

The Section requested,

(1) the requirement to manual submit claims from when total time spent is 120 minutes to 180 minutes; and
(2) fee increases to the critical care life threatening fees (G521, G522 and G523) as follows:

FC	Descriptor	Current	Proposed	$ Increase	% Increase
G521	Life Threatening Critical Care -First 15 minutes	$110.55	$120.97	$10.42	9.4%
G523	Life Threatening Critical Care - Second 15 minutes	$55.20	$60.40	$5.20	9.4%
G522	Life Threatening Critical Care - Subsequent 15 minute blocks	$36.35	$39.78	$3.43	9.4%

The Section put forward the following in support of their request:

- Life Threatening Critical Care (LTCC) are the services rendered when a physician provides critical care to a critically ill or critically injured patient
- When one compares the relative fees for a benchmark Comprehensive Internal Medicine Consult that lasts 75 minutes with the fees paid for 75 minutes of Life Threatening Critical Care

(LTCC), there is a significant disparity, with the LTCC paid at 9.43% less than the consult for exactly the same amount of time.
- We request that the fee codes for Life Threatening Critical Care be increased so that they are commensurate with the benchmark IM Consult.

The Committee noted the following:
- The Section on Emergency Medicine supports the Section's request, however the Section on Emergency Medicine believes that the later time blocks are not in relativity to the first 15 minutes and would like to see a larger increase to the G391 than the G395 and a larger increase to the G522 and G523 than the G521 (See Emergency Medicine's submission items #11.6-11.10).

Committee Comments:
- The OMSPC supports in principle the Section's proposed fee increase.
- The OMSPC supports in principle to amend the requirement to submit claims for Manual Review from when total time spent is 120 minutes to 180 minutes.

8.19 A/C777 Intermediate assessment - Pronouncement of death Certification of death
8.20 A/C771 Certification of death

Section is requesting A/C777 and A/C771 fees be allowed to be billed with Critical Care per diem fees.

The Section put forward the following in support of their request:
- Pronouncement or certification of death in the ICU are not eligible for payment.
- This is unfair because it can take a significant amount of the physician's time to assess the patient, console the family and complete the necessary paperwork.
- The Schedule provides fee codes for the completion of a multitude of other forms and physicians are allowed to claim those in addition to other codes.

Committee Comments:
- The OMSPC supports in principle the Section's request to allow A/C777 and A/C771 fees to be billed with Critical Care per diem fees.

8.21 Exxx Intensivist-Specific Complexity Modifier - adult aged from 70 to 79 years, inclusive
8.22 Exxx Intensivist-Specific Complexity Modifier - adult aged 80 years and older
8.23 Exxx Intensivist-Specific Complexity Modifier - patient with body mass index (BMI) ≥ 40
8.24 Exxx Intensivist-Specific Complexity Modifier - patient in prone position during mechanical ventilation
8.25 Exxx Intensivist-Specific Complexity Modifier - Patient on Continuous Renal Replacement Therapy (CRRT) in ICU
8.26 Exxx Intensivist-Specific Complexity Modifier -ECMO Management

The Section put forward the following in support of their request:
- In the practice of Anesthesiology, it is recognized in the OHIP Fee Schedule that patients who are elderly, have high acuity or a high BMI, present additional challenges for which the Anesthesiologist receives additional compensation.

- Critical Care patients fulfill many and often all of these additional criteria yet there is no provision for additional compensation to the Intensivist.
- Certain patients inherently present additional challenges to the CCM physician and there should be additional compensation for the added burden of their care.

The Committee discussed the following issues:

- The committee noted that the per diem fees already take into account various complexity via the averaging principle.
- The committee was not convinced that complexity premiums applicable to the critical care per diem fees were warranted based information provided in terms of time, intensity and work effort.

Committee Comments:

- The committee does not support the creation of the proposed new premium fees at this time, as insufficient evidence has been provided to justify in terms of time and work effort.

8.27 K015 Counselling of relatives - on behalf of catastrophically or terminally ill patient

Section is requesting K015 fee be allowed to be billed with Critical Care per diem fees.

The Section put forward the following in support of their request:

- Care of a critically ill patient is complex and time consuming.
- Sometimes the time spent with a critically ill patient's relatives can exceed the time spent with the patient.
- Per-diem fee code descriptors do not include family counselling.
- There exists a fee code that expressly states that it is intended for the counselling of relatives of a critically ill patient.
- Yet, this fee code is routinely rejected when it is submitted with a per-diem fee code.

Committee Comments:

- The OMSPC supports in principle the Section's request to allow K015 to be billed with Critical Care per diem fees.

9 Dermatology

9.1 Axxx Advanced Dermatology Consultation

The Section is requesting a new fee for an advanced dermatology consultation fee paid at $157.00 (set equal to A135 Internal Medicine Consultation fee).

The Section put forward the following in support of their request:

- To support the management of complex medical patients in the community, the Section of Dermatology strongly recommends the creation of a new consultation code for Dermatologists. Propose Linking to A135.

- Ontario Dermatologists are increasingly being asked to care for more advanced Medical Dermatology cases. There are many more non-dermatology trained physicians practicing 'with a specialty in skin disease' but their focus is on the simpler conditions. These non-dermatology trained physicians are able to use billing codes with higher fees to see simple cases leaving complicated conditions and advanced variants of common conditions to Dermatologists.
- The OMA recognizes that the medical profession has become increasingly gender balanced and pay equity has become an issue of increasing concern. The issue of Gender Pay Gap is one of OMA's Health Policy Recommendations.
- The majority of our section identifies as female. Our survey data also suggests that patients with more complex dermatologic needs gravitate towards female Dermatologists.

Committee Comments:

- The OMSPC supports in principle.

10 Diagnostic Imaging

10.1 Xxxx 3-dimentional model

The Section is requesting a new fee code for 3D modelling for medical use, paid at $400.

The Section put forward the following in support of their request:

- Medical application of 3D printing can be highly beneficial to the patient and cost-effective for the system.
- There are two core uses of 3D printing that will only become more popular:
    a. Pre-op planning. Surgeons may need an exact replica of the operative anatomy/pathology to plan his/her approach and fine-tune measurements to improve accuracy and reduce risk of complication.
    b. Surgical instruments. The advancement of new surgical techniques and improvement of established techniques sometimes requires specialized tools. These can be extremely expensive. 3D printed tools can be a much cheaper alternative due to material cost.

The Committee discussed the following issues:

- How was the fee determined, and is it in relativity with similar services?
- What is the role of the Radiologist in developing and/or creating the model?
- What role do surgeons (or other sections) have in developing the model?
- How much dedicated physician-time is involved in rendering this service?
- Given this is a novel service to Ontario, are there any comparator fees from other jurisdictions (e.g., other provinces or the US)?
- Are there different demands depending on the nature of model, for example body region vs type of procedure intended?
- Is there a variance in time between services? If so, would it be more reasonable to establish a time-based code instead of a flat fee?
- What other Sections would be billing this code?
- Can you distinguish the technical vs professional components?

Committee Comments:

- The OMSPC supports in principle.
- Additional consideration is required to establish an appropriate fee.

10.2 Interventional Radiology procedures except angioplasty and stenting codes

The Section requested a 50% across the board increase to all Interventional Radiology (IR) procedures except angioplasty and stenting codes.

The Section put forward the following in support of their request:

- The Interventional Radiology procedures are undervalued in comparison to the Diagnostic Radiology fees.
- IR is on the leading edge of innovation, with procedures becoming increasingly complex and time-consuming. Yet fees for IR procedures have not gone up (and in fact, have gone down substantially due to inflation as well as across-the-board cuts) for decades.
- It is difficult to recruit IR positions and there are fewer than 10 IR fellows currently training; this could help reduce shortages
- Due to the lack of HOCC funding, in addition to the lack of IRs available, it is extremely difficult to recruit IRs for practices that cover IR on-call.
- A common complaint among older IR radiologists is the long-term impact of wearing a 7-10 kg lead apron for 8-10 hours, 5 days or more per week. Back problems are a fact that tends to shorten the working life of a number of IR radiologists as well as the force impact on the physician's joints.

Committee Comments:

- The OMSPC supports in principle.
- The committee noted this is an intra-sectional relativity exercise that will need to fit within the Section's funding allocation.

10.3 Xxxx MR Elastography, Fat and Iron quantification

The Section is requesting a new fee code for MR Elastography at a value of $73.35 and would be an add-on to existing MRI Abdominal procedures.

The Section put forward the following in support of their request:

- The proposed value is identical to multi-slice sequence service as the work is of similar value.
- Acquisition of MRE sequences is a completely new addition to a routine abdominal MRI examination.
- Specifically, in addition to surface coil placement, the study requires appropriate placement of a passive driver to generate mechanical waves which are transmitted through the liver via the chest/abdominal wall. Breathing instructions are also significantly modified compared to a routine abdominal MRI.
- The entire procedure requires significantly more radiologist time and involvement in technologist supervision, scan acquisition and quality assurance that suitable diagnostic information is acquired while the patient is on the scanner table.

- Depending on the above, additional repeats may be required involving further radiologist time and supervision prior to interpretation.
- Interpretation of MRE images and assessment of fat and iron quantification requires specific radiologist training and software (vendor-specific or third party).
- Interpretation of this portion of the study is separate from, and in addition to evaluation of routine abdominal MRI findings.

Committee Comments:

- The OMSPC supports in principle.

10.4 Cxxx Non-emergency hospital in-patient services extended to all Diagnostic Radiologists

The Section is requesting new hospital in-patient fee codes be set equivalent to the GP/FP hospital "Subsequent visits" fees listed on page A11 (C002, C007 and C009)

The Section put forward the following in support of their request:

- They currently do not have hospital "Subsequent visits" codes within their menu of fees.
- This is modernization of the OHIP Schedule, such that it would allow radiologists to claim their own codes.
- Radiologists have over the several past years provided direct inpatient care to their patients, performing and documenting in-patient assessments related to their imaging-guided procedures.

Committee Comments:

- The OMSPC supports in principle.

10.5 X184/X172 Unilateral Mammogram

10.6 X178/X185 Bilateral Mammogram

The Section is requesting that the fee value for unilateral and bilateral mammogram be increased from $16.90 to $25.00 and $27.00 to $40.00, respectively.

The Section put forward the following in support of their request:

- Mammograms are underpaid based on the associated time and intensity.
- Mammogram funding has been a longstanding issue and this was highlighted by the Section during the 2010-11 MSPC process.
- the value of mammographic services professional services are among the lowest in Canada and are falling further behind.

Committee Comments:

- The OMSPC supports in principle.
- The committee noted this is an intra-sectional relativity exercise that will need to fit withing the Section's funding allocation.

10.7 X1xx Digital Breast Tomosynthesis – Unilateral
10.8 X1xx Digital Breast Tomosynthesis – Bilateral

The Section proposes developing new fee codes for unilateral and bilateral digital breast tomosynthesis valued at $23.50 and $38.50, respectively.

The Section put forward the following in support of their request:

- This involves Acquiring a minimum of 60 slice image dataset along with reference to related diagnostic or screening study done separately or in tandem when an appropriate finding is made warranting a digital breast tomosynthesis study performed and interpreted by a diagnostic imaging physician with appropriate breast imaging training and/or related tomosynthesis experience, including DBT physics and technique.
- Performed on Full Field Digital Mammography equipment capable of incorporating digital breast tomosynthesis hardware and software to perform the study.
- X185/X178 are comparable in terms of time and intensity. However, the procedure requires a different dataset of images capable only with Digital Breast Tomosynthesis software and hardware on a Full Field Digital Mammography scanner.
- Patients referred for Digital Breast Tomosynthesis are a small sub-set of women presenting for mammographic studies and further qualified as patients with known disease, findings requiring further study, family history, and other complex breast disease abnormalities.
- Experience to date indicates that approximately 10% of diagnostic mammography cases require DBT referrals.

Committee Comments:

- The OMSPC supports in principle.

10.9 J1xx Ultrasound Elastography Evaluation of Liver

The section proposes the creation of a new code for elastography evaluation of the liver, valued at $40.00.

The Section put forward the following in support of their request:

- Ultrasound elastography is a safe non-invasive tool for screening and surveillance of liver fibrosis
- The service involves multiple (5-10) static ultrasound elastography measurements are obtained within the liver with the patient breath-holding.
- Once a breath-hold is achieved and the image is in the correct location within the liver, the sonography machine obtains a measurement of stiffness.
- The software within the ultrasound machine calculates the average stiffness value which represent the level of fibrosis within the liver.
- The procedure takes approximately 15-20 minutes, depending on patient cooperation.
- The Section provided the following comparator codes noting that this take more time for the radiologist to interpret since it involves both qualitative and quantitative assessment with several measurements that must be reviewed:
    - J135 Abdominal Ultrasound - Complete ($26.45)
    - J205 – Doppler evaluation of organ transplantation (arterial and/or venous) ($14.20)

- J206 – Duplex Evaluation of portal hypertension (must include Doppler interrogation and documentation of superior mesenteric vein, splenic vein, portal veins, hepatic veins and hepatic arteries) ($14.20)
- J207 – Duplex assessment of patency obstruction, and flow direction of vascular shunts (must include Doppler interrogation and documentation of vascular shunts) ($14.20)

Committee Comments:

- The OMSPC supports in principle.

10.10 J182 Diagnostic Ultrasound J182 Extremities - per limb (excluding vascular studies)

The Section is requesting,

a) A fee increase from $14.95 to $29.90, and
b) Revise the descriptor from "per limb (excluding vascular study)" to "Both extremity limbs", thus removal of restriction to add doppler vascular study

The Section put forward the following in support of their request:

- the time and intensity required for MSK examinations is, on average, similar to that for an abdominal ultrasound which has a fee of $26.45
- radiologists scan these cases in person more often than for abdominal ultrasound cases with a broader range of time spent with the patient compared to abdominal ultrasound, resulting in a higher average time with the patient
- Rationale for allowing more than one MSK billing per day is that patients don't limit their problems to one MSK site and it is more efficient and cost-effective for the patient, physician, and the health care system to carry out all needed MSK examinations in one sitting.
- Completing one MSK examination does not diminish the time required for each additional MSK examination.
- Bilateral MSK exams represent approximately 10% of referrals.

Committee Comments:

- The OMSPC supports in principle the Section's request for a fee increase and descriptor revision.

10.11 Axxx Exceptional Complex Multi-Imaging Services Patient Consultation

The Section is proposing a new fee code valued at $75.00.

The Section put forward the following in support of their request:

- The service would include a documented mix of complex CT, MRI, Nuclear Medicine, Ultrasound Studies and/or Interventional Radiology for acutely ill patients typically with highly unstable multi-system disease or complex conditions such as cancer that involve multiple imaging modalities/procedures to obtain the necessary diagnostic imaging information to diagnose, evaluate, manage and/or confer with multiple clinical colleagues.
- The intent is to recognize the necessity of unplanned but necessary time while recognizing this is a reflection of documented extraordinary cases and well-beyond-the-average levels of care knowing that most of the time will still remain uncompensated.

The Committee discussed the following issues:

- The request appears to reflect primarily the additional time required for complex patients to determine what imaging modalities are required.
- Diagnostic Imaging already has A365 “special interventional radiological consultation” for minimum 50 minutes.
- Should there be a time factor distinguishing A335 consultation ($50) from Axxx, but less than A365?
- As an alternative, a novel generic purely time-based consultation code (e.g., such as time intervals of 15 minutes) could be established.

Committee Comments:

- The committee does not support the creation of a new fee until after receipt of Section response justifying proposal in terms of time and work effort.

10.12 Diagnostic Radiology Fee Codes in Section D of the OHIP Schedule of Benefits

The Section proposes a 25% across-the-board fee increase to Diagnostic Radiology fee codes in Section D of the OHIP Schedule of Benefits.

The Section put forward the following in support of their request:

- Catching up for several clawbacks, fee reductions, a 30-year price freeze on all x-ray imaging fee codes and 2018 MSPC unilateral reduction which affected some key general x-ray professional fees.
- This would not apply to the mammography (unilateral and bilateral PFAFs) unless this increase superseded it.
- General x-ray codes have become the overlooked area of DI because of their relatively low prices but higher volumes of service.
- Radiography professional fees have experienced significant erosion also due to 30+ years remaining at the same basic levels, notwithstanding clawbacks and other cuts, and are further compromised by the static level of technical fees in IHFs that have caused radiologists to use a substantive portion of their professional fees to subsidise the shortfall in clinic overheads.
- General x-ray services continue to provide the health care system with an overall low cost but high impact value providing quick and reliable diagnoses for thousands of referring physicians every day across the province so that they in turn can better manage their patients in a timely way while maintaining the Ontario patients’ confidence in the publicly funded health care system.
- The inflationary impact is not even covered by the suggested increase, nor is the significant technology change that affect general radiography more than any other imaging modality.
- Since the conversion to digital imaging, the ability to interpret and adjust the general x-ray images has changed completely with all of the software tools to view x-rays with window and levelling and an increasing number of different views previously available only on CT or MRI. This has directly contributed to more work and time spent by the radiologist viewing these images because they are afforded many more options to view to make a diagnosis.

The Committee discussed the following issues:

- It is unclear how the 25% across-the-board fee increase was derived

- Lack of justification for the proposed increase in terms of intra-sectional fee relativity, time and intensity
- By increasing the Diagnostic Radiology fees would further exacerbate fee relativity with Interventional Radiology procedures

Committee Comments:

- The Committee does not support the proposed across-the-board fee increases, as this will cause further intra-sectional relativity issues with Interventional Radiology procedures

10.13 X1xx Post-Mortem Imaging in Children Using Advanced Imaging (CT and/or MRI)

The Section proposes a new fee code related to post-mortem imaging at $350.

The Section put forward the following in support of their request:

- Post-mortem imaging of the child and adults serves as a virtual autopsy in certain circumstances, or it is an adjuvant to conventional autopsy.
- Study involves evaluation of Head, Neck, Chest, Abdomen, Pelvis and all 4 limbs of the baby. Acquisition of the images takes approximately one hour dependent on modality. Interpretation time ranges between 1-3 hours, depending on the complexity of the case.

The Committee noted the following:

- The committee acknowledged the Section's feedback on comparison in time/complexity to X235 (CT cardio-thoracic, 147.50), X234 (CT colonography, 235.30) and X496 (MRI complex spine, 101.65)

Committee Comments:

- The OMSPC supports in principle the Section's proposed new fee code, noting that autopsies might not be an OHIP insured service, and thus outside the scope of the committee.

10.14 Exxx General Anaesthesia Complexity Modifier for Diagnostic Imaging

The section proposes a modifier for diagnostic imaging when the patient is under general anaesthetic at a proposed 75% add-on premium.

The Section put forward the following in support of their request:

- Procedure can only be performed under anaesthesia or sedation requiring attendance or immediate and continual supervision of radiologist to ensure acquisition of appropriate image quality free of motion artefact while the child is under anaesthetic or sedation as repeat GA is rarely done due to associated risks.
- Paediatric Radiologists are at a distinct billing disadvantage due to the continual time penalties involved with having to perform a large volume of their work in conjunction with anaesthesia.
- the involvement of anaesthesia requires a minimum of 60 minutes of the radiologist's time per case (pre-procedure assessment, supervision during imaging acquisition, post-procedure monitoring and case reporting)
- In the same timeframe for non-GA work, a multiple of other studies could be performed. The assessment of a 75% fee premium was proposed to try and offset the inherent discrepancy

between providing GA and non-GA services. 75% was chosen as it represents a premium fee already in place within the schedule (for after-hours emergency reporting)

The Committee noted the following:

- Depth of sedation should be clearly defined to avoid ambiguity. For example, patients receiving 1 mg Ativan anxiolysis would not fulfil the intent.
- To justify the higher fee, constant attendance should be a requirement
- Consideration was given to redefining E475 (i.e., bedside ultrasound) to include all continuous attendance of a radiologist during performance of diagnostic imaging, to the exclusion of any other work

Committee Comments:

- The OMSPC supports in principle the Section's proposed new fee code.
- The committee is of the opinion this should be a time-based fee where the Radiologist is in continuous dedicated attendance for patient indication exclusive of time spent engaging in any separately payable services.
- The Section is to propose an appropriate fee based on intensity and fee relativity with other comparable services.

10.15 Age-Based Premiums for Diagnostic Services Rendered by an Imaging Physician

The Section is requesting a revision to the preamble to allow age-based premiums to be applied to diagnostic services under certain circumstances. The Section proposed the following changes to the Schedule language on page GP64:

> *1.b. A surgical procedure listed in Parts K to Z inclusive of this Schedule or a Diagnostic Procedure (Part D or E) which requires the attendance of the physician to perform the procedure/study*. (Revisions are underlined)

The Section put forward the following in support of their request:

- The Physician must attend on-site and personally provide the service to be eligible for billing.
- Paediatric intussusception reductions require the staff paediatric radiologist to attend on site to perform a procedure.
- The criterion for age based premiums should not be speciality-based but based on whether the staff specialist is required to attend.

The Committee discussed the following issues:

- Surgical procedures listed in Parts K to Z of the Schedule are eligible for the paediatric premiums
- It is unclear why procedures listed in Section E Clinical Procedures Associated with Diagnostic Radiological Examinations were excluded from the paediatric premiums listed on page GP64

Committee Comments:

- The OMSPC supports in principle of allowing age-based premiums be applicable to the same list of procedures as After Hours Premiums E409 and E410 as follows:

  Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations,

Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures: E111A, G060, G061, G062, G065, G066, G067, G068, G082, G083, G085, G090, G091, G092, G099, G117, G118, G119, G125, G176, G177, G178, G179, G211, G222, G224, G246, G248, G249, G260, G261, G262, G263, G268, G269, G275, G277, G279, G280, G282, G287, G288, G290, G294, G295, G297, G298, G303, G309, G322, G323, G324, G330, G331, G336, G347, G348, G349, G356, G376, G379, G380, G509, J001 to J068

10.16 After-Hours Premiums for Diagnostic Services Rendered by an Imaging Physician

The Section is requesting a revision to the After Hours Procedure Premiums Schedule language on page GP104 to include GI contrast examinations and acute intussusception reductions be added to the list of Clinical procedures associated with Diagnostic Radiological Examinations.

The Section put forward the following in support of their request:

- The Physician must attend on-site and personally provide the service to be eligible for billing.
- Paediatric intussusception reductions require the staff paediatric radiologist to attend on site to perform a procedure.
- There is no difference between a staff diagnostic radiologist having to attend to "perform" a diagnostic GI series/Intuss reduction and a Staff IR having to attend to "perform" an IR procedure.

Committee Comments:

- The committee supports adding X112 (Colon barium enema including survey film, if taken) to the list of Major Invasive Procedures list on page GP104.

10.17 G370 Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath

The Section is requesting an increase to G370 from $20.25 to $50.00.

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

10.18 Special Visit Premiums and After Hours Premiums for Urgent CT/MRI Interpretation

The Section has proposed to remove the maximum service limits on the existing special visit premiums and after hours premiums for urgent CT/MRI Interpretation fee codes E406, E407, C102, C109, C105, C103, C108, C106, C104, C110 and C107.

The Section put forward the following in support of their request:

- This would recognise the huge workload borne by Ontario radiologists to support their clinical and surgical colleagues in off-hours, their attendance in hospitals throughout the dark days of the pandemic lockdowns

- Relaxing of the limits would also bring radiologists into closer parity with other sections' after-hours premiums
- It would serve to recognise that radiologists have respected the limits in the past as this new fee code was implemented across the province. It has proven to be very successful, but it is time to recognise that radiologists' time must be compensated fairly for the increasing burden and burnout of work in unsocial hours that has leached into every evening and weekend of every day of the calendar year to keep up and catch up where wait lists are at unprecedented levels
- Surgical involvement after-hours involve smaller number of patients but are compensated at greater quantum along with HOCC and after-hours premium top-ups that are greater than received by radiologists
- Whereas surgeons and other medical specialties are required to provide on-call services as demanded, radiologists are continually on-call due to the nature of the specialty's services.

The Committee noted the following:

- The committee is unsure exactly why the Special Visit Premium limits differ for Diagnostic Radiology; may have been a funding allocation matter in 2009-2011

Committee Comments:

- The OMSPC supports in principle of revising the limits such that the maximums are equivalent to other professions for similar clinical circumstances.

10.19 J1xx Ultrasound - Biophysical Profile (BPP)

The Section proposes the creation of a new fee code for a biophysical profile ultrasound, valued at $30.00.

The Section put forward the following in support of their request:

- The Biophysical Profile (BPP) ultrasound is a 30 minute, 4-part examination that is clinically indicated and ordered in 3rd trimester to assess fetal well-being, particularly in high-risk pregnancies (eg. Patients noting decreased fetal movements, gestational diabetes mellitus, gestational hypertension, previous IUGR, previous intra-uterine fetal demise, etc.).
- It involves assessment of amniotic fluid, fetal movements, fetal tone, and fetal breathing movements. In clinical practice as well as in evidence-based medical literature, an abnormal BPP exam directly correlates with fetal hypoxemia, fetal distress, increased risk of perinatal morbidity and cerebral palsy, and may prompt urgent intervention and delivery.
- BPP is currently non-reimbursed and, like the remainder of obstetrical ultrasound imaging, the non-reimbursed BPP ultrasound exam is interpreted disproportionately by female radiologists compared to their male counterparts. This further widens the gender pay gap within the specialty.
- The fee is a reasonable amount compared to other ultrasound codes, such as abdominal (J135 - $26.45) and head/neck studies (J105 - $23.70), as well as CT and MRI codes, taking into account the time requirements, training, degrees of difficulty and risks.
- The physician is also required to take extra time in reviewing those images, any video files and also participate in the scanning, if required.

The Committee noted the following:

- Acknowledged the Section's feedback that J160 (High risk pregnancy US - $26.55) deals with all the measurements taken as part of a high-risk assessment at any stage. It does not account for the additional requirements of an additional >30 minutes taken to perform a biophysical profile.
- However, the committee noted that the additional time is related to the technician's time and not the physician.
- The committee noted that a professional fee already exists to provide these services
- Consideration of technical fees are not within the OMA-MSPC's scope.

Committee Comments:

- The OMSPC does not support the Section's request to create a new fee on the basis that fee values should reflect the time and intensity for the physician.

10.20 J476 Diagnostic Ultrasound - Transvaginal Sonohysterography (with tubal assessment)

The Sections on Diagnostic Imaging and Reproductive Biology requested revising the descriptor to J476 to "Transvaginal sonohysterography – including contrast media for demonstration of tubal patency."

The Committee noted the following:

- The Section on Reproductive Medicine submitted a similar request. Please see submission item #47.1
- The Section on Obstetrics and Gynaecology supports the proposal.

Committee Comments:

- The OMSPC is supportive of the Sections' proposal to revising J476 and J165 as follows:

  J165 Transvaginal sonohysterography for the assessment of the uterine cavity ~~- for the assessment of the uterine cavity~~ – including contrast median ~~may include saline or other intracavitary contrast media except Echovist for demonstration of tubal patency~~

  J476 Transvaginal sonohysterography for the assessment of the uterine cavity and tubal patency - including ~~Echovist~~ contrast media ~~for demonstration of tubal patency~~

  Note: J165 cannot be billed in conjunction with J476.

  (Revisions underlined, deletions ~~strikethrough~~)

10.21 J167 Fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158

The Section proposes to amend the payment rules of J167 as follows:

"Fetal Doppler evaluation of middle cerebral artery, ductus venosus, umbilical artery, and/or uterine artery, to J160 or J158.

Note: J167 is only eligible for payment when rendered by a physician for assessment of fetal anemia, intrauterine growth retardation with estimated fetal weight OR abdominal circumference measuring below the 10th percentile, and/or significant drop in estimated fetal weight (>=30 percentile decrease) since previous imaging, and/or in high-risk pregnancies."

(Revisions underlined)

The Section put forward the following in support of their request:

- The proposed changes will allow the J167 code to apply to a greater number of cases.
- The current billing code's narrow scope limited to EFW <10% or query of fetal anemia is outdated and does not include the full scope of high-risk scenarios in which fetal doppler assessment is clinically indicated.
- Middle Cerebral Artery (MCA) should be added to all IUGR's, drop in expected growth and monochorionic twins.
- There are many false positives due to poor technique and physicians have to work with the techs (in real time) to ensure findings are correct and then contact referring MD.
- In addition, like the remainder of obstetrical ultrasound imaging, fetal dopplers are also performed disproportionately by female physicians compared to their male counterparts. By restricting the clinical scenarios in which the billing code can be applied, further widens the gender pay gap within the specialty.
- Approximately 15% of pregnancies are high risk.

The Committee noted the following:

- The Section on Obstetrics and Gynaecology supports the proposal.

Committee Comments:

- The OMSPC supports in principle.

10.22 J160 - Diagnostic Ultrasound – Complete – for high risk pregnancy or complications of pregnancy

The Section requests a fee increase to J160 from $26.55 to $45.00.

The Section put forward the following in support of their request:

- The second and/or third trimester ultrasound requires significant time, knowledge, clinical judgment and skill, and communication and interpersonal skills.
- As an ultrasound exam performed in the context of a high-risk pregnancy, and/or pregnancy with complications, it has a higher probability of being abnormal.
- It requires understanding of fetal and placental pathophysiology and pathology.
- When abnormal, it requires emergent or urgent verbal communication by the radiologist to the referring clinician, or if they cannot be immediately reached, to the appropriate hospital Labour and Delivery Unit On-call physician, since urgent clinical assessment, delivery and/or tertiary centre referral may be warranted.
- When abnormal, the situation and ultrasound findings often require discussion with the patient, so she is aware of the clinical situation, and as to why she is being directed to proceed immediately to referring clinician office or the hospital.
- Many imaging centres decline providing third and late second trimester ultrasound exams, since it involves increased technologist and radiologist training, time, complexity, communication skills, and liability.

- Like the remainder of obstetrical ultrasound imaging, the third and late second trimester high-risk ultrasound exam is interpreted disproportionately by female radiologists compared to their male counterparts. This further widens the gender pay disparity within the specialty.

The Committee noted the following:

- The Section on Obstetrics and Gynaecology supports the proposal.

Committee Comments:

- The OMSPC supports in principle.

10.23 J159 Diagnostic Ultrasound – Complete - on or after 16 weeks gestation (maximum one per normal pregnancy)

The Section requests a fee increase to J159 from $26.55 to $50.00.

The Section put forward the following in support of their request:

- The current fee of $26.55 does not reflect the technological advances, the complexity of interpretation of a fetus' entire body --- head to feet in multiple planes (e.g., Axial, coronal, sagittal), nor the current expectations of patients and referring clinicians to detect birth defects that only a couple of decades ago were ultrasound-occult.
- In contrast, CT and MRI fees are drastically disproportionately higher for interpreting an adult single body region. For example,
    - CT abdomen without contrast, CT pelvis without contrast, CT spine all each have fees of $86.60;
    - CT head without contrast and CT chest without contrast each $64.95;
    - MRI head and MRI abdomen, MRI pelvis each $73.35,
    - MRI complex spine (2 or more adjoining segments) $101.65
- The time, knowledge, and skill required in scanning the patient and interpreting the fetal anatomy ultrasound is not fairly reflected in the current fee for this comprehensive exam.
- Medico-legal risk of interpreting obstetric ultrasound, particularly of fetal anatomy, is significantly higher than for other areas of medicine. This is also not fairly reflected in the current fee.

The Committee noted the following:

- The Section on Obstetrics and Gynaecology supports the proposal.

Committee Comments:

- The OMSPC supports in principle.

10.24 X4xx Functional MRI (fMRI)

The Section is requesting a new fee for Functional MRI (fMRI) at $1,400.00.

The Section put forward the following in support of their request:

- The fMRI consultant does a brief assessment of the patient's functional status and chooses a battery of stimulus paradigms based on the lesion location/epileptogenic focus and the patients functional abilities.
- The consultant trains the patient on these tasks prior to entering the MRI and administers the stimulus paradigms during image acquisition.
- Following acquisition, the consultant processes the data and conducts detailed statistical analyses in order to identify functional brain activation relevant to the lesion and surgical plan.
- The consultant then interprets and communicates the findings by written report and illustrative images and provides the neurosurgical team with full-brain functional maps that can be used for surgical planning and intraoperative navigation.

Committee Comments:

- Decision deferred pending the receipt of additional information in support of the physician time required in to perform the service.

11 Emergency Medicine

11.1 Emergency Department Geriatric Assessment Premium

The Section is requesting a new E-add on 25% premium for patients aged 70 and older applicable to the Emergency Department H-codes (H102, H103, H132, H133, H152, H153 and H122, H123).

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that this is a top priority.
- There is a precedent for age premiums in the Schedule of Benefits which recognizes the additional time and complexity of caring for a geriatric patient population (e.g., family medicine and anaesthesia)
- Patients presenting to the ED are more complicated and require more time than those presenting for routine primary care assessment that get the automatic 15% premium.
- Emergency Medicine is a hospital-based specialty with a practice approach to geriatric patients more like general Internal Medicine than primary care.
- Complexity Contributors include:
    - Polypharmacy – often neither the patient nor the ED physician have a list of medications
    - Complicated past medical history which is sometimes difficult to obtain from the patient
    - Social – lack of family/caregiving presence at the visit
    - Cognitive impairment – despite having dementia, patients come to the ED alone
    - Safe discharge planning and transportation, including late at night
    - Acute illness in the elderly is often multifactorial so they require a wider differential and more investigations – this is different from routine office visits for management of stable chronic disease
    - Advanced directives and Goals of Care, are often relevant in the ED but not the office
- The premium would improve intra-sectional relativity as well as a realistic way to improve the gender pay gap in emergency medicine.
- The Section also made reference to,
    - Anaesthesia age premiums (E007C - $15.29 and E018C - $45.87)

- E078 Chronic disease assessment premium (50%)

The OMSPC noted the following:

- Current geriatrics premium pays a 15% premium on selected fee codes for persons who are at least 65 years of age.
- Other Sections have requested age premiums (both paediatric and geriatric) and an alternative approach could be to establish a step wise approach, similar to paediatrics premium (e.g., 15% over 65 and something more for patient over 80 years of age).

Committee Comments:

- The OMSPC supports in principle but would support setting premium at 15% in accordance with exiting age-based premiums.

11.2 H13X Monday to Friday - Evenings (17:00h to 24:00h) and H15X Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) Revision

The Section is requesting a revision to the H13X Monday to Friday - Evenings (17:00h to 24:00h) and H15X Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) requirements as follows:

Monday to ~~Friday~~ Thursday - Evenings (17:00h to 24:00h)
H132 Comprehensive assessment and care $51.85
H133 Multiple systems assessment $46.80
H131 Minor assessment $20.65
H134 Re-assessment $20.65

Friday – Evenings (17:00h to 24:00h), and Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)
H152 Comprehensive assessment and care $65.70
H153 Multiple systems assessment $58.50
H151 Minor assessment $26.20
H154 Re-assessment $26.20

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- Many EDAFAs count their Friday evening shifts as part of the weekend coverage for the purposes of shift equity as well as to calculate the base pay rate for shifts.
- It is our understanding that many specialists who cover whole weekends of call would cover Friday-Sunday as their weekend (not Saturday and Sunday with a different physician on call for Friday evening).
- Emergency Medicine is facing a critical health human resource shortage. Smaller communities regularly report that covering weekends is difficult, and urban centres notice that physicians who request a weekend off, include the Friday evening in their schedule requests.
- It is our opinion that a majority of people when asked when a weekend begins, would include Friday evening and the Section believes that the Schedule of Benefits should also reflect this reality for our shadow billings and our fee for service doctors.

The OMSPC noted the following:

- Other after-hours premiums apply to Friday evenings (e.g., E409 and E410)

Committee Comments:

- The OMSPC supports in principle.

11.3 H102, H132, H152, H122 - H1X2 Comprehensive assessment and care

The Section is requesting a definition change for the H1X2 comprehensive assessments codes as follows:

> **~~Comprehensive~~ Complex assessment and care**
> ~~Comprehensive~~ Complex assessment and care is a service rendered in an emergency department or Hospital Urgent Care Clinic that requires a ~~full~~ detailed history (which may include ~~including~~ systems review, past history, medication review and social/domestic evaluation), a ~~full~~ physical examination of more than 2 systems, parts or regions, concomitant treatment, and intermittent attendance on the patient over many hours as warranted by the patient's condition and ongoing evaluation of response to treatment.
>
> It also includes the following as indicated:
> a. interpretation of any laboratory and/or radiological investigation; and
> b. any necessary liaison with the following: the family physician, family, other institution (e.g. nursing home), and other agencies (e.g. Home Care, VON, CAS, police, or detoxification centre).
>
> (Revisions underlined, deletions ~~strikethrough~~)

- The Section put forward the following in support of their request:
- When compared to a family medicine general assessment A003, the ED comprehensive assessment involves more work (specifically ongoing care during testing and treatment in the ED) but pays about 50% of the fee code - $41.65 compared to $84.45.
- It is important the ED have a code which recognizes assessments that are more complex than our H1X3 multiple system assessment codes.
- We believe that the ongoing care and complexity warrant the small increase in fees from our intermediate assessment and that the requirement of a full physical examination is not reasonable.
- The requirement for breast, rectal and genital examination is specifically EXCLUDED as part of the A003 definition. Emergency physical exams are tailored to the chief complaint and differential diagnosis.
- A detailed history and 2 or more system exam would differentiate this assessment from our multiple system assessment codes and more accurately represent the workload of a complex ED patient.

The OMSPC noted the following:

- The proposed revision makes it more difficult to distinguish itself from a multiple systems assessment

- Wondered whether it would make sense to increase the fee for H1X2 (and maintain the requirement for a full physical) or collapse the two fees into a single fee code

Committee Comments:

- The OMSPC supports in principle and acknowledged the Section's feedback that this proposal could be deferred.

11.4 G365 Papanicolaou Smear - periodic

The section requested a revision to G365 Periodic Papanicolaou smear to include an emergency department speculum exam.

The Section put forward the following in support of their request:

- Pelvic exams in ED tend to be done more frequently by women staff and as such could help address gender pay gap.
- These procedures take a significant amount of additional time and counselling, especially for women who are in pain. As such, a fee for the pelvic exam, such as the G365 (the office code for pap tests) could address this issue.
- Doing a pelvic speculum exam in the ED is more difficult than a routine office pelvic exam due to
    - the crowded environment,
    - lack of physician/patient relationship,
    - and the symptoms the patient is having which make an emergency speculum exam required.

The OMSPC noted the following:

- Rather than revising the descriptor of G365, a better approach might be to create a new fee code
- Other Sections have proposed new fees for similar type services (e.g., new fees for removal of foreign body and removal of IUD). Rather than creating several new fee codes, one pelvic exam/speculum fee might address the various needs.
- The Section would prefer to have a unique code that is 'gynaecological exam with use of a speculum in the emergency department', noting issues with overlapping practice. It would be complicated to have office based speculum exams appearing on our costing table in the future, and it would be better to have a code that is unique to the emergency department.
- The Section on Obstetrics and Gynaecology supports the proposal to create a new code for gynaecological exam with use of speculum at a fee equivalent to G365 ($8.65).
- The Section on Emergency Medicine requested that this item be deferred to the second allocation.
- The committee envisions a working group of involved Sections to create a combined proposals for this item (e.g., OB/GYN, SGPF and Emergency Medicine).

Committee Comments:

- The OMSPC does not support revising G365 descriptor.
- Instead, the OMSPC proposes a new code for gynaecological exam with use of speculum at a fee equivalent to G365 ($8.65)

- E542 (when performed outside hospital) would be eligible for payment in addition to the new fee.
- Please review Section on Obstetrics and Gynaecology for common submissions.
- The committee agrees with the Section on Emergency Medicine to defer this item to the second allocation and envisions a working group of involved Sections to create a combined proposals for this item (e.g., OB/GYN, SGPF and Emergency Medicine).

11.5 Emergency Department Assessment Fees

As requested, the Section provided additional details on their request to increase the Emergency Department assessment fees and noted that the proposed increases are intended to stay within their funding allocation. The Section proposed the following fee increases:

FC	Descriptor	Current	Proposed	$ Increase	% Increase
H101	GP/FP - Monday to Friday - Daytime (08:00h to 17:00h) - Minor assessment	$16.55	$18.20	$1.65	10.0%
H102	GP/FP - Monday to Friday - Daytime (08:00h to 17:00h) - Comprehensive assessment and care	$41.65	$45.80	$4.15	10.0%
H103	GP/FP - Monday to Friday - Daytime (08:00h to 17:00h) - Multiple systems assessment	$39.35	$41.30	$1.95	5.0%
H104	GP/FP - Monday to Friday - Daytime (08:00h to 17:00h) - Re-assessment	$16.55	$18.20	$1.65	10.0%
H121	GP/FP - Nights (00:00h to 08:00h) - Minor assessment	$30.60	$30.90	$0.30	1.0%
H122	GP/FP - Nights (00:00h to 08:00h) - Comprehensive assessment and care	$76.70	$77.45	$0.75	1.0%
H123	GP/FP - Nights (00:00h to 08:00h) - Multiple systems assessment	$67.75	$68.45	$0.70	1.0%
H124	GP/FP - Nights (00:00h to 08:00h) - Re-assessment	$30.60	$30.90	$0.30	1.0%
H131	GP/FP - Monday to Friday - Evenings (17:00h to 24:00h) - Minor assessment	$20.65	$21.50	$0.85	4.1%
H132	GP/FP - Monday to Friday - Evenings (17:00h to 24:00h) - Comprehensive assessment and care	$51.85	$53.90	$2.05	4.0%
H133	GP/FP - Monday to Friday - Evenings (17:00h to 24:00h) - Multiple systems assessment	$46.80	$48.65	$1.85	4.0%
H134	GP/FP - Monday to Friday - Evenings (17:00h to 24:00h) - Re-assessment	$20.65	$21.50	$0.85	4.1%
H151	GP/FP - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Minor assessment	$26.20	$26.70	$0.50	1.9%
H152	GP/FP - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Comprehensive assessment and care	$65.70	$67.00	$1.30	2.0%

FC	Descriptor	Current	Proposed	$ Increase	% Increase
H153	GP/FP - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Multiple systems assessment	$58.50	$59.65	$1.15	2.0%
H154	GP/FP - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Re-assessment	$26.20	$26.70	$0.50	1.9%

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that the Emergency Department assessment fees are under valued.
- The Section's position is that all 16 H codes do not adequately remunerate the work that we do (both in terms of time and intensity).
- At this time, we believe that the best use of our time and yours is to submit proposed fee code changes within the allocated budget, which is what we have done. We are hoping that our higher priority items such as the geriatric premium will be successful. Once these are funded, we can adjust the fee code PFAFs accordingly.
- The Section hopes, however, that the ratios we have submitted can be maintained even if the final dollar values are adjusted to allow funding of our other priorities.
- We believe that our day codes are the most undervalued and would like to see them increased by the largest amount, followed by evenings, then weekends and apply a smaller percentage increase to the nights.

Committee Comments:

- The submission will be reviewed by the committee at its next meeting.

11.6 G521 Life Threatening Critical Care -First 15 minutes
11.7 G523 Life Threatening Critical Care - Second 15 minutes
11.8 G522 Life Threatening Critical Care - Subsequent 15 minute blocks
11.9 G395 Other Critical Care - first 1/4 hour (or part thereof)
11.10 G391 Other Critical Care - after first 1/4 hour per 1/4hour (or part thereof)

As requested, the Section provided additional details on their request to increase the Emergency Department assessment fees. The Section proposed the following fee increases:

FC	Descriptor	Current	Proposed	$ Increase	% Increase
G521	Life Threatening Critical Care -First 15 minutes	$110.55	$112.75	$2.20	2.0%
G523	Life Threatening Critical Care - Second 15 minutes	$55.20	$60.70	$5.50	10.0%
G522	Life Threatening Critical Care - Subsequent 15 minute blocks	$36.35	$40.00	$3.65	10.0%

G391	Other Critical Care - after first 1/4 hour per 1/4hour (or part thereof)	$28.35	$29.50	$1.15	4.1%
G395	Other Critical Care - first 1/4 hour (or part thereof)	$56.80	$57.95	$1.15	2.0%

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that the Emergency Department assessment fees are under valued.
- The Section's position is that all 16 H and 5 G codes do not adequately remunerate the work that we do (both in terms of time and intensity).
- The Section agrees with the Section of Critical Care that the Life Threatening Critical Care codes are significantly undervalued (See items #8.16 – 8.18). However, we understand the MSPC process and want to be successful doing what we can to slowly correct intra-sectional relativity problems.
- We believe that the later time blocks are not in relativity to the first 15 minutes and would like to see a larger increase to the G391 than the G395 and a larger increase to the G522 and G523 than the G521.
- At this time, we believe that the best use of our time and yours is to submit proposed fee code changes within the allocated budget, which is what we have done. We are hoping that our higher priority items such as the geriatric premium will be successful. Once these are funded, we can adjust the fee code PFAFs accordingly.

Committee Comments:

- The submission will be reviewed by the committee at its next meeting.

12 Emergency Medicine (Member group)

12.1 H100 Emergency department investigative ultrasound

12.2 Hxxx Emergency Department Point-of-Care Ultrasound for static or dynamic guidance of invasive procedures

On behalf of 50 plus members of the Section (member group), a submission was made to,

1. Create a new fee Hxxx Emergency Department Point-of-Care Ultrasound for static or dynamic guidance of invasive procedures at a fee of $32.10
2. Revise the descriptor of H100 to "Emergency Department Point-of-Care Ultrasound"
3. Increase H100 fee from $19.65 to $32.10
4. The proposed new descriptor and payment rules and requirements are as follows:

Emergency Department Point-of-Care Ultrasound

An Emergency Department Point-of-Care Ultrasound is only eligible for payment when:

1. the procedure is personally rendered by an Emergency Department Physician who meets standards for training and experience to render the service;
2. the procedure rendered for a patient falls into one of these areas of Point-of-Care Ultrasound:

a) Core (e.g., aorta, cardiac-subxiphoid, abdominal for free fluid, obstetrical-abdominal, obstetrical-endovaginal, thorax-pleural effusion/pneumothorax)
b) Resuscitative (e.g., IVC, cardiac-parasternal/apical, transesophageal, thorax- respiratory distress, pneumonia/other)
c) Diagnostic (e.g., ocular, gallbladder, deep venous thrombosis, renal, bladder)
d) Musculoskeletal (e.g., fracture, joint effusion, tendon, soft tissue-infection-foreign bodies)
e) Procedure guidance

Payment rules:

1. H100 is limited to three (3) services per patient per day.
2. Services listed in the Diagnostic Ultrasound section of the Schedule, both technical and professional components are not eligible for payment to any physician when ultrasound images described by H100 are eligible for payment.
3. When a Point-of-Care Ultrasound is performed on the same area for both diagnostic indications and procedure guidance (e.g., joint effusion and arthrocentesis of the same joint), H100 can only be billed once.
4. H100 can only be billed once when one of more of the procedures listed in 2a-d above is performed upon during an initial assessment at the patient's bedside.
5. H100 can be billed a second time when the same or new procedures are repeated at a different point in time to reassess the patient. The same rule applies for a third visit.
6. Hxxx can be billed in combination with billing for an invasive procedure for which Emergency Department Point-of-Care Ultrasound is used as a guide.
7. Services listed in the Diagnostic Ultrasound section of the Schedule with respect to ultrasonic guidance (i.e., J149 code) are not eligible for payment to any physician when ultrasound guidance described by H099 are eligible for payment.

Medical record requirements:
The service is only eligible for payment when the Emergency Department investigative ultrasound includes both a permanent record of the image(s) and an interpretative report.

Claims submission instructions:
Claims in excess of three (3) services of H100 per day by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

[**Commentary:**
See page GP50 for the definition of an "Emergency Department Physician".
An example of current standards and minimum requirements for training and experience for Point-of-Care Ultrasound may be found at the Canadian Point-of-Care Ultrasound Society website at the following internet link: http://www.cpocus.ca.]

The member group put forward the following in support of their request:

- The number of PoCUS scans for which the H100 code can be utilized is restrictive, and now only represents a small minority of the scans in the skill set of emergency physicians.

- The growth in the use of PoCUS in EDs and other clinical settings in Canada has been exponential over the last 20+ years.
- PoCUS is a vital part of emergency medical care in Canada. PoCUS is used several times per shift by many physicians. It improves the quality and efficiency of care in the face of otherwise deteriorating conditions.
- Physicians working in Ontario EDs should not be penalized for adding PoCUS to their skill set. The promise of some remuneration at the end would encourage even more adoption of this skill, a skill that has been clearly proven to increase patient safety and improve efficiencies, often at a cost savings to the system
- Due to the growing utility and rapid incorporation of PoCUS in emergency medical care, Canadian Emergency Medicine programs have added PoCUS to their curriculums. This started in the mid to late 2000s for both Royal College and CCFP-EM residencies.
    - All emergency medicine training programs now have PoCUS as part of their training.
    - The Royal College now has competency-based requirements for PoCUS.
    - The Canadian Association for Emergency Physicians has a committee dedicated to PoCUS.
- Physicians working in the ED care for patients 24 hours per day. Decisions must be made at 2 PM and 2 AM with the expectation that the care provided will be equivalent, regardless of the time of day. Yet we face significant support challenges. Diagnostic services and specialty consultation are restricted by system issues, of which there are too many to list. Although access to these services is often nonexistent at 2 AM, this access is almost as challenged at 2 PM. PoCUS has helped us to dramatically mitigate the negative effects of these limitations both by improving the quality of care as well as its timeliness.
- Case examples highlight not only the improved care that PoCUS provides, but also the improved efficiency of care with lower wait times and less admissions in some cases. Specialty consultation can be optimized or deferred, thus avoiding further exhaustion of our radiologist and other specialist colleagues.
- This improved efficiency results in cost-savings to the health-care system. While the case examples are anecdotal, there is an abundance of evidence supporting the use of PoCUS in the ED, with the attendant improvements in the quality and efficiency of care.
- The scan itself requires a significant amount of time. This is because, with each PoCUS scan performed, there are many small tasks that must be completed by the physician. These tasks include:
    - Deciding if a scan is indicated
    - Locating the ultrasound machine (this task alone often takes a couple of minutes.)
    - Wheeling the machine to the patient's room
    - In the case of a hallway patient, finding a room where the scan can be performed in private.
    - Plugging the machine in, turning it on, and waiting for it to boot up
    - Altering the settings of the machine as appropriate
    - Informing the patient of the reason for the scan and what to expect
    - Placing the patient in an appropriate position for the scan
    - Performing the steps necessary to generate dynamic images of the Area(s) of Interest while simultaneously interpreting the scan
    - Integrating the results of the scan into the diagnostic decision-making and treatment for the patient

    - Documenting the scan results
    - Providing the patient with the results
    - Cleaning the patient
    - Cleaning the machine
    - Returning the machine to its proper location
    - Acting on the results as appropriate
- These tasks cover both the technical and professional components of elective ultrasound performed in the radiology department, in this case carried by a single individual, the Emergency physician. They require knowledge and judgement, communication and interpersonal skills, technical skills which require significant training, as well as added risk and stress.
- In Quebec, their code can be used for all types of POCUS scans that are in the skill set of the individual physician, with no limits on the type of scan which can be billed. At present, that code pays $26.05 in contrast to the H100 code in Ontario, which only pays $19.65.

Committee Comments:

- The submission will be reviewed by the committee at its next meeting.

13 Endocrinology & Metabolism

13.1 Consultation and visit fee increase

The Section requested the following fee increases:

Fee Code	Descriptor	Current	Proposed	$ increase	% Increase
A/C/W155	Consultation	$162.65	$178.92	$16.27	10.0%
A/C/W153	Medial specific Assessment	$82.75	$86.89	$4.14	5.0%
A/C/W151	Complex medical specific re-assessment	$73.45	$77.12	$3.67	5.0%
A/C/W154	Medical specific re-assessment	$61.85	$64.94	$3.09	5.0%
A/C/W760	Complex endocrine neoplastic disease assessment	$90.75	$95.29	$4.54	5.0%
A/C/W158	Partial assessment	$38.45	$41.00	$2.55	6.6%
C152	Subsequent visits - first five weeks	$31.00	$41.00	$10.00	32.3%
K045	Diabetes management by a specialist	$75.00	$78.75	$3.75	5.0%
K046	Diabetes team management	$115.00	$121.00	$6.00	5.2%

The Section put forward the following in support of their request.

- Consultation and visit services are increasingly taking more time and are dealing with more complex patients
- In comparison to Internal Medicine, once the 12% office assessment premium is accounted for, Endocrinology visit fees pay less. Given addition sub-specialty training they should at least be paid on par. Otherwise, why do additional sub-specialty training.

Committee Comments:

- The OMSPC supports in principle.

14 Gastroenterology

14.1 Exxx Gastroenterology Chronic disease assessment premium

The Section is requesting a new Gastroenterology chronic disease assessment premium modelled after E078 Chronic disease premium where the premium is to be set to fit within the Section's funding allocation. Thus, the premium would be applicable to A413 Medical specific assessment, A414 Medical specific re-assessment, A411 Complex medical specific re-assessment and A418 Partial assessment when billed with an E078 applicable diagnostic code.

The Section put forward the following in support of their request:

- Medical Specialists in many other areas are being paid a premium for seeing complex chronic disease patients in their area of expertise (E078 Chronic disease assessment premium – 50%).
- Gastroenterologists were able to bill E078 until April 1, 2015, when the Ministry unilaterally disallowed Gastroenterology (and three other specialties – Cardiology, Internal Medicine and Nephrology) from billing it.
- This change has disproportionately impacted the lower earning members of the specialty, and such it widened our intra-sectional income relativity since 2015.
- The premium code would mainly apply to patients with Crohn's disease, Ulcerative Colitis (collectively IBD), chronic liver cirrhosis, and chronic GI motility disorders secondary to other chronic conditions such as diabetes, connective tissues disorders, and neurological disorders, etc. IBD and cirrhosis are both medically complex chronic conditions which are associated with significant morbidity, disability.
- Management of these conditions is complex and has becoming increasingly so in the recent past. Patients with IBD and cirrhosis require close monitoring of their medical management to reduce the risk of life long complications or the need for rescue surgery and to reduce the risk of treatment-related side effects.
- Persons with IBD and cirrhosis may have multiple medical and mental health comorbidities, which frequently require multidisciplinary care. IBD significantly impacts on mental health, and many gastroenterologists will also provide significant counselling and support. Cirrhosis patients are at high risk of hospitalization, and readmission. Whereas management of GI motility disorders are very complex and improvement of such symptoms will improve their quality of life and reduce their chance of chronic disability.
- Gastroenterologists who have focus practice to provide chronic care of these patients often took on extra years of medical training to gain expertise in providing more complex care for these patients. (I.e Loss of opportunity cost with extra training).

- Ongoing gastroenterology patient assessments and management for the above chronic medical conditions are often more time consuming and complex required higher intensity of work.

The Committee noted the following

- The Ministry's motives for disallowing Gastroenterology from billing E078 was, in part, an attempt to address specialty income relativity.
- The committee considered, as an alternative, whether creating a new assessment code for these patient population that accounts for the increased complexity of these patients would meet the Section's needs.

Committee Comments:

- The OMSPC supports in principle.

14.2 Z570 Fulguration of first polyp through colonoscope

14.3 E719 Fulguration of first polyp through colonoscope - each additional polyp (max 4)

The Section requested the deletion of Z570 and E719 Fulguration of polyp through colonoscope.

The Section put forward the following in support of their request:

- Fulguration or hot biopsy forceps/hot snare tip fulguration (HBF) via electrocautery is a procedure that uses heat from an electric current via hot forceps or hot snare tip to destroy abnormal tissue such as polyp or tumor.
- Over the years, the use of HBF alone for polyp management has fallen out of favour when compared to cold snare polypectomy due to its higher chance of residue polyp and higher risk of deeper colonic mucosal injury.
- Because of reported complications with the hot biopsy forceps (HBF), many endoscopists only use them to eradicate polyps in the range 1-5 mm.
- We are proposing to eliminate Z570/E719 as it is an inferior smaller polyp management technique to cold snare polypectomy.

Committee Comments:

- The OMSPC supports in principle.
- The committee requests a combined submission from the Sections on General Surgery and Gastroenterology to modernize the colonoscopy and polypectomy fee listing, to include all aspects of their proposals (i.e., re-write of OHIP Schedule page S19 accordingly).
- Please see General Surgery submission item #17.12-17.17.

15 Gastroenterology (Member group)

15.1 E078 Chronic disease assessment premium

On behalf of 50 plus members of the Section (member group), a submission was made to reintroduce E078 Chronic disease premium for Gastroenterologist. If insufficient funding is available, then a new premium with the same payment rules and requirements as E078 be created at a premium set to fit within the Section's funding allocation.

The member group put forward the following in support of their request:

- Medical Specialists in many other areas are being paid a premium for seeing complex chronic disease patients in their area of expertise (E078 Chronic disease assessment premium – 50%).
- Gastroenterologists were able to bill E078 until April 1, 2015, when the Ministry unilaterally disallowed Gastroenterology (and three other specialties – Cardiology, Internal Medicine and Nephrology) from billing it.
- This change has disproportionately impacted the lower earning members of the specialty, and such it widened our intra-sectional income relativity since 2015.
- The premium code would mainly apply to patients with Crohn's disease, Ulcerative Colitis (collectively IBD), chronic liver cirrhosis, and chronic GI motility disorders secondary to other chronic conditions such as diabetes, connective tissues disorders, and neurological disorders, etc. IBD and cirrhosis are both medically complex chronic conditions which are associated with significant morbidity, disability.
- Management of these conditions is complex and has becoming increasingly so in the recent past. Patients with IBD and cirrhosis require close monitoring of their medical management to reduce the risk of life long complications or the need for rescue surgery and to reduce the risk of treatment-related side effects.
- Persons with IBD and cirrhosis may have multiple medical and mental health comorbidities, which frequently require multidisciplinary care. IBD significantly impacts on mental health, and many gastroenterologists will also provide significant counselling and support. Cirrhosis patients are at high risk of hospitalization, and readmission. Whereas management of GI motility disorders are very complex and improvement of such symptoms will improve their quality of life and reduce their chance of chronic disability.
- Gastroenterologists who have focus practice to provide chronic care of these patients often took on extra years of medical training to gain expertise in providing more complex care for these patients. (I.e Loss of opportunity cost with extra training).
- Ongoing gastroenterology patient assessments and management for the above chronic medical conditions are often more time consuming and complex required higher intensity of work.

The Committee noted the following

- The member group's submission complied with approved OMA-MSPC Fee Proposal Evaluation Process for 2021/2022.
- The Ministry's motives for disallowing Gastroenterology from billing E078 was, in part, an attempt to address specialty income relativity.
- The committee considered, as an alternative, whether creating a new assessment code for these patient population that accounts for the increased complexity of these patients would meet the Section's needs.

Committee Comments:

- The OMSPC supports in principle.

16 General & Family Practice

16.1 Exxx Complexity Add on Fee to A007

The Section requested an Exxx complexity add-on fee to A007 Intermediate assessment at $33.85 per additional 10-minute units that would be eligible for payment where an A007 visit service time exceeds 20 minutes in duration.

The Section put forward the following in support of their request.

- A key finding of our consultations and Intra-Sectional Relativity (ISR) survey results is that family physicians are caring for more complex patients, patients presenting with multiple medical complaints, etc which require more time to service.
- Results indicate a strong direct relationship in that higher service intensity ratings lead to higher service times.
- Mean service time of A007 is 19.9 minutes, however, approximately 25 percent of family physicians report times in excess of 20 minutes.
- The mean and median service time for A007 reported by those who spend in excess of 20 minutes is approximately 30 minutes duration, or about 10 minutes longer than the overall average time.
- The proposed value of $33.85 is 50% of the value of other time-based codes for 20 minutes of time, to fairly compensate those physicians that typically spend about 10 minutes longer than the average time (e.g., K013 Individual counselling).
- A007 + one unit of Exxx would pay a total of $70.70 (i.e., $36.85 + $67.75/2), a value closer to but below the A003 General assessment value ($84.45 currently) which the Section feels is appropriate.
- The mean service time of female physicians exceeds male physicians by 3.8 minutes, or 21 percent. As such, this new add-on fee would contribute to narrowing the gender pay gap.

The Committee noted the following.

- Other Constituencies proposed similar time-based complexity add-on fees.
- The option of amending K001 Detention as an alternative option. This could include revising payment rules (e.g., minimum time requirements and requirement to manually submit) and adjustment to fee value.
- The Section on Emergency Medicine was in support of the fee proposal.

Committee Comments:

- The OMSPC agrees in principle, noting that improvements to existing detention services may render this proposal unnecessary.

16.2 G378 Insertion of intrauterine contraceptive device

The Section requested a fee increase to G378 from $31.10 to $40.00.

The Section put forward the following in support of their request.

- Based on the Section's assessment of the time and intensity of service, and verbatim comments from the Intra-Sectional Relativity (ISR) survey, this service is undervalued.

- Almost 75 percent of physicians providing these services are female, these physicians provide about 80% of services. As a result, any increase to this fee would contribute to narrowing the gender pay gap.

The Committee noted the following.

- The Section on Obstetrics and Gynaecology is also proposing a fee increase to G378 from $31.10 to $70.00.
- With creation of a pelvic exam code, should the payment for this service be adjusted down accordingly, or should this not be eligible to be billed with that pelvic exam?

Committee Comments:

- The OMSPC agrees in principle with a fee increase but requests that the Sections on General and Family Practice and Obstetrics and Gynaecology agree on a proposed fee value.
- Please review Section on Obstetrics and Gynaecology for common submission.

16.3 Gxxx Removal of intrauterine contraceptive device (IUD)

The Section requested a new fee code Exxx removal of intrauterine contraceptive device (IUD) at $20.00, which would be eligible for payment with add-on fee code E542 when performed out of hospital.

The Section put forward the following in support of their request.

- There is no fee for this service
- Based on Sections assessment of time and intensity, the fee is equal to one-half the fee for IUD insertion (G378 - $31.10; the Section has proposed G378 be set equal to $40).
- The proposed new fee should be outside the FHO/FHN basket

The Committee noted the following.

- The Section on Emergency Medicine proposed a new code for pelvic exam with use of speculum, which could potentially address the Section's needs.

Committee Comments:

- The OMSPC agrees in principle, noting that this may need to be reassessed if a pelvic exam code is created.
- Please review Section on Emergency Medicine and Obstetrics and Gynaecology's submission item #33.12 for common submission.

16.4 Eyyy Gender add-on premium to periodic health visit fee codes K131 (adult age 18 to 64 inclusive) and K132 (adult 65 years of age and older)

The Section requested a new gender add-on premium to K131 and K132 at a premium of 20%. The premium modifier would be applicable for female patients and for X gender patients. X gender includes

Trans, Non-Binary, Two-Spirit, and Binary patients and persons who do not wish to disclose their gender identity[1].

The Section put forward the following in support of their request.

- Based on the Section's Intra-Sectional Relativity (ISR) survey, complexity of the service for female and X gender patients is on par with male patients (i.e., 3 to 3.5 out of 5), the time to provide the service to these patients is about 20 percent longer. Hence, the proposal for a 20% add-on fee would be appropriate.
- Reasons provided for the additional time included
    - The problems are different
    - the preventative care discussions are different and more involved.
    - the social determinants of health that need to be addressed are different.

The Committee noted the following.

- The option of amending K001 Detention as an alternative option. This could include revising payment rules (e.g., minimum time requirements and requirement to manually submit) and adjustment to fee value.
- The Section on Urology cautioned that a multitude of health outcomes including suicidality, cardiovascular disease, cancer death and overall mortality are worse in males. The concept of compensation for time, which is suggested repeatedly in the document, would address many concerns raised about the current fee schedule including this one. We support the addition of time based compensation (as add on fees or otherwise) for cognitive and procedural work.

Committee Comments:

- The OMSPC agrees in principle, noting that improvements to existing detention services may render this proposal unnecessary.

16.5 Services provided after hours in small rural hospitals

The Section requested that fee codes in the FHO basket provided for after-hours coverage at the local hospital (e.g., inpatient ward, emergency department, obstetrics) be paid at full value rather than discounted to the shadow billed rate of 15%.

The Section put forward the following in support of their request.

- When a group of family physicians in a small community are in the same FHO and provide after-hours coverage at the local hospital, claims submissions of fee codes in FHO basket are shadow billed at 15%.
- In larger communities, the emergency department visits are probably being provided by the Emergency Department physician and billed using applicable H-codes and/or the calls to the ward may often be provided by the Internists or Obstetricians, for example.
- Concern was raised that family physicians in small communities may withdraw services to the small rural hospitals.
- This would address equity, as it would allow payment for work at rural hospitals, similar to those in larger urban centres who are getting paid in full.

[1] Refer to the following for more information on gender identity: https://www.ontario.ca/page/consultation-gender-and-sex-information-government-ids-and-forms

The Committee noted the following.

- This is a primary care contract issue and therefore, outside the OMA-MSPC's mandate.

Committee Comments:

- The OMSPC will not consider this proposal, as it is outside the committee's mandate.

16.6 Relative Value Fee Code Adjustment Proposal

The Section submitted a relative value fee code adjustment proposal that calculated Relative Value Units (RVUs) for each of the 27 fee codes surveyed in the Intra-Sectional Relativity (ISR). The results are depicted below in Table 1.

Table 1: Relative Value Units (RVUs) for each of the 27 fee codes surveyed in the Intra-Sectional Relativity (ISR)

Fee Code	Descriptor	Time (min)	Intensity	RVUs
A001*	Minor assessment	10.9	1.9	20
A003	General assessment	34.5	3.6	124
A005	Consultation	38.7	3.5	135
A007	Intermediate assessment or well baby care	19.9	3.9	77
A888	Emergency department equivalent -partial assessment	19	3.1	58
A900	GP/FP - Complex house call assessment	51.8	4	208
A905	GP/FP - Limited consultation	27.9	3	83
G010	Laboratory Medicine - Miscellaneous - one or more parts of	6.2	1.7	11
G365	Papanicolaou Smear - periodic	17.2	3.2	56
G370	Injection of bursa, or injection and/or aspiration of joint,	16.8	3.2	54
G371	Injection of bursa, or injection and/or aspiration of joint,	14.4	3	43
G420	Ear syringing and/or extensive curetting or debridement u	15.2	2.8	42
G538	Other immunizing agents not listed above	8.5	2.3	19
G590	Influenza agent	7.7	2.1	16
G841	Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio V	9.1	2.4	21
K005	Primary mental health care - Individual care, per unit	32.9	4.2	140
K013	Counselling - Individual care - first three units of K013 and	30.2	3.8	115
K017	Periodic health visit - child	22.9	2.9	67
K023	Palliative care support, per unit	35.4	4	142
K028	STD management	24.5	3	75
K030	Diabetic management assessment (DMA)	23.2	3.3	77
K037	Fibromyalgia/chronic fatigue syndrome care	32.9	4.1	134
K131	Periodic health visit - adult age 18 to 64 inclusive	30	3.3	99
K132	Periodic health visit - adult 65 years of age and older	35.3	3.8	134

P003	General assessment (major prenatal visit)	34.3	3.6	124
P004	Minor prenatal assessment	18.9	2.9	55
P005	Antenatal preventative health assessment	26.4	3.2	85

*A001=Benchmark Fee

The Section put forward the following in support of their request.

- RVUs are defined as the product of the service time (in minutes) and service intensity (a scale of 1 to 5).
- RVU ratio was calculated relative to the benchmark code (A001), which was assumed to be appropriately valued relative to the other surveyed codes.
- This establishes a relative value-based ranking between the selected fee codes.
- This is the same process that was used in the 2019 MSPC allocation exercise to gauge undervalued fee codes and improve intra-sectional relativity
- This methodology for evaluating fee codes is based on the Resource-Based Relative Value Scale (RBRVS) Commission of Ontario methodology.
- Top and bottom 1% of reported times were trimmed to eliminate the impact of outlier values

The Committee discussed the following issues.

- Focus practice assessment (FPA) codes are currently in relativity with A007 Intermediate assessment and this should remain except where decided otherwise
- Time-based K-codes (e.g., K013, case conference codes, etc.) should remain in relativity except where decided otherwise; the Section was in support of this concept. See **Appendix II** for complete list of GP/FP time based codes.
- Some of the fee codes are under consideration by the Appropriateness Working Group (AWG), and as such consideration will be deferred until after AWG recommendations have been finalized (e.g., G370 and G371)
- Some of the fee codes, other Sections have proposed fee changes that will need to be reconciled (e.g., A005, G365, P003-P005)

Committee Comments:

- The OMSPC acknowledges the merits of the Section's Intrasectional relativity exercise.
- Deferred on the basis that some items are before AWG and other items compete with other recommendations
- OMSPC also notes that there may not be sufficient allocation to fund this proposal
- Please review Section on Obstetrics and Gynaecology and Primary Care Mental Health for common submissions requiring your Section's feedback.

17 General Surgery

17.1 Exxx Collaborating Surgeon Supplement

The Section requested a new collaborating surgeon supplement fee of $200.00 that would be payable in addition to assistant fees when the assistant is a general surgeon.

The fee would only be eligible for payment,

- When assisting another general surgeon with a complex case.
- Not to be billed by fellows in a teaching hospital.
- The collaborating surgeon must be the only assistant except in exceptional circumstances where more than one assistant is required for surgical reasons.
- The collaborating surgeon must be scrubbed for the majority of the case.
- These fee codes would not apply to common procedures such as gallbladders, appendixes, hernias or breast surgery
- May only be billed when the primary surgeon is performing one of the following codes.
    - Major Hepatic resections: S267, S270, S271
    - Major Pancreatic resections: S298, S299, S300, S304, S309
    - Paediatric Surgery index cases: S346, S347, S117, S118, S346, S347, S104, R352, S293, S348, S349, R993
    - Major colon and rectal resections: S166, S167, S168, S169, S171, S172, S213
    - Transplant surgery: S197, S202, S265, S266, S294, S295, S308
    - Gastric Surgery: S120, S122, S123, S125, S128, S129, S115, S114, S134, S139

The Section put forward the following in support of their request.

- The practice of surgery is gradually changing from independent surgeons who provide the sole care of their patients to collaborative practice models wherein a group of surgeons work together to provide comprehensive care, working together in the operating room for complex cases and sharing in the burden of postoperative care.
- Encourages general surgeons to assist each other in complex cases is a good model that has benefits for the patient, the surgeon and the system.
- Facilitates a mentoring model for junior staff and helps with complex intraoperative decision-making and is almost certainly more efficient in terms of duration of surgery.
- The learning process is bidirectional, and this facilitates introduction of new techniques. Importantly, for rare and complex cases, the exposed case volume can increase significantly.
- It improves the quality of postoperative care as on call partners are more likely to be fully aware of the patient's circumstances, and in general it makes the system more resilient.
- Quebec already has a similar model for complex cases, which they call "collaborating surgeon". Their system is much more generous than what we are proposing here and pays a substantial proportion of the primary surgeon's operating fee.
- This is not to be billed by fellows, as we do not view this as a method of funding fellowships, but rather as a mechanism to foster collaborative practice models, which is the reason for this restriction
- Would not apply it to surgeons whose primary practice is assisting, nor other non-surgeon surgical assists (MIG); again, the premise is bilateral operating and learning and collaboration in care
- Our current estimate is that only about 10% of such cases currently have a second surgeon currently assisting them. Our hope is that will gradually increase but we think it will be a slow transition that will take many years.

The Committee noted the following.

- An alternative option would be to create a percentage premium to be applied against the surgical assist fee. The committee acknowledged the Section's rationale behind a flat fee is that the differential earnings for assisting case per case are so variable.
- The Section on Cardiac Surgery supports the proposal and requested that all cardiac surgery codes should be applicable except take back for bleeding.
- The Section on General Thoracic Surgery supports the proposal and requested that the following surgical procedures be eligible:
    - Major lung resections such as M143, M144, M142, M145;
    - Major esophageal and Gastric procedures: S090, S089, S093, S123, S125, S128
    - Mediastinal tumour: M107, M106, M105
    - Major thoracic surgeries not covered by those: M133, M134, M132, M135
- The Section on Urology supports the proposal and is requested to provide a list of applicable surgical procedures.

Committee Comments:

- The OMSPC supports in principle the Sections on General Surgery, Cardiac Surgery and General Thoracic Surgery's request.

17.2 Rxx1 Level I Oncoplastic Lumpectomy (or partial mastectomy)

17.3 Rxx2 Level II Oncoplastic Lumpectomy (or partial mastectomy)

17.4 Rxx3 Level III Oncoplastic Breast Conserving Reduction Mammoplasty

The Section requested three new fees for oncoplastic breast surgery, as follows

Fee Code	Descriptor	Fee	Fee Rationale
Rxx1	Level 1 - Oncoplastic Lumpectomy (or partial mastectomy)	$404.10	R111 with 50% increase (1.5x R111), commensurate with incremental increase in BC Oncoplastic codes and calculated increased OR time in Ontario hospitals
Rxx2	Level 2 - Oncoplastic Lumpectomy (or partial mastectomy) (i.e.: round block/donut, racquet, batwing and VJ mammoplasty)	$538.80	R111 with 100% increase (2x R111), commensurate with incremental increase in BC Oncoplastic codes and increased OR time in Ontario hospitals
Rxx3	Level 3 - Oncoplastic Breast Conserving Reduction Mammoplasty	$808.20	R111 with 100% increase (2x R111), commensurate with incremental increase in BC Oncoplastic codes and increased OR time in Ontario hospitals

Notes:

- Rxx1 is for malignancy with closure of glandular defect including mobilization of breast parenchyma > 5 cm, advancement glandular flaps, skin flaps and layered closure- restricted to surgeons with appropriate training and/or mentoring.
- Rxx2 is for malignancy with closure of glandular defect including mobilization of breast parenchyma > 5 cm, rotational glandular flaps, skin flaps, layered closure. Must include

reduction in skin envelope AND nipple/areolar repositioning – restricted to surgeons with appropriate training and/or mentoring.

- Rxx3 to include Wise pattern reduction with local pedicle flaps, applicable to ipsilateral oncoplastic reduction procedure
- Contralateral balancing procedures would be billed under R143 and R144

The Section put forward the following in support of their request.

- Oncoplastic breast surgery is a new technique used to treat breast cancer, having evolved in Canada over the past decade and for which no OHIP codes currently exist.
- These techniques involve complex glandular rotational flaps in patients able to have breast conserving surgery, and time-consuming nipple and skin sparing mastectomy techniques that permit one stage immediate reconstruction in patients requiring mastectomy
- These new techniques take 1.5-3 times as much OR time, require significant additional training and expertise, and significantly improve patient outcomes.
- Female surgeons disproportionately operate on women and procedures that focus on women which, historically, have been lower paying. The majority of breast surgeons are female and advanced breast surgery fee codes are currently non-existent or under paid. Creating new oncoplastic breast surgery procedure fees would help address this disparity.
- The following table provides a summary overview of the Section's fee proposal:

The Committee noted the following.

- The Section on Plastic Surgery made a submission relating to complex breast reconstruction surgery and as such the committee is feels that two Sections should review each other's submissions and potentially collaborate on a joint submission

Committee Comments:

- The OMSPC supports in principle and requests that the Sections on Plastic Surgery and General Surgery develop a combined proposal that captures all services relevant to oncoplastic breast surgery. See Plastic Surgery's submission item #42.7.

17.5 Surgical unbundling

The Section is requesting a revision to the Surgical Preamble to allow pre- and post-operative care and visits to be billed.

The Section put forward the following in support of their request.

- Currently, under the SOB, any in-hospital billings on a patient perioperatively (2 days preop and 14 days post op) are rejected and are seen to be "bundled" into the surgical fee code with the exception of visits for post-operative day 1 and 2 (C032) and for day of discharge (C124).
- With the advent of Enhanced Recovery After Surgery programs, "prehabilitation" for elderly patients, and significant changes in post-operative care of patients, average lengths of stays for surgery are significantly decreasing.
- Currently almost all elective general surgical patients are admitted the day of surgery. As such, care provided for patients in hospital preoperatively, is almost always for emergency cases, where a decision to operate is made after admission, not before.

- These people are being actively cared for non-operatively by surgeons until such time as that route of care is no longer effective and surgery is required.
- Obvious examples of this are acute diseases such as bowel obstructions, diverticulitis and pancreatitis to name but a few. This care should not be offset by an operative fee if that operation is required. It may have made sense when admission was part of preparation for elective surgery, but that is no longer the case.
- Patients admitted with emergent conditions that later may require surgery require ongoing care and management that is outside the "routine" of preoperative care. These patients are not admitted to "optimize" them for an elective operation. They are often sick and require significant care and are not all planned to go to the operating room.
- With current perioperative care plans, and significant changes in perioperative care, any patient in hospital longer than 7 days has a reason that requires active care and should not be included in the "routine" postoperative care that is bundled into the surgical fee.

The Committee noted the following.

- The Section on General Surgery has requested that this submission be deferred and request that a committee be struck to formulate a proposal over the next 2.5 years comprised of all surgical sections, OMA Economic/Tariff and other appropriate parties to work towards unbundling surgical fees. Further, this should be negotiated monies outside of surgical section's specific allocation funding, similar to previous MRP codes, and obesity premium codes.
- The Section on Vascular Surgery made the same request. See Vascular Surgery item #54.6.
- The Sections on Cardiac Surgery, General Thoracic Surgery and Urology supports the proposal.

Committee Comments:

- The OMSPC supports in principle and recommends consultation with affected Sections prior to final recommendation.
- The committee defers a decision until cost estimates can be examined.

17.6 E523 repair of abdominal defect by same surgeon, under myocutaneous flaps
17.7 R155 Latissimus dorsi or unilateral rectus abdominus, under myocutaneus flaps
17.8 S340 Ventral -post-operative
17.9 S344 Massive incisional hernia
17.10 E793 laparoscopic or laparoscopic assisted, to S344, add 25% - (no change)
17.11 E725 - recurrent hernia - all types, except oesophageal - add $130 - (no change)

The Section is requesting modernization of the abdominal wall hernia fee codes by,

- Moving the fee codes to be listed under a new heading
- Revising descriptors to reflect current practice
- No change in fee values

The new fee listing would be as follows:

Ventral hernia
S340 Ventral - post-operative/incisional hernia, maximum transverse diameter less than 5 cm

S344 ~~Massive incisional hernia~~ Ventral - post-operative/incisional hernia, maximum transverse diameter 5 cm or more
E793 - laparoscopic or laparoscopic assisted, to S344, add 25%
E725 - recurrent hernia - all types, except oesophageal - add $130

Note:

1. Functional reconstruction of abdominal wall by muscular component separation and advancement flap - hernia defect less than 10 cm in transverse diameter - Add E523 to S340 or S344
2. Functional reconstruction of abdominal wall by muscular component separation and advancement flap - hernia defect 10 cm or more in transverse diameter - Add R155 at 85%, per side released, to S344
3. If removal or explanation of existing mesh, use Z115 (removal foreign body – general anaesthetic

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request.

- The area of abdominal reconstruction (ventral hernia repair) has greatly evolved over the last 20 years, but the fee-schedule has not.
- The purpose is to streamline and simplify the schedule section that deals with ventral/incisional codes, mostly by creating definitions that are non-existent in the current language. These definitions will limit the potential for abuse of certain codes.
- The current codes are poorly defined, poorly formatted, and confusing; fixing all this would be easy and quick and practical.
- One very obvious example is the fact that the code "S344 - Massive incisional hernia" does not have any further descriptor. There is no definition or suggestion of what the term "massive" entails, nor is the word "massive" the most appropriate, since we are referring to size, not mass.
- This is a cost neutral exercise.

Committee Comments:

- The OMSPC supports in principle.

17.12 Z571 Excision of first polyp greater than or equal to 3mm through colonoscope
17.13 E720 -each additional polyp greater than or equal to 3mm (maximum of 2)
17.14 Zxxx Excision of first polyp 1 cm to 2 cm
17.15 Exxx - excision of each additional polyp 1 cm to 2 cm
17.16 Zxxx Excision of first polyp 2.1 cm to 3 cm
17.17 Exxx - excision of each additional polyp 2.1 cm to 3 cm

The Section is requesting modernization of the colonoscopy/polypectomy fee codes by,

- Revising Z571 and E720 descriptors for excisions of polyps less than 10 mm,
- Creating new fee codes for excisions of polyps 1 – 2 cm and 2.1 3 cm, and
- No change in fee values

The new fee listing would be as follows:

Z571 Excision of first polyp less than 10 mm ~~greater than or equal to 3mm~~ through colonoscope - $150.15
E720 - each additional polyp less than 10 mm ~~greater than or equal to 3mm~~ (maximum of 2), add - $77.50
Zxx1 Excision of first polyp 1 cm to 2 cm - $150.15
Exx1 excision of each additional polyp 1 cm to 2 cm, (maximum of 2), add - $77.50
Zxx2 Excision of first polyp 2.1 cm to 3 cm - $150.15
Exx2 excision of each additional polyp 2.1 cm to 3 cm, (maximum of 2), add - $77.50

Payment Rules:

1. When multiple polyps between 3 mm and 3 cm are removed, all polypectomies should be billed with the appropriate Z code (Z571, Z572, Z573. Only one of Z571, Z572, Z573 is payable per patient per day.
2. When multiple polyps between 3 mm and 3 cm are removed, all subsequent polypectomies should be billed using the appropriate E code (E720, E913, E914) based on size of the subsequent polyp regardless of the initial Z polypectomy code. Only two of these services is payable per patient per day.
3. Z571 and E720 are not billable for polyps under 3mm in size

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request.

- Would like to focus on establishing revenue neutral tracking codes for colonoscopic polypectomy that will enable subsequent changes to be made in an informed environment.
- A number of factors contribute to this need, including advances in technology such as high definition colonoscopes with enhanced features, and an improved knowledge base around challenging and advanced adenomas including flat and depressed polyps.
- Clinical guidelines for polypectomy including the raising of polyps, snare polypectomy and hemostatic techniques are evolving and changing. Indeed, endoscopic polypectomy has progressed to the point where surgery for large or advanced polyps, previously common, has become very rare.
- The current set of billing codes is not sufficiently granular to properly remunerate for endoscopic polypectomy. In particular, there is currently one billing code – Z571 – that covers polypectomy for polyps between 3 mm and 3 cm, whereas the complexity and work effort of polyps on the extreme ends of this range varies significantly.
- There should be more stratification of polyp sizes for billing purposes.
- We are hoping to create a stratification that most closely mirrors clinical guidelines and time and work effort.
- Propose setting up a set of tracking codes, stratifying polyps between 3 mm and 3 cm (currently covered by a single fee), which will continue to be paid according to currently established fees, but will allow us to track utilization of these codes.
- Similarly, we will undertake, in parallel, research on relative complexity, time and work effort differences in these procedures to help guide a future funding allocation or re-allocation, which we hope can be acted upon within 1-2 years.

- Our Section feels very strongly that an overhaul of all of the endoscopy codes needs to occur and requires a group of endoscopists, and endoscopy leaders working with OMA economics and the Ministry to overhaul this section.

Committee Comments:

- The OMSPC supports in principle and requests a combined submission from the Sections on General Surgery and Gastroenterology to modernize the colonoscopy and polypectomy fee listing, to include all aspects of their proposals (i.e., re-write of OHIP Schedule page S19 accordingly).
- Please see Gastroenterology's submission item #14.2-14.3.

17.18 A034 Partial assessment

17.19 A033 Specific assessment

17.20 A0xx Assessments of greater than 30 minutes

The Section is requesting modernization of their menu of assessment fees as follows,

- Revise A034 Partial assessment to a time-based fee taking less than 15 minutes (no change in fee value),
- Revise A033 Specific assessment to a time-based fee taking between 15 and 30 minutes (no change in fee value), and
- Create new code A0xx – assessments of greater than 30 minutes at a fee of $67.75

The Section put forward the following in support of their request.

- The definitions in the OHIP Schedule for partial and specific assessments are effectively the same.
- The gender billing gap has identified "time spent" as a contributing factor. By making our assessment codes time based, it will better represent the value associated with them, as well as attempt to address the gender billing gap.
- The new code for greater than 30 minutes is less costly than the current counselling codes (e.g., K013/K040) that are currently billed.
- For the newly suggested code A0xx it is comparable to counselling codes K013/K040 (Paid in time units of ½ hour or major part thereof at $67.75 per unit)

The Committee noted the following.

- Contemplated idea of creating a single time-based assessment code to accommodate for the variability of time
- Other Sections have proposed "complexity" add-on fees billable with an assessment fee where minimum time requirements are met.

Committee Comments:

- The OMSPC supports in principle.

18 General Thoracic Surgery

18.1 Intrapleural Thrombolysis

The Section requested a new code for Intrapleural Thrombolysis at $250.

The Section put forward the following in support of their request:

- In empyema, this procedure is provided to avoid surgery and involves instilling TPA or equivalent into the pleural space.
- The procedure is similar to other minor thoracic procedures (relative to lobectomy).
- The process involves sterile prepping the existing pleural drain, mixing the thrombolytic agent (which is done by the physician, as it needs to be fresh), puncturing the tube, injecting the agent, repairing the tube afterwards, hooking it back up to the drainage system and then watching for complications.
- It is estimated that the procedure is provided 50-80 times per year per the 20 thoracic institutions.
- In response to the committee, the Section explained that Z339 is intercostal drainage under general anaesthesia, and this procedure is not done under a GA, rather it is done at the bedside.
- In terms of procedure, it is most similar to Z349 (administration of intrapleural sclerosing agent) but takes twice as long and has much more risk in terms of complications. Therefore, the proposed fee of approximately $50, which is roughly double that of Z349

Committee Comments:

- The OMSPC supports in principle the creation of the new code but at a fee of $50.00 based on the Sections statement that it is approximately double the value of Z349 ($23.25).

18.2 Zxxx Removal of chest tube

The Section requested a new fee code for removal of indwelling chest tube at $100.

The Section put forward the following in support of their request:

- Z341 is the chest tube insertion code, and it pays $76.80; the proposed fee us half the chest tube insertion fee, which is $38.00
- Thoracic surgeons are often referred patients with chest tubes already in place. The management and removal of these tubes are not insignificant.
- The procedure involved interpreting the chest Xray, removing the tube and closing the hole. Getting another cxr and looking at it and then sending the patient off.
- Similar to minor thoracic procedure like a bronchoscopy.
- Service is not currently billed under another code or Independent Consideration.
- It is estimated that the procedure is provided 200 times per year per the 20 thoracic institutions.
- Chest tube removal is another time consuming, non-renumerated procedure that is done by thoracic surgeons. If done incorrectly, it can lead to complications which can then lead to morbidity and possible repeat procedures.
- It requires a sterile technique to prevent complications and therefore can be only done by a physician.

Committee Comments:

- The OMSPC supports in principle the creation of the new code but at a fee of $38.00 based on the Sections statement that it is approximately half the value of Z341 ($76.80).
- The OMSPC recommends adding clarifying language to the descriptor for Z341 as follows, "Insertion of chest tube for closed drainage effusion or pneumothorax"
- The Section on Cardiac Surgery supports the proposal.

18.3 Zxxx Diaphragm Plication

The Section requested a new code for Diaphragm Plication at $900.

The Section put forward the following in support of their request:

- Presently there is no fee code for the plication of the diaphragm, which is medically indicated for diaphragm paralysis. This paralysis can either be iatrogenic (post cardiac surgery), neoplastic (i.e., thymoma or lung cancer) or else idiopathic.
- Diaphragm plication is currently billed by most of us as repair of ruptured diaphragm (M132 Thoraocotomy for repair of diaphragm rupture - $507.45), which is not technically correct but it is the closest fee that approximates the procedure.
- Suture repair of a torn diaphragm is a much easier operation than a plication, however, and we feel the renumeration for this is too low. Plus the diaphragm plication is more time consuming and requires more pre and post operative care.
- The plication is more involved than a simple repair. On average it takes more than the amount of time as a wedge resection. There should be a VATS or minimally invasive modifier for this procedure as well.
- Diaphragm plication is a well recognized technique to manage diaphragm paralysis. The paralyzed diaphragm contributes to chronic dypsnea because it is a flaccid structure that negates the work of breathing. Negative pressure inside the chest would result in pulling the abdominal contents into the chest, and therefore patients often have orthopnea or exertional dyspnea. Plication creates a taut diaphragm surface which improves the FEV1/FVC on average 15-25%. These results are durable and result in significant improvement in patient outcomes. Often times, patients can come off of CPAP at night, and are able to return to work.
- It requires several meetings beforehand, and analysis of spirometry, CT scan, and fluoroscopy data. Technically, it can be quite challenging to do the procedure and there is risk of injury to the heart, intraabdominal organs and lung.
- The post operative care can be complex, and they can have delayed pleural effusions. They are in hospital on average for 2 days.
- Comparable fees:
    - M132 Thoracotomy for repair of diaphragm rupture - $507.45
    - M145 Wedge resection of lung - $843.40
- It is estimated that the procedure is performed roughly 1-2 times per year. There are many patients who do not fit the diagnostic criteria for this procedure.

Committee Comments:

- The OMSPC supports in principle.

18.4 S096 Ruptured oesophagus, suture and drainage

The Section requested an increase to S096 Ruptured oeseophagus, suture and drainage from $661.65 to $1,000.00.

The Section put forward the following in support of their request:

- This procedure is grossly underpaid. These patients are usually catastrophically unwell from mediastinal sepsis. There is often a lot of work involved in assessment and resuscitation of the patient which extends into the post operative period.
- The procedure is often very difficult, due to the exposure which is a low thoracotomy, or else VATS, and the repair is extremely delicate. Often times, there is required a intercostal muscle for safe repair or else pericardial fat pad and this modifier should be permitted as well.
- Patients are usually extremely sick with Booerhaave's syndrome who presents with mediastinal sepsis, usually transferred from an outside facility for specialist consult.
- The risk to the patient and the stress of the surgeon are very high. This is a very delicate procedure as the esophageal mucosa tears easily, even more easily when it is inflamed. And yet, it pays about the same as a closure of a duodenal ulcer, which is much simpler to perform, and the patients are not as acute nor do they stay in hospital as long as these patients do.
- Comparable fee codes:
    - S089 Partial esophageal resection - $1,180.50
    - S090 Total thoracic oesophageal resection - $1,912.30
    - S139 Gastrorrhaphy - $672.75.
- The procedure presently pays about the same as Gastorrhaphy, which is a much simpler procedure to do, does not require an intercostal muscle transfer, and the patients often aren't as septic, and they do very well in the post operative period.
- It is also a much easier exposure (laparotomy vs. thoracotomy). The time required is roughly double or three times that of the gastric or duodenal ulcer repair.
- The workup, exposure, and time required to do this procedure is around the same as a partial resection.

Committee Comments:

- The OMSPC supports in principle.

18.5 Zxxx Repair of Massive Paraesophageal Hernia with Complete Intrathoracic Stomach or Herniation of other organ through crus

The Section requested a new code for Repair of Massive Paraesophageal Hernia with Complete Intrathoracic Stomach or Herniation of other organ through crus at $1,100.00.

The Section put forward the following in support of their request:

- The fee is not intended to include reduction of hernia with gastropexy (the so-called Boerma procedure) and is intended to be billed a massive hiatus hernia (greater than 50% stomach intrathoracic) or herniation of another organ.
- At present, repair of hiatus hernia is offered as the same fee Schedule code as a massive hiatus hernia (S091 - $750.00). However, a massive hiatus hernia takes roughly twice as long as the standard, non-massive hernia, and it is much more difficult, with a higher chance of complications.

- A typical patient will present either electively or emergently with a giant hiatus hernia and require repair.
- This is a very difficult operation, even for experienced thoracic surgeons. There are often adhesions to the crus, aorta and pleura that make the surgery very technically challenging.
- You have to also remove the sac from the mediastinum, and the risk of injury to these structures are high. You also have to deal with scarred tissues, that often are adherent to critical structures. It is very stressful, much more stressful than a standard hernia repair.
- Comparable codes:
    - S091 Abdominal or transthoracic approach with fundal plication - $750
    - S089 Partial esophageal resection and reconstruction - $1,180
- A standard hiatus hernia (2-3 cm in size) is a much easier operation than a massive hiatus hernia. The adhesions are much more dense and there is a higher risk of injury.
- The operation takes roughly 2x or 2.5x as long to do, and it is paid exactly the same.
- The amount of dissection and the amount of time required for this procedure is roughly the same as a S089, hence the proposed billing code.
- The median surgical time is roughly 4 hours, making it roughly on par with S089, and on par with M143 (lobectomy - $1,402.60).
- This procedure has been performed for as long as we have been doing hiatus hernias (over 40 years) however, the complexity of a massive hernia repaired properly is now being recognized as much more difficult.
- It is estimated that the procedure is performed roughly 5-10 times per year per surgeon, however, it would supplant the other code, S091 for larger hernias.

Committee Comments:

- The OMSPC supports in principle.

18.6 M142 Pneumonectomy

The Section requested a fee increase to M142 Pneumonectomy from $1485.40 to $1600.00.

The Section put forward the following in support of their request:

- M142 is only $83 more than the regular lobectomy (M143 - $1,402.60). However, in this era, pneumonectomy is only performed if there is a large aggressive tumour, and therefore the case complexity is much higher in 2021 than previously.
- Previously, when the operation was done open, the two techniques were comparable. Now, the indications to perform pneumonectomy are for large, proximal tumours.

Committee Comments:

- The OMSPC supports in principle.

18.7 E613 Sleeve pneumonectomy

The Section requested a fee increase to E613 Sleeve pneumonectomy from $248.40 to $500.00

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that the fee is undervalued

- A sleeve pneumonectomy is an extremely challenging operation, with a high risk of injury and a long, complicated post operative course.
- Pneumonectomy has become more difficult since in the modern era, only the most proximal and difficult to remove tumours are getting a pneumonectomy.
- Therefore, we are doing much less of this procedure, but when it does occur, it is usually very risky and also much more difficult

Committee Comments:

- The OMSPC supports in principle.

18.8 E615 Intrapericardial dissection

The Section requested a fee increase to E615 Intrapericardial dissection from $120.80 to $250.00

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that the fee is undervalued
- Any lung resection that requires intrapericardial dissection is by definition a high risk, difficult surgery, with a chance of major post operative complications.
- Pneumonectomy has become more difficult since in the modern era, only the most proximal and difficult to remove tumours are getting a pneumonectomy. Therefore, we are doing much less of this procedure, but when it does occur, it is usually very risky and also much more difficult

Committee Comments:

- The OMSPC supports in principle.

18.9 S092 Recurrent Hiatus Hernia

The Section requested a fee increase to S092 Recurrent Hiatus Hernia from $709.85 to $1000.00.

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results indicated that the fee is undervalued
- There is ample data that recurrent laparoscopic hiatus hernia surgery is more difficult, takes a longer amount of time, and is more fraught with complications than primary repair and yet it is presently billed as being lower than a primary repair (S091 - $750.00). This does not make sense, and it should be corrected.

Committee Comments:

- The OMSPC supports in principle.

18.10 Zxxx Uniportal or Robotic Assisted Thoracic Surgery

The Section requested a new 30% premium modifier “Surgery performed by Uniportal or Robotic Assisted Surgery” to be billed in place of E683 (when performed thorascopically or by video-assisted thoracic surgery (VATS)).

The Section put forward the following in support of their request:

- There is emerging data to suggesting that uniportal VATS and Robotic assisted surgery result in a faster recovery, with a similar oncologic outcome.
- Similar to VATS except via a single port or using robotic assisted techniques.
- The skill set requires a modification of the existing minimally invasive techniques to accommodate either a single incision or else robotic surgery.
- Comparable code to E683 that pays a premium of 28%; we propose an additional 2% increase.

The OMSPC noted the following

- The OMSPC discussed with the Section and there was agreement to expand E683 descriptor to include adding "robotic and uniportal approaches" and increase the premium from 28% to 30%

Committee Comments:

- The OMSPC proposes adding "robotic and uniportal approaches" to E683 and increasing E683 from 28% to 30%.

18.11 E644 - radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy

The Section requested a fee increase to E644 Radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy from $207.45 to $350.00 and to allow it to be claimed with S128 Total gastrectomy.

The Section put forward the following in support of their request:

- Presently, this code is being used for proximal gastrectomy, as well as esophagectomy and lobectomy/pneumonectomy.
- The addition of preoperative chemotherapy and radiation has been the single biggest advance in esophageal and gastric surgery in the last decade. It has been proven to improve patient outcomes and increase odds of cure.
- However, it is not well renumerated, despite being much more difficult a procedure, with a higher risk of complications.
- It is not eligible to be paid with total gastrectomy, whereas it is for proximal gastrectomy (total gastrectomy includes the same lymph node dissection as a proximal gastrectomy), which does not make sense.
- The addition of chemo/radiation therapy makes the dissection much more difficult, with a greater chance of injury to the surrounding structures and also complications.

Committee Comments:

- The OMSPC supports in principle.

19 Genetics

19.1 Kxxx Genetic Clinical Analysis and Care Planning

The Section requested a new time based fee code Kxxx for Genetic Clinical Analysis and Care Planning at $44.00 per 10 minutes with a maximum of 8 units per physician, per patient, per 12-month period.

The Section put forward the following in support of their request:

- Genetic Clinical Analysis and Care planning is a time-based service that includes: diagnosis, prognosis and treatment recommendations for rare disease care. It requires the assessment of the patient history and/or relevant genetic or metabolic testing to inform the above and documentation of the recommendations or treatment. This may also include oversight of rare disease care and health maintenance, information or recommendations regarding reproductive planning.
- The service can only be provided following a written request for opinion from the patient's physician OR are acting as the most responsible Geneticist for the patient's care.
- Genetic technology has advanced incredibly rapidly and has outpaced the current Schedule of Benefits.
- In order to update our section of the Schedule to reflect the evolution of our specialty, we recommend removal of K223 and replacement with the above-described new code.
- It is now common that a Geneticist encounters patients with unique or extremely rare conditions for which 'standard' care or experience does not exist and these recommendations are made exclusively by Geneticists.
- This new code will better reflect the current level of complexity and scope for the work provided to patients by Geneticists. The code encompasses the activities of these codes (e.g. assessment of the patient related data without direct patient contact) but also other care planning that is not currently covered by the Schedule of Benefits that is based on innovations in our field.
- Genetic care includes work done for a patient outside of direct patient contact for which we currently have no ability to bill. Examples include (but not limited to):
    - Determination of the most appropriate course of genetic testing (matching the patient phenotype to genotypes). This reduces the number of inappropriate tests, as an example of efficiency.
    - Planning the surveillance and recommended care for the patient with rare disease, given that technology has advanced to make diagnoses but no clinical practice guidelines exist.
    - Assessing the patient's clinical information to provide risk assessments for reproductive planning/family and providing a written opinion.
    - Due to advances in technology and genetic complexity of rare patients, we are making more diagnosing of rare conditions that require active management. It is 2-4 hours of non-patient facing care per complex patient.
- Similar codes exist for other specialties such as: Radiation Oncology code X310 and X322 treatment planning and dosage calculation in recommendation of any special treatment Laboratory Medicine/Pathology code A585 Review of slides and providing a written opinion.
- The risk and stress associated with the interpretation can be exemplified by interpreting genetic testing results where a diagnosis would change management drastically (e.g. in the context of a pregnancy when termination is being considered). It would be creating individualized risk assessments and care plans for patients with rare disease and potentially family members as well. This service is similar in intensity to a consultation (A220/223/225).
- Currently there is no comparable fee code. Often this service is not remunerated. Some of the service is functionally addressed by K223 by Geneticists as it is the closest approximation,

however the intensity of work due changes in technology and clinical practice has become similar to a consultation (A220/223/225).

- The value was based on the per minute billing time used from the fee we have previously used as a benchmark fee code (A223). Our other time-based code, A220 is $40 per 10 minutes. Therefore, our work, when valued in accordance with time, lands in the range of $40-$44 which is how we selected our proposed fee value.

The OMSPC noted the following

- The committee acknowledges the Section's explanation that the proposed service is not part of the consultation. It is the care planning that happens after a consultation, diagnosis and investigations or perhaps in between follow up visits.
- As there are no standards of practice or clinical practice guidelines in our discipline, Geneticists must review all the patient and medical literature and then develop a plan of care. This is separate from a consultation (A225) or interpretation of a result (K229).

Committee Comments:

- The OMSPC supports in principle.

19.2 K223 Clinical Interpretation

19.3 K044 Genetic Family Counselling

19.4 K016 Genetic assessment, patient or family

19.5 A221 Genetic minor assessment

19.6 A325 Limited consultation

The Section requested that the following fee codes be delisted:

- K223 Clinical interpretation ($38.20)
- K044 Genetic family counselling ($62.75)
- K016 Genetic assessment, patient or family ($74.05)
- A221 Genetic minor assessment ($38.05)
- A325 Limited consultation ($105.26)

The Section put forward the following in support of their request:

- Due to rapid advances in genetic technology our practice has changed. These codes are ineffective at capturing the work that is being done. As a result, codes K014, K016, A221, A325 are essentially not billed by our members (total billing in 2019-2020 fiscal year was a total of $1505)
- Therefore, to streamline our portion of the Schedule of Benefits we recommend their removal.
- For K223, we have proposed a new more comprehensive code that would better capture the work of a Geneticist.
- For the majority of these codes (with the exception of K223, which is widely used and our third most billed code) the membership use data does not support their value for the typical genetics encounter.
- The typical K223 use is currently limited to a patient encounter for which a genetics opinion is sought and an opinion/recommendations are provided in writing, but the Geneticist does not meet the patient.

Committee Comments:

- The OMSPC supports in principle provided that the replacement code is approved.

19.7 K222 Genetic care, patient or family

The Section requested an increase to K222 Genetic care, patient or family from $75.75 to $106.50 (40.6%).

The Section put forward the following in support of their request:

- This code is undervalued and does not reflect current practice needs nor the advances in technology for genetics.
- K222 shares the same reality as for A225 many more diagnoses, averaging around 50%. This has resulted in more time needed to explain complex results, patient management and family implications.
- The level of complexity of most patients requires significant patient facing time in comparison to other disciplines.
- There is a disparity in the remuneration of consults, which range from ($2.79/min-4.45/min) versus the follow up within Genetics ($2.5/min), which is no less complex than an initial consult. Increasing K222 would provide a fairer balance of remuneration for equally complex work.
- K222 follow-up care is often more complex than the initial consult and requires many of the same elements as the consultation.
- Comparator codes include
    - A220 Special genetic consultation Special genetic consultation is a consultation in which the physician provides all the elements of a consultation and spends a minimum of 75 minutes of direct contact with the patient with or without family - $300.70
    - A223 Extended special genetic consultation (considered our 'benchmark code') is a consultation in which the physician provides all the elements of a consultation (A225) and spends a minimum of 90 minutes of direct contact with the patient with or without family - $401.30.

Committee Comments:

- The OMSPC supports in principle.

19.8 A225 Consultation

The Section requested a fee increase to A225 Consultation from $167.35 to $213.00 (27.3%).

The Section put forward the following in support of their request:

- Genetics is primarily a consultative practice, and the A225 code is our most billed code.
- This code is significantly undervalued.
- The patient population seen in genetics has changed; when this code was initially created, the level of complexity and available testing options for patients was limited (e.g. undergoing a karyotype only)
- Many of the patients that have more 'straightforward' diagnoses are obtaining assessments and genetic testing through our non-Geneticist colleagues.

- The remaining patients referred to Genetics are both more complex, moreover testing technology has evolved dramatically and along with an ever-expanding understanding of the genetic contributions to human disease.
- The level of complexity of most patients requires significant patient facing time in comparison to other disciplines. The majority of our patients require a full hour.
- There is a disparity in the remuneration of consults within Genetics, in that a shorter consultation is compensated at $167.35 ($2.79/min), while a special consult, (75 min) is $300.70 ($4/min) and the extended consult (90 min) is $401.30 ($4.45/min).
- Increasing A225 would provide a fairer balance of remuneration, and while continuing to encourage efficiency and keeping wait times reasonable.
- The value was based on the per/min billing time used from the current code to bring it in line with A220 and A223, making the remuneration per minute of 3.55, 4.00 and 4.45 respectively.
- Our other time-based code, A220 is $40/10min. Therefore, our work, when valued in accordance with time, lands in the range of $4/min but we adjusted for the difference of the extended code which is how we selected our proposed fee value.
- A comparable code, A195 is found in Psychiatry, which is currently remunerated at $215.65. This would also seem to be comparable to the amount of patient facing time with the complex patient.

Committee Comments:

- The OMSPC supports in principle.

20 Geriatric Medicine

20.1 A075 Consultation

The Section requested a fee increase to A075 Consultation from $183.30 to $215.65.

The Section put forward the following in support of their request:

- Results of the 2021 intra-sectional relativity survey results indicate that the average service time to provide this service (pre-, intra-, and post-service) is 86 minutes, with the mean being 75 minutes
- Despite this not being a time-based code, on average it takes Geriatricians longer than the dedicated 75-minute code (A775) and yet we are only requesting an increase that is still 28% less than that time-based code
- The intensity assigned in the survey to this code on average was 5 (i.e., the highest intensity)
- This service is therefore grossly undervalued given the service time that Geriatricians spend providing this service and the skill and intensity that it demands
- For comparison, note that the equivalent Psychiatry A195 consultation code is remunerated at $215.65

Committee Comments:

- The OMSPC supports in principle.

20.2 C/W075 Consultation

20.3 A070 Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient

The Section requested a fee increase to C/W075 Consultation and A070 Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient from $203.30 to $251.70.

The Section put forward the following in support of their request:

- Admitted Geriatric patients (be it at a hospital in the ER or at a Long-Term Care facility) are significantly more complicated with multiple comorbidities that require more time and effort towards their management
- Their assessments also often entail significant family and patient counselling, as well as interfacing with allied health team members and attending specialists
- Complex patient characteristics greatly influence the additional time required and should be recognized accordingly – a higher fee is needed to correct this inequity
- The current remuneration is grossly undervalued given the time and skill that it demands
- For comparison, note that the equivalent Psychiatry A895 consultation code is remunerated at $251.70

Committee Comments:

- The OMSPC supports in principle.

20.4 A775 Comprehensive geriatric consultation

The Section requested a revision to A775 Comprehensive geriatric consultation ($300.70) by removing payment rule "The consultation must be scheduled at least one day before the service is rendered."

The Section put forward the following in support of their request:

- The results of the 2021 intra-sectional relativity survey results indicate that Geriatricians frequently spend more than 75 minutes on patient assessments
- However, they are precluded from using the A775 code, especially in the inpatient setting, because of its requirement that it be pre-booked
- Geriatricians are therefore not appropriately compensated for work despite clearly spending a significant amount of time with their complex patients
- We make note that the Internal Medicine code equivalent A130 (with the same remuneration of $300.70) has no similar pre-booking requirement
- We also make note that the Neurology code equivalent A180 (with the same remuneration of $300.70) has no similar pre-booking requirement

Committee Comments:

- The OMSPC supports in principle.

20.5 A/C073 Medical specific assessment

The Section requested an increase to the annual limit for A/C073 Medical specific assessment from 1 to 2 per year.

The Section put forward the following in support of their request:

- Specific assessments or medical specific assessments are limited to one per patient per physician per 12-month period unless either of the following circumstances are met in which case the limit is increased to two per patient per physician per 12-month period.
- Our patients are complex and need interval reassessments. Currently we spend significant time with our patients doing complex assessments but bill lower codes despite spending almost an hour with each patient.
- This service is a detailed interval reassessment for patients with multiple complex medical conditions. It often involves care of patients with dementia which is a multifaceted and complex disease. As geriatricians, we cover multiple medical issues and address the complex needs of our patients. This is a very time intensive process to ensure excellent outcomes and reduce future healthcare needs with proactive approaches.
- Results of the 2021 intra-sectional relativity survey results indicate that the average service time to provide this service (pre- intra- and post-service) is 55 minutes with a median intensity of 4

The Committee noted the following.

- Annual limits for medical specific assessments are outlined in the General Preamble and, as such, a new code may need to be created if General Preamble payment rules cannot be modified.

Committee Comments:

- The OMSPC supports in principle.

20.6 A/C/W071 Complex medical specific re-assessment

The Section requested the following changes to A071 Complex medical specific re-assessment,

(a) A fee increase from $84.35 to $97.00 and
(b) Revision to the annual limit from 4 per patient per 12-month period to 8 per patient per 12-month period

The Section put forward the following in support of their fee increase request:

- Results of the 2021 intra-sectional relativity survey results indicate that the average service time to provide this service (pre- intra- and post-service) is 53 minutes, with the mean being 50 minutes
- This code was also identified by the survey as being the most severely undervalued of the most used geriatric assessment codes
- The section requests a 15% increase in the code to address ongoing concerns regarding its being undervalued

The Section put forward the following in support of their limit increase request:

- Our patients are complex and need interval reassessments. Currently we spend significant time with our patients doing complex assessments but bill lower codes despite spending almost an hour with each patient.

- Geriatric Medicine patients require interval repeat assessments that are time intensive
- Results of the 2021 intra-sectional relativity survey results indicate that the average service time to provide this service (pre- intra- and post-service) is 53 minutes with a median intensity of 4
- To provide good comprehensive care for frail older adults we must continue to provide high quality, time intensive care more often than the codes currently allows and therefore the section is requesting the descriptor be modified to reflect current Geriatric practice for fairer compensation

Committee Comments:

- The OMSPC supports in principle.

21 Haematology & Medical Oncology

21.1 Axxx Systemic Therapy planning

The Section requested a new fee for Systemic Therapy planning at $125.00.

The Section put forward the following in support of their request:

- The treatment of cancer has evolved substantially over the last decade. Medical and Haematology Oncologists are tasked with the management of an increasingly complicated patients.
- For oncologists to determine the most appropriate curative or palliative treatment plan, they are often required to coordinate care with Surgical and Radiation Oncologists, consult diagnostic services such as radiology, anatomic pathology, molecular pathology.
- They are often required to coordinate, attend and participate in multidisciplinary case conferences.
- Oncologists are spending significant amount of time obtaining, interpreting, and implementing the results of this testing.
- This Treatment planning process cannot be performed during the time allotted by the OHIP fee schedule during consultations and follow up visits.
- Often patients with cancer are treated with multiple lines of therapy. Each change in a patient's treatment needs to be determined in this complex/time consuming process.
- This is similar to the Treatment Planning done for cancer by our colleagues in Radiation Oncology (OHIP fee codes X310, X311, X312, X313). We propose a new code for Medical and Haematology oncologists for treatment planning. We feel that this should be billable for the initial and subsequent lines of therapy

The Committee noted the following.

- The committee wondered if an alternative approach would be to create a time-based fee to compensate for work outside of direct patient care.
- The Section considered the committee's suggestion to create a time based code but it was very clear that such an approach would not be pragmatic. Much of the planning for treatment occurs asynchronously so the thought was it would be too time consuming and administratively burdensome to time based bill given the sheer volume of patients.

Committee Comments:

- The OMSPC supports in principle.

21.2 A615 Consultation

The Section requested a fee increase to A615 Consultation from $168.50 to $175.00 (3.9%).

The Section put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results supported the proposed fee increase

Committee Comments:

- The OMSPC supports in principle.

21.3 Z403 Bone marrow aspiration

The Section initially requested a fee increase to Z403 Bone marrow aspiration from $42.40 to $79.20 (86.8%). The Section supports the committee's suggestion to combine Z403 and Z408 into a single code with the following new descriptor "bone marrow aspiration and biopsy" at a fee of $122.10.

The Section put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results supported the proposed fee increase and was ranked by their members as the third most time intensive activity performed by haematologists
- The Ministry does not payment of both Z403 Bone marrow aspiration ($42.40) and Z408 Bone marrow biopsy ($79.20) together, although they are typically performed concurrently with Z403 typically occurring first.
- The Z403 (aspiration) requires landmarking, freezing the bone and obtaining a liquid marrow sample.
- Once this part of the procedure is completed, the bone marrow biopsy (Z408) is performed either via the same site as the aspiration, or in close proximity.
- Rarely haematologists perform only an aspirate bone marrow, such as when the site is the sternal region. In the vast majority of cases, both aspirate and biopsy of the bone marrow are performed for both diagnostic and follow-up purposes
- The Section is supportive of combining these two codes into a single code to streamline billing and to reflect the reality of the procedure.

The Committee noted the following.

- Consideration was given to combining the codes into a single fee of $122.10 (Z403 + Z408 = $42.40 + $79.90); this is an option that could address the Section's request.
- The new descriptor could be "bone marrow aspiration and/or core biopsy" and one of the codes could be delisted
- Further consideration is needed on circumstances where only one of bone marrow aspiration or core biopsy is performed.

Committee Comments:

- The OMSPC recommends combining Z403 and Z408 with a new descriptor "bone marrow aspiration and/or core biopsy" and a fee of $122.10

21.4 Gxxx Intravenous (IV) Iron Therapy Planning

The Section requested a new annual fee for Intravenous (IV) Iron Therapy Planning at $54.25 (set equal to G381) with the following payment rules:

- Limited to a maximum of one service per patient per 12 month period
- The fee cannot be claimed for patients undergoing dialysis treatment, where intravenous iron is being infused as part of this therapy.
- The risks and benefits of IV iron therapy must be documented by the treating physician.
- Follow up bloodwork work and monitoring plans must be outlined.
- Procedures must be outlined to manage infusion reactions.

The Section put forward the following in support of their request:

- This fee is to reimburse physicians for implementing a therapy plan for outpatient IV iron treatments.
- This involves arranging treatments at an infusion centre, monitoring iron parameters and being available to assist with side effect management of IV iron.
- This applies to patients not receiving IV iron as part of dialysis treatments.
- The Intra-Sectional Relativity (ISR) survey results indicated haematologists do not get properly compensated for managing outpatient IV iron infusions.
- IV iron is now the standard of care in the management of iron deficiency anaemia refractory to oral iron, sparing blood transfusions. There are significant improvements in the quality of life for women who receive IV iron for significant iron deficiency anaemia. Appropriate iron therapy in pregnancy may prevent adverse fetal outcomes. An article outlining this important therapy is attached.
- The clinician would need to calculate appropriate dosing based on the Ganzoni formula. Side effect counselling and monitoring would be needed - nurses at the infusion centre would need direction on contacting the prescribing physician in the event of allergic or infusion reaction.
- A set of outpatient bloodwork monitoring would need to be arranged to ensure hematologic parameters are within appropriate ranges.
- The provincial health programs do not routinely fund intravenous iron for patients; as such the process of obtaining funding for IV iron is laborious.
- The sheer magnitude of patients who require IV iron has risen dramatically over the years adding to the workload of haematologists in our province. This is due to changing guidelines with respect to avoiding blood transfusions, increasing number of patients with gastric bypass surgery (who can't absorb oral iron) and greater recognition of perioperative optimization of haemoglobin prior to elective surgery.
- In response to the committee, the Section indicated that on reviewing the toxicities of all classes of chemotherapeutic agents and toxicities/infusion reactions, the administration of IV iron is most comparable to the present code G381 Standard chemotherapy.

The Committee noted the following.

- Chemotherapy codes referenced require supervision and immediate availability of the physician, it is unclear what the likelihood is of having to intervene in an IV iron therapy treatment. In response, the Section indicated that a recent study noted that while anaphylaxis is rare (0.3 %)

there is a need to be available to manage this and the other non-anaphylactic reactions that can occur immediately or in a delayed fashion (4.1 - 6.9 %)[2].

- Clear and concise payment rules would need to be developed to ensure appropriate billing and avoid abuse.
- The Section on Internal Medicine supports the proposal and requested to also be eligible to bill if within the Section's funding allocation.

Committee Comments:

- The OMSPC acknowledged the Section's feedback and supports in principle.
- The committee supports in principle the Section on Internal Medicine's request to be eligible to bill.

21.5 E078 Chronic Disease Premium

The Section requested that Hereditary Hemolytic Anemias (Thalassemia Major and Sickle Cell Disease) be added to the list of diseases that qualify for the E078 Chronic Disease Premium (50%)

The Section put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results support the proposed addition
- Additional work effort includes counselling patients about therapies, pain management, opioid management, outpatient multidisciplinary service arrangement (social work, ophthalmology). Outpatient exchange therapy, transfusions and iron overload monitoring in advanced cases (although the latter is captured by the G098 code).
- Management of Haemophilia and Coagulation Disorders (286) does qualify for EO78 chronic disease premium.
- Workload actually greater than equivalent chronic diseases in haematology such as haemophilia.
- Immigration patterns in Ontario creating need for non-malignant haematologists to diagnose, manage and care for diverse patients with hemoglobinopathies

The Committee noted the following.

- In the event that the E078 diagnostic code list cannot be revised (e.g., Ministry disagrees), the Section is open to establishment of a new complex assessment code for this patient population, as has been done for other specialties (e.g., Neurology, Rheumatology, and Physical Medicine).

Committee Comments:

- The OMSPC supports in principle.

21.6 G389 Infusion of gamma globulin, initiated by physician, including preparation per patient, per day

[2] Source - Bhandari S, Kalra PA, Berkowitz M, Belo D, Thomsen LL, Wolf M. Safety and efficacy of iron isomaltoside 1000/ferric derisomaltose versus iron sucrose in patients with chronic kidney disease: the FERWON-NEPHRO randomized, open-label, comparative trial. Nephrol Dial Transplant. 2021 Jan 1;36(1):111-120

The Section requested a descriptor revision to G389 Infusion of gamma globulin, initiated by physician, including preparation per patient, per day to include "subcutaneous", as follows:

> Infusion of <u>intravenous or subcutaneous</u> gamma globulin, initiated by physician, including preparation per patient, per day.
>
> (Revisions <u>underlined</u>)

The Committee noted the following.

- The Intra-Sectional Relativity (ISR) survey results support the proposed revision
- There are multiple studies indicating switching to subcutaneous administration of immunoglobulin is more cost efficient to the system but still requires physician monitoring and pursuing drug coverage
-

Committee Comments:

- The OMSPC supports in principle.

22 Hospital Medicine

22.1 Hospital inpatient subsequent visits (C002/C132, C007/C137, C009/C139 and C121)

The Sections on Hospital Medicine and Internal Medicine are requesting a revision to the descriptors of C007, C137, C009 and C139 by removing the maximum number of times the service can be billed per week and the following fee increases,

Fee Code	Descriptor	Current	Proposed	$ increase	% Increase
C002	GP/FP Subsequent visits - first five weeks	$34.10	$42.45	$8.35	24.5%
C132	Internal Medicine Subsequent visits - first five weeks	$32.65	$42.45	$9.80	30.0%
C007	GP/FP Subsequent visits - sixth to thirteenth week ~~(max 3/week)~~	$31.00	$42.45	$11.45	36.9%
C137	Internal Medicine Subsequent visits - sixth to thirteenth week ~~(max 3/week)~~	$32.65	$42.45	$9.80	30.0%
C009	GP/FP Subsequent visits - after thirteenth week ~~(max 6/month)~~	$31.00	$42.45	$11.45	36.9%
C139	Internal Medicine Subsequent visits - after thirteenth week ~~(max 6/month)~~	$32.65	$42.45	$9.80	30.0%
C121	Additional visits due to intercurrent illness	$31.00	$61.05	$30.05	96.9%

> (Revisions <u>underlined</u>, deletions ~~strikethrough~~)

The Sections put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results support the proposed increases, which included establishing a relative value scale where A007 Intermediate assessment was selected as the benchmark.
- Long stay acute care patients are complex patients who may require daily visits from the MRP or for which the hospital requires daily MRP assessments. Physicians need to be paid daily for these visits.
- Compared to other medical and surgical specialties, internal medicine inpatients are older, more comorbid, and have multisystemic and/or undifferentiated disease
- The fee code values for C007, C137, C009 and C139 should be equal.
- The proposed increases would bring MRP billing codes into line with similar intensity outpatient services in internal medicine C132/C137/C139 = A138 Partial assessment.
- Like in inpatient Paediatrics (C262), we do not feel there should be a weekly limit to hospital inpatient subsequent visits.
- On alternate level of care (ALC) patients, it may be reasonable to maintain current limits, with C121 remaining available for intercurrent illness.

Committee Comments:

- The OMSPC supports in principle.

22.2 Most Responsible Physician (MRP) Premiums (E082, E083 and E084)

The Sections on Hospital Medicine and Internal Medicine are requesting the E084 premium be increased to 95% (50% increase) and the following revisions,

(1) Elimination of (a) E082 payment rule #2 and (b) E083 and E084 payment rule #4; and
(2) Include C121, W002 and W132 as an eligible code for E083 and E084 premiums, as follows:

> … Subsequent visit by the MRP, to subsequent visits and C121, C122, C123, C124, C142, C143, C882, ~~or~~ C982, W002, W121 and W132
>
> ~~2. E082 [*4. E083 or E084*] is only eligible for payment:~~
> ~~a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or~~
> ~~b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.~~
>
> (Revisions underlined, deletions ~~strikethrough~~)

The Sections put forward the following in support of their request for an increase to E084 premium:

- 2020 MSPC committee agreed with GIM section that weekend MRP work should pay a premium over weekday work, so E084A premium was generated.
- For included sections, this 45% premium resulted in an overall 11.5% increase to MRP services provided on weekends versus weekdays.

- The MSPC indicated that weekend premiums should be consistent, and E400-E409 premiums quoted, which provide a 50% premium on all associated weekend services.
- Consistent with the previous MSPC decision, E084A premium should be raised to 95% so weekend MRP rounds pay 50% more versus equivalent service on weekday.
- An increase to weekend MRP services will reduce weekend SVP utilization amongst MRPs and may be cost-effective.

The Sections put forward the following in support of their request for revisions:

- Some hospitals have been asking physicians to remit E082/E083/E084 earnings to pay for the top-ups given to hospitalists. This is not the case in all hospitals and is inconsistently applied.
- The E082/E083 codes were introduced as compensation when the request for an alternate funding arrangement (AFA) for Hospitalists was not implemented in 2008.
- The rationale was that the additional fee-for-service earnings would offset the need for stipends to make the remuneration for Hospital Medicine positions closer to what physicians, primarily family physicians, could earn in other types of clinical practice.
- It was not equivalent. The MRP Expert Panel acknowledged this did not work, and recommended proceeding with an AFA in its report in 2013, using a combination of stipends and fee-for-service, as well as performance premiums.
- In practice, due to the low payments provided by fee-for-service despite the E082/E083/E084 premiums, many hospitals offer top-up stipends to attract and retain physicians to work as hospitalists. Rule 2 (E082) and Rule 4 (E083-E084) creates confusion in these arrangements.
- There is inconsistency and lack of clarity in how Rule 2 (E082) and Rule 4 (E083-E084) is applied in practice.
- It should be removed to allow for a clear playing field between hospitals.

Committee Comments:

- The OMSPC supports in principle.

22.3 Hospitalist Premium

The Sections on Hospital Medicine and Internal Medicine are requesting that,

(1) W002 (Chronic care or convalescent hospital – first 4 subsequent visits), C121(Additional visits due to intercurrent illness), W121 (Additional visits due to intercurrent illness) be added to the list of qualifying services for the Hospitalist Premium, and
(2) Reducing the total requirement of qualify services and required days of service by 50%.

The proposed Schedule amendments are as follows:

> **Definitions:**
> "Qualifying services" means E082, C121, C122, C123, C124, C002, C007, C009, C132, C137, C139, C142, C143, A/C933, ~~and~~ C882/C982, W002 and W121.
>
> **Payment rules:**
> For the 12 month period following the date of determination of eligibility for the premium, the amount payable to a physician shall be automatically increased by 17% for all qualifying services except for E082 in the following circumstances:

1. The physician has provided at least ~~1500~~ 750 qualifying services in the qualifying year; and
2. The physician has provided at least one qualifying service per day on at least ~~110~~ 55 days in the qualifying year; and
3. The physician is a General and Family Practice (00) or an Internal Medicine (13) specialist.

(Revisions underlined, deletions ~~strikethrough~~)

The Sections put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results indicated that the Hospitalist Premium exacerbates the gender pay gap.
- The Hospitalist Premium was implemented in 2020 which aimed at recognizing the value of hospitalist inpatient care by addressing relativity gaps in earnings for hospitalist physicians within the traditional OHIP FFS (fee for service) payment model.
- The current eligibility requirements however are resulting in fewer physicians being eligible for the premium as they reduce their working hours to help avoid burnout associated with increasing medical complexity and COVID-19.
- We have not yet received the requested Ministry data on the gender split for those qualifying for the hospitalist premium, however, consultations with Section members suggest that a disproportionate number of female physicians are not qualifying for the hospitalist premium based on current eligibility requirements.
- The impact has been particularly severe on younger physicians and female physicians working as Hospitalists, who have been facing increasing childcare requirements related to COVID restrictions.
- By incentivizing those physicians who bill high volumes of qualifying service codes, the criteria exclude a significant portion of dedicated hospitalist MRPs who work fewer hours, despite demonstrating similar expertise.
- Unintended consequences of this paradigm include:
    - Exacerbation of the gender pay gap.
    - Worsening physician burnout, potentially compromising patient care and leading to increased costs for organizations.
    - Disincentivizing part-time and chronic care hospitalists, fuelling higher turnover, risking attrition and compounding pre-existing challenges with both recruitment and retention within programs.
- In response to the committee, an alternative method is awarding the hospitalist premium to physicians who have at least 12 inpatients per day (i.e., premium eligibility could be amended such that the physician who bills at least 12 eligible services on a given day would receive a premium-adjusted fee for each of those particular services.
- A disproportionate number of females practice inpatient medicine in our section
- At current levels, the hospitalist premium does not apply to most of our section as internists also practice in the emergency department and outpatient settings
- A disproportionate number of females practice inpatient medicine in our section
- At current levels, the hospitalist premium does not apply to most of our section as internists also practice in the emergency department and outpatient settings

Committee Comments:

- The OMSPC supports in principle but recommends consideration of modifying the conditions to allow an additional approach to qualify (>50% of billings), while maintaining the existing pathway.

22.4 Cxxx Inpatient transfer of care

22.5 Admission Assessment – General Requirements - Payment Rule 3 amendment

The Sections on Hospital Medicine and Internal Medicine requested,

(1) A new fee for inpatient transfer of care at $31.35 payable to the Most Responsible Physician (MRP) who is transferring care of medically complex patient to another oncoming MRP with the following descriptor and payment rules:

Inpatient transfer of care is eligible for payment to the MRP (Most Responsible Physician) provider who is transferring care of medically complex patients to an oncoming MRP. This service requires a formal exchange of information which comprehensively details the patient's current needs and care plan to the oncoming provider assuming responsibility.

Payment rules:

1. Payment is eligible when there is a minimum of 10 minutes work to provide a safe and effective handover and requires start and stop times.
2. Medically complex patients include those with 3 or more diagnoses keeping them in the health care setting.
3. Service code is recognized as an add-on to daily assessments in the settings of acute care (C122, C123, C002, C007, C009, C132, C137, C139, C142, or C143) or chronic care (W002, W001).
4. Eligible transfers of care include those within the same facility where a discharge would not be payable.
5. Not to be used for transferring care to the after hours on-call physician
6. Cxxx is limited to one per patient per week

(2) Amend Admission Assessment – General Requirements - Payment Rule 3 (GP40), such that

   a. A general or specific assessments or reassessment are eligible for payment per physician per admission when care is transferred from one physician to another physician, so long as the applicable assessment criteria are met.
   b. Such assessments related to transfer of care should be limited to once a week (Monday-Sunday).
   c. E083 or E084 should apply to these codes to reflect the MRP (Most Responsible Physician) providing the service.

For reference, payment rule 3 is as follows:

3. When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is eligible for payment per patient admission. The amount eligible for payment for services in excess of this limit will be adjusted to a lesser assessment fee. An additional admission assessment is *not eligible for payment* when a

hospital inpatient is transferred from one physician to another physician within the same hospital.

The Sections put forward the following in support of their request:

- Inpatient transitions of care between physicians have become the norm.
- Ward patients are typically covered by a single MRP between 7-14 days, at which point it becomes untenable to continue working without a break.
- Transfers of care are times of higher risk for adverse patient outcomes. The safe and appropriate transfer of care is essential to maintaining continuity between MRP providers, minimizing errors, and ensuring the timely delivery of the patient's care plan.
- Any patient who is hospitalized or in another health care setting, has co-morbid conditions involving multiple organ systems requiring ongoing active management.
- Despite the absence of an OHIP fee code, significant work (for departing and incoming MRPs) goes into ensuring transitions of care maximize patient safety and conform to new CPSO requirements.
- Handovers should be done in keeping with the CPSO Continuity of Care policy on Transitions of Care and with the CMPA Good Practices Guide.
- The amount of work required is between an A001 Minor assessment and A007 Intermediate assessment and takes about 10-15 minutes in duration.
- This would occur approximately 15 times per hospitalist per week or about 360 times annually per hospitalist, 180,000 claims per year potentially.

The Committee noted the following.

- Consideration was given on setting a limit to how many times per week this can be billed per patient per provider and acknowledged the Sections proposed limit of one per patient per week.
- These services may be accounted for in the other fee proposals, such as change in limits, fee increases to Cxxx, and/or hospitalist premium.

Committee Comments:

- The OMSPC supports in principle.

22.6 C124 Day of discharge

22.7 Cxxx Day of discharge, medically complex patient

The Sections on Hospital Medicine and Internal Medicine is requesting either

(1) a fee increase to C124 from $61.15 to $106.85 (74.7%), or
(2) the creation of a new medically complex patient day of discharge at a fee of $106.85 with the same service elements as C124 plus the following payment rules:

Proposed payment rules include:

A. Only one of C124 or Cxxx is payable to the MRP and limited to one service per hospital admission.
B. The physician who provides all the elements of a discharge and spends a minimum of forty-five (45) minutes in patient care exclusive of time spent rendering any other separately billable intervention to the patient.
C. Cxxx is not eligible for payment under any of the following circumstances:

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

The Sections put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results indicated that C124 is the second most undervalued code after A135
- ISR survey noted intensity of C124A is similar to A135A and time commitment is 20% less; this would suggest a fee of $100-125 is appropriate
- ISR survey results indicated the mean service time is 60 minutes and the median time is 45 minutes. To address the issue of complexity we propose a new code Cxxx for day of discharge services for medically complex patients.
- Risk/stress associated with C124A is high, yet hospitals demand rapid discharges to meet increased demand/volumes
- CPSO requirements have dramatically increased scope of C124A, particularly for medical inpatients with multiple medical issues, follow up visits and patient/family counselling
- Medical discharges are distinct from surgical or single-system discharges.
- The time and work routinely involved in discharging a patient is comparable to doing a 50-minute admission consultation (A911)

Committee Comments:

- The OMSPC supports in principle to creating a Complex Patient Day of Discharge code, eligible for both medical and surgical patients, consistent with the payment rules proposed by the Sections.
- The OMSPC supports in principle the proposed fee value.

22.8 MRP Subsequent visits (C122, C123, C142 and C143)

The Sections on Hospital Medicine and Internal Medicine are requesting fee increases to C122, C123, C142 and C143 as follows,

Fee Code	Descriptor	Current	Proposed	$ increase	% Increase
C122	day following the hospital admission assessment	$61.15	$71.35	$10.20	16.7%
C123	second day following the hospital assessment	$61.15	$71.35	$10.20	16.7%

C142	first subsequent visit by the MRP following transfer from an intensive care area	$61.15	$71.35	$10.20	16.7%
C143	second subsequent visit by the MRP following transfer from an intensive care area	$61.15	$71.35	$10.20	16.7%

The Section put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results support the proposed increases, which included establishing a relative value scale where A007 Intermediate assessment was selected as the benchmark.
- The proposed increases would bring MRP billing codes into line with similar intensity outpatient services in internal medicine A133 Medical specific assessment - $79.85

Committee Comments:

- The OMSPC supports in principle.

22.9 Chronic Care/LTC inpatient subsequent visits (W002/W132, W001/W131 and W121)

The Section on Hospital Medicine requested a revision to the descriptors of W002 and W132 by removing the maximum number of times the service can be billed per week, the deletion of W001 a and W131, and the following fee increases,

Fee Code	Descriptor	Current	Proposed	$ increase	% Increase
W002	GP/FP Subsequent Visits, Chronic care or convalescent hospital ~~– first 4 subsequent visits per patient per month~~	$32.20	$34.10	$1.90	5.9%
~~W001~~	~~Subsequent Visits, Chronic care or convalescent hospital – additional subsequent visits (maximum of 6 per patient per month)~~	~~$21.20~~	~~$0.00~~	~~-$21.20~~	~~-100.0%~~
W132	Internal Medicine Subsequent Visits, Chronic care or convalescent hospital - ~~first 4 subsequent visits per patient per month~~	$32.20	$34.10	$1.90	5.9%
~~W131~~	~~Subsequent Visits, Chronic care or convalescent hospital – additional subsequent visits (maximum of 6 per patient per month)~~	~~$21.20~~	~~$0.00~~	~~-$21.20~~	~~-100.0%~~
W121	Additional visits due to intercurrent illness	$31.00	$34.10	$3.10	10.0%

(Deletions ~~strikethrough~~)

The Sections put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results support the proposed increases, which included establishing a relative value scale where A007 Intermediate assessment was selected as the benchmark.
- Patients in chronic care or convalescent hospitals are usually those who require complex rehabilitative programs and require daily MRP care as required by their institutions. It is insufficient to be only able to be paid once weekly for these medically complex patients.
- Long stay acute care patients are complex patients who may require daily visits from the MRP or for which the hospital requires daily MRP assessments. Physicians need to be paid daily for these visits.
- The Section on Long-Term Care & Care of the Elderly is supportive of these proposed changes.

Committee Comments:

- The OMSPC supports in principle.

22.10 Wxx1 MRP day of discharge, long term care or chronic care facility

22.11 Wxx2 MRP day of discharge, medically complex patient, long term care or chronic care facility

The Section requested to create MRP day of discharge fees for inpatients in chronic care settings, similar to MRP discharge fees for hospital inpatients; Wxx1 = C124 ($61.15) and Wxx2 = Cxx1 ($106.85)

The Section put forward the following in support of their request:

- There is no fee code for discharging patients from long term care or chronic care facilities
- To address the issue of complexity we propose new fee codes Wxx1 and Wxx2 for day of discharge services.
- Intra-Sectional Relativity (ISR) survey results indicated the day of discharge assessment service has a mean service time of 60 minutes and the median time is 45 minutes.
- Proposed fee values and payment rules are set equal to proposed MRP discharge fees for hospital inpatients
- The CPSO Continuity of Care Policy and hospital policies guided by Accreditation Canada have led to increased practice demands on hospitalists.

Committee Comments:

- The OMSPC supports in principle.

22.12 Kxxx Interprofessional Rounds

The Sections on Hospital Medicine and Internal Medicine are requesting a new time based fee for interprofessional rounds at a fee of $31.35 per 10 minute period of time with the following descriptor and payment rules:

> Descriptor:
> Daily sessional fee for Interprofessional Rounds for a set of inpatient in an eligible inpatient unit. "Interdisciplinary Rounds" means each 10 minute period, or major part thereof, on any day (including weekends or holidays) spent in collaboration with other regulated health professionals to promote patient care, including timely interventions, discharges and transitions of care to the community.

Payment rules:

1. Interdisciplinary rounds, administrative or leadership services are to be requested by a hospital or nonemergency long-term care in-patient setting, including chronic care hospitals, convalescent hospitals, nursing homes, homes for the aged, designated chronic or convalescent care beds within hospitals, nursing homes or homes for the aged.
2. Applies to interdisciplinary rounds scheduled in the setting of eligible inpatient units or designated beds, and approved by the eligible organization
3. Does not apply to patients in designated palliative care beds.
4. Inpatient Care Conference (K121) should not be claimed simultaneously when claiming sessional fees for Interdisciplinary Rounds.
5. A maximum of 4 units may be claimed per day per physician
6. Kxxx is only payable to the MRP

The Sections put forward the following in support of their request:

- Interprofessional rounds are key to co-ordinating inpatient care services which are comprehensive and patient-centred.
- They allow the team to share a unified understanding of the patient's coexisting medical, functional and social needs to be able to expeditiously support them in-hospital and facilitate a well-coordinated discharge.
- Most medically complex patients have several co-existing, often chronic conditions which can result in functional and social challenges within hospital and upon discharge. Patient care needs are increasing with the aging demographic and successful treatments of chronic disease.
- Interprofessional collaboration on a set of inpatients with a goal towards addressing patient needs towards transition from health care institution.
- Interprofessional rounds/inpatient case conferences are considered standard of care for all hospitalized medical inpatients; most hospitals will allocate a daily 30 minute time slot to discuss 20 inpatients.
- The patient's nurse, social worker, LHIN coordinator, physiotherapist, occupational therapist (and other allied professionals) join with the MRP to discuss daily goals and ensure all members of the team are up to date with the patient's current status; meetings typically last 15-20 minutes and cover, on average, 16 – 20 patients.
- K121 Hospital in-patient case conference ($31.35) was introduced to compensate for these daily meetings. However, the 10-minute time requirement on this code makes it difficult to bill as each patient typically takes less than 10 minutes to discuss.

The Committee noted the following.

- Without having the service attached to a patient, payment rules may need to be well articulated.
- OMSPC will need to confirm how the MOH billing system can accommodate this proposal.
- The Section submitted that the Kxxx interprofessional rounds could be billed as an H-code sessional fee (similar to COVID Assessment Centre work), which do not require the service to be attached to a patient.

- Additional details on limits, payment rules and medical record requirements are required. For example, is the service payable on the same day as a subsequent visit claim? Start and stop time requirements?

Committee Comments:

- The OMSPC supports in principle.

22.13 K121 Hospital In-patient Case Conference

The Sections on Hospital Medicine and Internal Medicine are requesting that the limit of 4 services per patient, per physician, per 12 month period be removed (i.e., Payment rule #2).

The Sections put forward the following in support of their request:

- Case conferences should be permitted whenever they are needed to provide quality team collaboration with or without the patient/family present. Placing limits on this collaboration is not helpful towards patient care.
- Most medically complex patients have several co-existing, often chronic conditions which can result in functional and social challenges within hospital and upon discharge. Patient care needs are increasing with the aging demographic and successful treatments of chronic disease.
- Interprofessional collaboration on a set of inpatients with a goal towards addressing patient needs towards transition from health care institution.
- Interprofessional rounds/inpatient case conferences are considered standard of care for all hospitalized medical inpatients
- The patient's nurse, social worker, LHIN coordinator, physiotherapist, occupational therapist (and other allied professionals) join a meeting along with the MD to discuss daily goals and ensure all members of the team are up to date with the patient's current status.
- K121 Hospital in-patient case conference ($31.35) was introduced to compensate for these daily meetings.

Committee Comments:

- The OMSPC supports in principle.

23 Hyperbaric Medicine

23.1 Gxxx Hyperbaric Oxygen Therapy (HBOT) - Royal College Diplomate of Advanced Focused Competence (AFC) premium

The section proposes a creation of a new Gxxx 25% Royal College Diplomate of Advanced Focused Competence (AFC) premium applicable to the Hyperbaric Oxygen Therapy (HBOT) fee codes (G800, G801, G802, G804, G805 & G807). The premium would only be eligible for payment by those physicians or surgeons achieving the Royal College of Physicians and Surgeons of Canada AFC Diplomate status in Hyperbaric Medicine.

The Section put forward the following in support of their request:

- Special expertise has been achieved by as evidenced by the Royal College of Physicians and Surgeons certification in Hyperbaric Medicine by the candidate passing the requirements and attaining the designation of a Diplomate of the Royal College of Physicians and Surgeons for that specialty of Hyperbaric Medicine.
- That achievement requires residency training and at this point a Royal College accredited training program exists at the University of Toronto. It is scheduled to graduate two students per year. It has yet to commence and will only be available to a very limited number of candidates.
- As it currently stands, all AFC recipients / applicants are members of academic institutions where the more complex cases are treated. The majority of these institutions are involved in participating in CritiCall and Life or Limb on-call activities for critical care hyperbaric services in elderly patients and hence warrant financial compensation as such.
- In 2022 it is estimated that perhaps an additional 10-15 physicians in the province of Ontario could be candidates. it is estimated that 50% of these may apply and fewer will achieve Diplomate status.
- It is essential that training programs, regulatory process, and remuneration be harmonized to support this national certification of Diplomate status under the purview of the Royal College of Physicians and Surgeons of Canada.
- As in all specialist training, recognition of that skills achievement is associated with some degree of remuneration premium, and now with quality education standards which can uniformly be enforced, we need to ensure those with specific expertise remain within the specialty to increase the credibility and standards of practice.

The Committee discussed the following issues.

- Fee values should be established based on time, intensity and relativity with comparable services
- The Sections could consider codes that differentiate based on different levels of patient complexity

Committee Comments:

- The OMSPC is not supportive of the Section's proposal on the grounds that fee values should be based on time, intensity and relativity with comparable services and not based on the training of the physician providing the same service.

23.2 New Consultation and Visit Fees

The Section on Hyperbaric Medicine is requesting a new consultation and visit fee listing that would be restricted to those with the Royal College of Physicians and Surgeons of Canada AFC Diplomate status in Hyperbaric Medicine as follows,

A/Cxx1 Consultation - $$157.00
A/Cxx2 Repeat consultation - $105.00
A/Cxx3 Specific assessment - $79.85

The Section put forward the following in support of their request:

- The proposed fees are set equal to current Internal Medicine fee values.

- The majority of cases are of an older demographic and accompanied by multiple comorbidities; a complication of which typically incites the need for our services. They become more risky as a daily course of treatment proceeds as the cardiopulmonary stresses of the treatment environment is pitted against the benefit being achieved.
- Special expertise has been achieved by as evidenced by the Royal College of Physicians and Surgeons certification in Hyperbaric Medicine by the candidate passing the requirements and attaining the designation of a Diplomate of the Royal College of Physicians and Surgeons for that specialty of Hyperbaric Medicine.
- That achievement requires residency training and at this point a Royal College accredited training program exists at the University of Toronto. It is scheduled to graduate two students per year. It has yet to commence and will only be available to a very limited number of candidates.
- As it currently stands, all AFC recipients / applicants are members of academic institutions where the more complex cases are treated. The majority of these institutions are involved in participating in CritiCall and Life or Limb on-call activities for critical care hyperbaric services in elderly patients and hence warrant financial compensation as such.
- In 2022 it is estimated that perhaps an additional 10-15 physicians in the province of Ontario could be candidates. it is estimated that 50% of these may apply and fewer will achieve Diplomate status.
- It is essential that training programs, regulatory process, and remuneration be harmonized to support this national certification of Diplomate status under the purview of the Royal College of Physicians and Surgeons of Canada.
- As in all specialist training, recognition of that skills achievement is associated with some degree of remuneration premium, and now with quality education standards which can uniformly be enforced, we need to ensure those with specific expertise remain within the specialty to increase the credibility and standards of practice.

Committee Comments:

- The OMSPC supports in principle.

24 Infectious Diseases

24.1 Consultation and Visit Fees

The Section requested the following fee increases to their consultation and visit fees:

FC	Descriptor	Current	Proposed	$ Increase	% Increase
A/C465	Consultation	$178.65	$201.87	$23.22	13.0%
A/C466	Repeat consultation	$105.25	$136.82	$31.57	30.0%
A/C463	Medical specific assessment	$90.85	$118.11	$27.26	30.0%
A/C461	Complex medical specific re-assessment	$80.70	$104.91	$24.21	30.0%

C462	Subsequent visits	$31.00	$40.30	$9.30	30.0%
A468	Partial assessment	$43.30	$56.42	$13.12	30.3%
A/C464	Medical specific re-assessment	$69.70	$90.61	$20.91	30.0%

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results supports the proposed increases
- Most of the work comes from Consultations, repeat consultations, follow-up visits, and outpatient visits.
- Patients are often quite complex and compared to other specialties require more time for consultations – for example – according to the ISR results, a single ID consultation is 60 minutes.
- As noted in this Jama review in 2018[3], complexity in infectious diseases clinical care is ranked number 2 of specialists. However, given this complexity and the use of only non-technical billing codes, fiscal stability of outpatient clinics is not adequate.
- With a large amount of time spent per patient, many clinics unless supported by healthcare institutions, are unable to operate in a fiscally positive manner.
- Infectious Diseases has consistently ranked in the lowest decile (and at one point last) in CANDI/RAANI relativity. The specialty is 5 year – non-procedural and non-MRP specialty. Much of the relativity issue is that despite being a highly trained specialty, patients that are seen have a high level of complexity, require a deep dive into patient records, history, and physical exam, and require ongoing skilled follow-up with are time invasive compared to other specialties. Hence, the only way to accommodate a better relativity position would be increasing fees to the most used billing codes.
- With regards to C462, persistent follow-up of hospitalized patients, particularly with chronic infections, in intensive care, monitoring of antimicrobial toxicity, wound follow-up, etc., is an important but poorly renumerated event for ID physicians. Hence, an increase in this code would allow for more compensation for a service that again is time intensive.

Committee Comments:

- The OMSPC supports in principle.

24.2 Gxxx Supervision of Outpatient Antimicrobial Therapy

The Section requested a new code Gxxx Supervision of Outpatient Antimicrobial Therapy at $25.00 per week with the following payment rules:

i. Providers would need to be accessible within 24-48 hours for adverse reactions and access issues and provide follow-up to patients as clinically indicated.
ii. Providers would also need to be most responsible physician for any biochemical or other monitoring needed for therapy.
iii. Clinicians can bill weekly while the patient is actively on therapy.
iv. This service would be restricted to ID alone given that it is a specialized service.

[3] Tonelli, M. et al. Comparison of the Complexity of Patients Seen by Different Medical Subspecialists in a Universal Health Care System. JAMA Netw Open 1, e184852 (2018)

The Section put forward the following in support of their request:

- Most patients with infections requiring more than a week of treatment.
- Comparator services are (G381 - $54.25, G345 - $75.00 and G359 - $105.15) in Medical Oncology, but the proposed new service has less toxicity.
- The service encompasses a significant amount of non–renumerated work for ID physicians who have outpatient practices and is an important component to patient care.
- Patients who are discharged from hospital on a prolonged course of antimicrobial therapy need regular monitoring of efficacy, regular monitoring of bloodwork in order bloodwork as indicated (for vancomycin up to twice weekly), responding to requests from the LHIN, dealing with delayed adverse reactions, and management of intravascular devices if using parenteral therapy.
- This is not only time invasive, but introduces medicolegal risk, without any renumeration – other than timed clinical encounters with the medical assessment codes.
- This should apply to all antimicrobials (oral or intravenous), given it may then over incentivize outpatient IV therapy (despite evidence suggesting many infections can be treated orally), and there are still significant toxicity associated with oral therapies such as Voriconazole or Linezolid.
- This proposal would be related to all ID physicians who provide supervision of outpatient antimicrobial therapy who are essentially the MRP for all antimicrobial issues while that patient is on therapy.
- This would not be analogous to oncologist supervision of chemotherapy (G382 - $13.80 per month).

The Committee noted the following.

- The Section on Internal Medicine commented that Infectious disease physicians are not available in all communities where general internists will supervise outpatient antimicrobial treatment. As such, if funding is available, internal medicine would like to be eligible to bill for this service.
- The Section on Infectious Diseases and Internal Medicine are requested to develop appropriate definition and payment rules for this service.

Committee Comments:

- The OMSPC supports in principle with the rule that it may only be billed by Infectious Diseases and Internal Medicine specialists.

24.3 Axxx Management of Fecal Microbiota Transplant (FMT)

The Section requested a new code Axxx Management of Fecal Microbiota Transplant (FMT) at $250.00. To be eligible to bill the fee, the elements of a consultation would need to be met plus the performance of the fecal microbiota transplantation.

The Section put forward the following in support of their request:

- Clostridium difficile a cause of healthcare acquired diarrhea, is often managed by infectious diseases physician. Fecal Microbiota therapy is often a salvage step, but requires laboratory expertise and the administration of a product either orally or via enema in order to improve gut flora.

- FMT is an important component of clinical care (guideline recommended for recurrent C difficile) but is not renumerated.
- Part of this may be due to a grey zone in health Canada authorization of this therapy, leaving a significant administrative burden to offer this therapy (including route of administration, biosafety of donors, etc).
- Currently, this would be considered as part of a medical assessment/consultation with potentially a fee for route of delivery (enema or colonoscopy based).
- However, this requires a significant amount of time with the individual patient for counselling, the biosafety components of donation screening, filling out health Canada paperwork, and supervision of administration of therapy.
- While this is allowed either in GI via colonoscopy or NG route, or in other specialties via the enema route, it is poorly offered across the province.
- The hope is a proposal for a fee would drive some growth in this area, given it is a needed therapy that cannot be supported at the current pace.

Committee Comments:

- The OMSPC supports in principle

25 Internal Medicine

25.1 A/C135A Internal Medicine Consultation

The section has requested an increase to A/C135 Internal Medicine Consultation from $157.00 to $180.00 (14.6%)

The Section put forward the following in support of their request:

- The time a consultation takes goes well beyond face-to-face patient time, but also includes triage, chart review, writing orders, transcription, same-day reassessments, updating families, phone calls, etc.
- Our section also feels very strongly that our consultation fee should be paid at par with other internal medicine subspecialties of similar clinical training:
    - A/C155A endocrinology $162.65,
    - A/C615 haematology $168.75, A/C465 infectious diseases $178.65,
    - A/C165 nephrology $162.90, A/C265 paediatrics $175.40,
    - A/C475 respirology $169.65, A/C485 rheumatology $170.10,
    - A/C 075 geriatrics $183.30.

Committee Comments:

- The OMSPC supports in principle

25.2 A133A Medical specific assessment

The Section is requesting an increase to A133A Internal Medicine Medical specific assessment from $79.85 to $85.00 (6.4%)

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results identified A133 as an undervalued service
- There is a sectional pay gap between internists practicing in the emergency room where A135A is the predominant visit rendered and the outpatient setting where reassessments are more common
- As generalists, internists are expected to address multiple issues in a single visit (e.g., diabetes, hypertension, dyslipidemia, coronary disease, COPD, atrial fibrillation, falls, osteoporosis, hyponatremia, renal insufficiency, etc)
- General internists have similar training length to other medical specialists
- During the last MSPC allocation process in 2020, all other medical subspecialties with a non $0 allocation received an increase to their assessment fees – Internal Medicine was unjustly lumped in with the net $0 allocation specialties and did not receive an increase to our assessment fee
- The "internal medicine office assessment premium" awarded in the last MSPC process should not be viewed as an increase to A133A as this premium was generated in lieu of E078 Chronic disease assessment premium (add 50%)
- Internal medicine section proposes increasing A133A to $85, which is in line with other medical specialties

Committee Comments:

- The OMSPC supports in principle

25.3 Hospital inpatient subsequent visits (C132, C137, C139 and C121)

25.4 Hospitalist Premium

25.5 Cxxx Inpatient transfer of care

25.6 Admission Assessment – General Requirements - Payment Rule 3 amendment

25.7 C124 Day of discharge

25.8 Cxxx Day of discharge, medically complex patient

25.9 MRP Subsequent visits (C122, C123, C142 and C143)

25.10 Kxxx Interprofessional Rounds

25.11 K121 Hospital In-patient Case Conference

Committee Comments:

- The Sections on Hospital Medicine and Internal Medicine made joint submissions relating to hospital inpatient care. Please see Hospital Medicine for details.

26 Laboratory Medicine

26.1 Consultation and Visit Fees

The Section requested the following fee increases to their consultation and visit fees:

FC	Descriptor	Current	Proposed	$ Increase	% Increase
A285	Consultation	$102.00	$157.00	$55.00	53.9%

A286	Limited consultation	$71.20	$105.25	$34.05	47.8%
A586	Repeat consultation	$71.20	$105.25	$34.05	47.8%
A283	Medical specific assessment	$55.55	$79.85	$24.30	43.7%
A284	Partial assessment	$30.60	$38.05	$7.45	24.3%
C285	Consultation	$102.00	$157.00	$55.00	53.9%
C286	Limited consultation	$71.20	$105.25	$34.05	47.8%
C586	Repeat consultation	$71.20	$105.25	$34.05	47.8%
C283	Medical specific assessment	$55.55	$79.85	$24.30	43.7%
A585	Diagnostic consultation	$73.30	$118.70	$45.40	61.9%
C585	Diagnostic consultation	$73.30	$118.70	$45.40	61.9%

The Section put forward the following in support of their request:

- The consultations and assessments provided by Laboratory Medicine are equivalent to those provided by Internal and Occupational Medicine in terms of time taken to provide the service (pre-, intra-, and post- service) and the intensity of the service provided including knowledge and judgment, communications, and interpersonal skills, technical skills, risk, and stress.
- As such, the Section propose that their consultation and visit fee be set equal to Internal Medicine.

Committee Comments:

- The OMSPC supports in principle

26.2 Increase to Select Laboratory Medicine Fees

The Section requested the following fee increases to selected laboratory medicine fees to maintain consistency with their revised US-CPT RVUs as follows:

FC	Descriptor	Current	Proposed	$ Increase	% Increase
L805	Aspiration biopsy (lung, breast, thyroid, prostate, etc.)	$83.85	$90.15	$6.30	7.5%
L806	Bronchial, oesophageal, gastric, endometrial or other brushings and washings	$36.20	$36.35	$0.15	0.4%
L810	Fluids (pleural, ascitic cyst, pericardial, CSF, urine and joint, etc.	$25.00	$36.35	$11.35	45.4%
L825	Compensated polarized light microscopy for synovial fluid crystals	$12.80	$24.00	$11.20	87.5%
L820	Smear for spermatozoa	$8.15	$8.45	$0.30	3.7%
L834	Histochemistry of muscle – l to 3 enzymes	$15.15	$15.55	$0.40	2.6%
L835	Histochemistry of muscle – each additional enzyme	$15.15	$15.55	$0.40	2.6%
L841	Enzyme histochemistry and interpretation (per enzyme)	$15.15	$15.55	$0.40	2.6%
L837	Immunohistochemisty and interpretation – per marker	$15.60	$15.55	-$0.05	-0.3%

L849	Interpretation and handling of decalcified tissue	$15.20	$15.55	$0.35	2.3%
L843	Special microscopy of tissues (polarization, interference, phase contrast, dark field, autofluorescence or other) and interpretation	$23.55	$24.00	$0.45	1.9%
L844	Special microscopy of fluids (polarization, interference, phase contrast, dark field, autofluorescence or other microscopy and interpretation)	$14.55	$24.00	$9.45	64.9%
L846	Flow cell cytometry and interpretation - per marker	$12.60	$15.55	$2.95	23.4%
L800	Blood film interpretation (Romanowsky stain)	$22.70	$29.20	$6.50	28.6%
L826	Blood film interpretation (special stain)	$15.15	$15.55	$0.40	2.6%
L802	Bone marrow interpretation (Romanowsky stain)	$44.45	$60.95	$16.50	37.1%
L829	Hemoglobinopathy interpretation (billable for abnormal results only)	$14.65	$24.00	$9.35	63.8%

The Section put forward the following in support of their request:

- Since 2005, the Section has periodically utilized the US based Current Procedural Terminology (CPT) to make adjustments to their fees in order to bring the values of its codes into better relativity.
- CPT is a fee-based relative value system that uses empirically validated data to produce Relative Value Units (RVUs) for three measures, viz. physician work effort, practice expense and malpractice expense. For the Section's purpose, only the physician work effort RVUs were used. The codes are revalidated every five years.
- The CPT laboratory codes readily map onto the Ontario codes as most of them are the same.
- In order to equate the CPT RVUs, L864 Surgical Pathology was selected as a crossover code because it was most appropriately priced in Ontario.
- The comparable CPT code had 0.75 RVUs for physician work effort.
- For ease, this was converted to 1.00 producing a multiplier of 1.33 (1.00 / 0.75 = 1.33). The RVUs for all the other CPT codes were then multiplied by 1.33 so that they could be compared to the Ontario crossover code's value of 1.00.
- The adjusted RVUs are then used to determine whether the fees are in relativity or not.
- The Section is requesting fee changes to achieve internal relativity for the remaining codes.

Committee Comments:

- The OMSPC supports in principle

27 Long Term Care & Care of the Elderly

27.1 W003 First 2 subsequent visits per patient per month

27.2 W008 Additional subsequent visits (maximum 2 per patient per month)

The Section requested,

1. An increase to W003 from $32.20 to $36.85 (by 14.4%)

2. Revise W003 limits to allow once per week
3. Delist W008

The Section put forward the following in support of their request:

- It would be easier and make the most sense to revise the descriptor for W003 and then remove the W008 entirely.
- The W003 must be at the very least considered an equivalent of A007 in the LTC setting which is currently paid at $36.85.
- Intra-Sectional Relativity (ISR) survey results support the proposed fee increase.
- Every single long-term care resident/patient is considered complex, whereas the A007 is predominantly described as an "intermediate" assessment.
- Almost every W003 assessment requires a multi system assessment and review of multimorbidity and polypharmacy.
- The W008 is outdated and implies that care in the first 2 visits is more complex than the 3rd and 4th visit in a month if these are required. If a resident in LTCH requires a weekly visit by a physician, then these residents are usually the most clinically complex.
- The W008 must be at the very least considered an equivalent of A007 in the LTC setting which is currently paid at $36.85. Every single long-term care resident/patient is considered complex, whereas the A007 is predominantly described as an "intermediate" assessment. Almost every W008 assessment requires a multi system assessment and review of multimorbidity and polypharmacy.
- This service may be performed by any physician providing primary care in long-term care which may include SGFP, palliative care, and some from the section of emergency medicine.

The Committee noted the following.

- The Section on Hospitalist Medicine supports the proposal.

Committee Comments:

- The OMSPC supports in principle

27.3 W010 Monthly management of a nursing home or home for the aged patient

The Section requested an increase for W010 from $108.85 to $150.63 (by 38.4%), and a change of the descriptor as follows:

> Monthly Management of a long-term care home resident/patient ~~Nursing Home or Home for the Aged Patient~~

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results support the proposed fee increase.
- Historically when W010 was developed it included an average of three visits per month (two W003, + one W008 = $85.60) plus an additional amount to cover other additional indirect services ($23.25).
- The additional indirect services should be considered in similar quantity and difficulty of work to that provided through a K077 (Geriatric telephone support) which is currently paid at $40.05.
- Therefore, W010 must be paid as an equivalent of two W003 (2 x $36.85) + one W008 ($36.85) and K077 ($40.05) amounting to a total of $150.63.

The Committee noted the following.

- The Section on Hospitalist Medicine supports the proposal.

Committee Comments:

- The OMSPC supports in principle

28 Nephrology

28.1 Fee Relativity Exercise

The Section proposed the following to address modernization of the Schedule and intra-sectional relativity:

FC	Descriptor	Current	Proposed	$ Change	% Change
R849	Initial and acute (includes both medical and surgical components)	$621.35	Delete		
R850	Surgical component alone - insertion of Scribner shunt	$313.25	Delete		
Z450	Revision of Scribner shunt - single	$102.55	Delete		
Z451	Revision of Scribner shunt - both	$152.40	Delete		
Z452	De-clotting of Scribner shunt	$93.60	Delete		
G091	Continuous arteriovenous haemodialysis - initial and acute (for the first 3 services)	$253.85	Delete		
G295	Continuous arteriovenous haemofiltration - initial and acute (for the first 3 services)	$246.45	Delete		
G092	Continuous arteriovenous haemodiafiltration - initial and acute (for the first 3 services)	$317.25	Delete		
G294	Arteriovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)	$184.75	Delete		
G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services)	$444.15	$380.75	-$63.40	-14.3%
G325	Haemodialysis - Medical component alone	$317.25	$348.98	$31.73	10.0%
G323	Haemodialysis - Acute, repeat - for the first 3 services	$158.60	$174.46	$15.86	10.0%
G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	$219.50	$234.87	$15.37	7.0%

G331	Peritoneal dialysis - Repeat acute (up to 48 hours) - for the first 3 services	$197.55	$211.40	$13.85	7.0%
G860	Hospital haemodialysis	$127.20	$130.40	$3.20	2.5%
G861	Hospital peritoneal dialysis	$127.20	$130.40	$3.20	2.5%
G862	Hospital self-care haemodialysis or satellite haemodialysis	$127.20	$130.40	$3.20	2.5%
G863	Independent health facility haemodialysis	$127.20	$130.40	$3.20	2.5%
G864	Chronic dialysis weekly team fee - Home peritoneal dialysis	$127.20	$130.40	$3.20	2.5%
G865	Chronic dialysis weekly team fee - Home haemodialysis	$127.20	$130.40	$3.20	2.5%
G866	Intermittent haemodialysis - at an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above)	$68.80	$70.52	$1.72	2.5%
G412	Nephrological component of renal transplantation - 1st day following transplantation	$279.35	$307.30	$27.95	10.0%
G408	Nephrological component of renal transplantation - 2nd to 10th day, inclusive, per diem	$139.65	$153.60	$13.95	10.0%
G409	Nephrological component of renal transplantation - 11th to 21st day, inclusive, per diem	$69.80	$76.78	$6.98	10.0%

The Section put forward the following in support of their request.

- Removal of Scribner shut related medical procedures (R849, R850, Z450, Z451, Z452, G091, G295, G092, and G294)
    - Scribner shunts were used in the 1960s and 70s as access to perform haemodialysis, they are no longer in use in our area.
    - They have been replaced by central venous catheters, arteriovenous fistulas and arteriovenous graft.
    - As such, codes pertaining to this procedure simply add complexity to the fee schedule without being accurate nor reflective of modern practice.
    - Also, we are proposing to remove haemodialysis and continuous hemodiafiltration codes pertaining to arteriovenous access, as they are now done via venovenous methods

- Critical Care Nephrology and renal replacement therapy (G082, G325, G323, G330 and G331)
    - Acute renal replacement therapy in the context of either critical care or for very acutely ill patients is an important and very complex procedure.
    - Extracorporeal renal replacement therapy has become essential in the management of the ever increasingly complex critically ill patients.

- Evaluating such patients, prescribing, supervising the therapy, reassessing its impact, and managing complications that arise are similar irrespective of the type of dialysis modality chosen.
- Our proposal should be seen as an all-inclusive strategy to modernize critical care nephrology

- Chronic Haemodialysis Team fees (G860, G861, G862, G863, G864, G865, and G866)
  - Intra-Sectional Relativity (ISR) survey results support the proposed fee increase.
  - The chronic haemodialysis team fee is an all-encompassing weekly fee meant to compensate physicians for the care provided to patients receiving chronic dialysis.
  - It includes all aspects of care, all visits, review of all investigations.
  - The schedule of benefits outlines this concept in detail, but for clarity, we note that the fee encompasses

    "*all consultations and visits for management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital inpatients. All consultations and visits within the scope of practice of nephrology and general internal medicine for assessment and treatment of complications of chronic dialysis and management of end-stage renal disease and its complications in chronic dialysis patients*."
  - The complexity of care for patients with end-stage kidney disease has continuously increased. Patients are older, frailer and have morbidities. They take more medications, many of which require review and renal dose adjustment.
  - These patients also require more frequent visits.
  - Chronic dialysis fee code was an arbitrary 10% reduction by the MOH that did not at all reflect medical practice.

- Renal Transplantation (G412, G408 and G409)
  - Renal transplantation is not only life altering for end-stage kidney disease patients but also life extending. It is the optimal renal replacement modality for patients with end-stage kidney disease, improving both quality of life and longevity.
  - The complexity of transplantation medicine has increased dramatically over the last decade in a effort to improve access to transplantation for patients with end-stage kidney disease.
  - This includes expanding the donor pool to include donation after cardiac death donors, hepatitis C nucleic acid test positive donors, and expander-criteria donors.
  - The recipients are increasingly older and carry more comorbidities.
  - Moreover, transplant nephrologists are caring for patients undergoing highly challenging kidney transplants including ABO incompatible transplants, combined kidney-solid-organs transplants, and kidney-paired donation transplants.
  - Thus, the care of post-transplant patients has exceedingly complex and tedious.
  - Moreover, much of the time spent in planning and organizing such transplants are not captured in the schedule of benefits

The Committee noted the following.

- Section is requested to draft Schedule language to describing the differences between the various services

Committee Comments:

- The OMSPC supports in principle

29 Neurodevelopmental Disorders

29.1 Health Check for Adults with Intellectual and Developmental Disabilities (IDD)

The Section is requesting the creation of 2 new Health Check for Adults with Intellectual and Developmental Disabilities (IDD) fee codes as follows:

1. Axxx Preventative Review and Risk Assessment at $85.00 with the following descriptor

   Preventative Review and Risk Assessment includes proactive review of
   i) genetic and psychosocial risks,
   ii) special accommodations in clinic settings/health care access issues,
   iii) review of chronic diseases and
   iv) review of systems

2. Kxxx Physical Examination and Coordinated Care and Management Plan at $75.00 with the following descriptor

   Physical exam as directed and to include at a minimum vital signs, BMI, hearing, vision and dentition screening, musculoskeletal capacity and skin survey. Management plan must be communicated in writing to the patient and care team, preferably with an IDD care visit tool.

Both fee codes would have the following payment rules

1. Each health check code payable once in a 12 month period.
2. Both codes may be billed on the same day or as separate visits (the later often is required for patients with IDD who cannot tolerate a long clinic visit)
3. One or more of the following diagnostic codes should be used:
   - Intellectual Disability, Unspecified 319
   - Mild Intellectual Disability 317
   - Moderate Intellectual Disability 318.0
   - Severe Intellectual Disability 318.1
   - Profound Intellectual Disability 318.2
   - Down Syndrome 758
   - Fragile X Syndrome 759
   - Autism Spectrum Disorder 299
   - Asperger's Syndrome 299
   - Cerebral Palsy 343
   - Fetal Alcohol Syndrome 760
   - Spina Bifida 741

The Section put forward the following in support of their request:

- Many adults with IDD experience poorer physical and mental health, higher rates of premature mortality, and more complex health issues compared to those without
- IDD patients face barriers in access to primary care due to communication and behaviours that challenge.
- People with IDD were previously cared for in institutions, but their health care has moved to primary care in the community. Unlike children, for whom developmental paediatricians and multidisciplinary clinics are available in some settings, there are no specialists for adults with IDD; the responsibility falls to family physicians.
- Almost all family physicians encounter adults with IDD in their practices; given the prevalence of IDD among adults, approximately 15 adults in a typical general practice
- Heath Checks increase previously undiagnosed conditions and preventive manoeuvres
- Physical examination estimated to require 15-20 minutes of service time and explanation of management plan and care coordination following the visit estimated to take an additional 20-30 minutes of time equalling 43 minutes of time on average. Roughly estimated against counselling K codes of $67.75 per unit for family medicine our group determined a fee of $75.
- A Health Check will take several encounters to accomplish, e.g., consider at least three encounters:
    i. Explain the purpose of the health review. Engage the patient and caregiver through explanation of a patient questionnaire to help in data collection. Review the Cumulative Patient Profile, adding items specific to care of adults with IDD.
    ii. Review the patient questionnaire and do a functional enquiry/risk assessment. Perform a physical exam.
    iii. With patient and caregiver, develop an Action Plan, assigning responsibilities, timeline and follow-up
- The Health Check depends on basic family practice skills and resources: e.g., comprehensiveness, continuity, a patient-centered and holistic approach, development of trust in the patient doctor relationship, adjusting communication to the capabilities of the patient, assessing functional capacity and supporting decision-making, coordination of referral and community resources.
- Health Checks are aided by a knowledge of conditions common to adults with IDD as well as the potential different presentations of serious illness; this knowledge is facilitated by the "just-in-time" information provided by the Health Check medical record template and its annotations).
- The remaining requirement is the extra time required of the family physician to accomplish the tasks.

Committee Comments:

- The OMSPC supports in principle.

30 Neurology

30.1 Exxx After Hours Acute Stroke Premium (50%)

30.2 Exxx After Hours Acute Stroke Premium (75%)

The Section is requesting new after-hours premiums appliable to Consultation and Management for Acute Cerebral Vascular Syndrome (ACVS) fee codes A384 and K181 as follows:

- Add 50% if Evenings (17:00-24:00) Mon–Fri, or daytime and evenings on Sat/Sun/Holidays.
- Add 75% if Nights (00:00-07:00)

The Section put forward the following in support of their request:

- Stroke care has changed rapidly in recent years, requiring immediate intervention in life/organ-threatening situations at all hours of the day. Yet acute stroke protocols have been specifically excluded from the after-hours premiums that are afforded to colleagues performing similarly acute management/intervention for other organs.
- High-quality evidence for acute therapeutics allows us to greatly reduce morbidity, mortality, and long term healthcare costs. In the early moments of a stroke, a delay of 1-2 hours results in up to 2 years of life lost (QALY) and $13,000-$26,000 in extra costs.
- Despite the higher-acuity, the major benefit to patients and healthcare payers, the increased responsibilities, and the significant lifestyle restrictions associated with providing acute stroke care, stroke has been specifically excluded from both the after-hours premium and the life/organ-threatening premium afforded to colleagues providing similarly acute care for other organs (see E409, E410, E400C, E401C, GP107).
- Radiology and interventional colleagues are eligible for after-hour premiums (see E406, E407, E408, E409, E410) for their contribution to after-hour acute stroke care, while the MRP neurologist managing and coordinating the care is not. This is inequitable, anti-relativity, and reduces the incentive to provide extremely valuable intervention.
- Currently, visits can be billed as per the Special Visit Premium Table I (GP70):
    - 17:00-24:00 Monday–Friday: K994 ($60.00)
    - 07:00-24:00 Sat/Sun/Holidays: K998 ($75.00)
    - Nights (00:00-07:00): K996 ($100.00)

The Committee discussed the following issues.

- By creating the proposed new after-hours premiums may lead to duplicate payment unless a payment rule is added, such that Special Visit Premiums are not eligible for payment with A384 and K181.
- Additional rationale is required for the distinction of acute stroke management compared to other life threating conditions treated after hours without such a premium. For example, Critical Care resuscitation fees are not eligible for E409 and E410 After Hours premiums.
- After hours premiums, such as E409 and E410, are not applicable to consultation and visit fees, which A384 and K181 are classified as; Special Visit Premiums can be billed when payment criteria are met.

Committee Comments:

- The OMSPC does not support the Section's request to create new after hours premiums applicable to A384 and K181.
- The committee proposes that after hours premiums E409 and E410 be applicable to K181, as the committee views this fee to be more akin to a procedural fee. Special Visit Premiums would remain applicable to A384.

30.3 Axxx Neurology Cognitive Testing

The Section requested a new code Axxx Neurology Cognitive Testing at $200.00 that takes a minimum of 30 minutes.

The Section put forward the following in support of their request:

- A 20 minute cognitive testing is currently billed as K032 Specific neurocognitive assessment at $67.75.
- However, more detailed cognitive testing is often performed by Cognitive Neurologists in order to facilitate a more accurate diagnosis that often takes substantially more time due to the patient population being tested as well as the number of tests required.
- This testing is done in both in academic centres and in the community to help differentiate different dementia types.
- This is for TORCA or (BNA-short form + MOCA) or (BNA-short form + BNA-VEPS) would be in addition to MOCA or MMSE which takes an additional 20-30 min to administer.
- A682 Neurology Extended special neurology consultation pays $400 dollars where a minimum of 90 minutes is spent with the patient. An "extended cognitive assessment" takes about half the amount of time, thus $400/2 = $200.00.
- In addition, the 20 minute cognitive testing code is K032, which bills $67.75. An "extended cognitive assessment" takes about double the amount of time, thus $67.75 x 2 = $135.50.

Committee Comments:

- The OMSPC supports in principle

30.4 Kxx1 Epilepsy Surgery Multidisciplinary Rounds

30.5 Kxx2 Epilepsy Surgery Rounds Planning and Preparation

The Section is requesting two new codes related to Epilepsy Surgery Multidisciplinary Rounds,

1. Kxx1 Epilepsy Surgery Multidisciplinary Rounds at $31.35 per 10 minutes
2. Kxx2 Epilepsy Surgery Rounds Planning and Preparation at $150 per hour

The Section put forward the following in support for Kxx1 Epilepsy Surgery Multidisciplinary Rounds:

- Epilepsy Surgery Multidisciplinary Rounds are high-level, complex, case based discussions that occur for every patient who may be a candidate for epilepsy surgery.
- They involve various team members including Epileptologists, Electroencephalographers, Neurosurgeons, Neuropsychologists, and Nurse Practitioners.
- The rounds go over each patient in detail including their history, seizure type and frequency, EMU admissions with a thorough review of video/EEG for every seizure captured and interictal EEG, MRI, Neuropsychology and other pertinent additional information or tests.
- A comparable service is K121, paid $31.35. This code can be claimed by paediatric epilepsy teams doing the same work.
- Our estimate is that the code (K121) will be performed approximately 450 per year in Ontario. This estimate is based on weekly adult epilepsy surgery rounds being held in London and Toronto with roughly 3-4 patients presented each time.

The Section put forward the following in support for Kxx2 Epilepsy Surgery Rounds Planning and Preparation:

- The bulk of the work required for Epilepsy Surgery Multidisciplinary Rounds are prepared by Epileptologists prior to the rounds taking place.
- This work can take hours per patient
- Thorough review of the patient's chart including history, EEG/EMU, MRI, neuropsychological data and other supporting information is required. Currently this work is not reimbursed at all.
- Average duration for preparing a case for rounds is around 4 hours

The Committee noted the following.

- The committee acknowledge that the issue is the patients are typically outpatients and therefore K121 Hospital in-patient case conference.
- The committee noted that other Sections have requested new fee codes for outpatient case conferences.
- An alternative to creating several new outpatient case conference codes, would be to create a generic outpatient case conference fee; the Section was supportive of this approach.

Committee Comments:

- The OMSPC supports in principle to creating a generic outpatient case conference fee available to all physicians
- If unable to develop a generic out-patient case conference fee, then the OMSPC supports in principle to create a new epilepsy outpatient case conference fee.
- In principle, OMSPC supports creating a new code for Epilepsy Surgery Rounds Planning and Preparation. However, the section will need to submit clear description and payment rules for this new service.

30.6 Axxx Complex Headache Assessment

The Section requested a new code Axxx Complex Headache Assessment at $115.00 with the following restrictions:

a) Limited to a maximum of four times annually.
b) Patient must be booked for at least a 20 minute appointment.
c) Must claimed by a provider with expertise in headache (Neurologists or providers with advanced training in headache management).
d) Can be applied to both migraine diagnostic codes as well as cluster headache.

The Section put forward the following in support of their request:

- The E078 complex disease assessment premium is commonly used for comorbidities such as epilepsy, multiple sclerosis, dementia and parkinsonism.
- Complex headache assessments from a provider with advances training often is as complex or more complex than these assessments. For example, epilepsy has EEG and more clear events to gauge improvement and medication efficacy. MS has imaging evidence of disease progression or stability.
- Headache assessments are often much more timely and less specific measures are often needed to assessment for improvement which are more complex and time intensive to administer.
- Comparable services also billed are A183 + E078 at $119.70 or A181 + E078 at $109.20.

Committee Comments:

- The OMSPC supports in principle

30.7 Gxxx Ambulatory EEG monitoring – with quantification of sleep – technical component

The Section requested a new code Gxxx Ambulatory EEG monitoring - with quantification of sleep - technical component at $50.00.

Committee Comments:

- Submissions related to technical fees are outside scope of the OMA-MSPC and will not be considered.

30.8 G555 Ambulatory EEG monitoring professional component

The Section requested an increase for G555 from $47.75 to $150.00 (by 214.1%).

The Section put forward the following in support of their request:

- The increase is for the interpretation of 12-24 hours of an ambulatory EEG recording. This request is reasonable compared to the other professional fees for similar services:
    - The professional fee for interpretation of 60 minutes of a sleep-deprived EEG (G543 code) is $120.
    - The professional fee for interpretation of 3 hours of "prolonged EEG monitoring" (G545 x12 units) is $176.40.
    - The professional fee for interpretation of EEG with time-locked recording (G496 code - minimum 30 minutes) is $120
- Compared against G543 and G496, G555 takes more time to interpret, as more data needs to be reviewed.

Committee Comments:

- The OMSPC supports in principle

30.9 G544 Ambulatory EEG monitoring – technical component, per item

The Section requested an increase for G544 from $8.60 to $20.00 (by 132.6%) and revise the fee descriptor to "add $20 per additional polygraphic recording of parameters in addition to EEG (e.g. airflow, respiratory effort, oxygen saturation, heart rate, EMG, extraocular movements, body position, accelerometery, pulse transit time, temperature,). G544 is limited to a maximum of 8."

Committee Comments:

- Submissions related to technical fees are outside scope of the OMA-MSPC and will not be considered.

30.10 G456 Needle Electromyography and Nerve Conduction Studies – professional component

The Section requested an increase for G456 from $99.90 to $120.00 (by 20.1%).

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

30.11 Gxxx Neuromuscular Ultrasound

The Section requested a new code Gxxx Neuromuscular Ultrasound: per muscle or nerve at $50.00 with the following descriptor:

> Neuromuscular ultrasound study on the target Nerve or Muscle presumed to be involved in the disease process. Evaluation of the Nerve must include visualization of both a proximal and distal segment of the nerve. The evaluation also includes as necessary study of normal nerve and/or opposite side for comparison.

The Section put forward the following in support of their request:

- Neuromuscular Ultrasound is performed and interpreted by fellowship trained Neuromuscular Specialists with further training in the application and interpretation of Neuromuscular ultrasound (Ultrasound of Muscle and Nerve).
- There are no comparable codes, EMG is unique procedure in neurology that requires the direct physical presence of the electrophysiologist with the patient and comparisons to other electrophysiologic studies such as EEG would be fallacious.
- If a comparison must be made the closest electrophysiologic interpretive code would be the G543 EEG with Video code that requires similar certification and time intensity.
- The following code may be billed with this procedure: G456- EMG technical fee.
- Average time intensity for nerve for image acquisition of both distal and proximal segments is 15 minutes with 5 minutes at located for dictation and report

The Committee noted the following.

- The Section only proposed a professional fee.
- The Section confirmed that the fee is intended to be a standalone fee and not an add-on fee to another service and is occasionally billed as J182, which is not a reasonable comparator.

Committee Comments:

- The OMSPC supports in principle.
- Submissions related to technical fees are outside scope of the OMA-MSPC and will not be considered.

30.12 Z804 Lumbar Puncture

30.13 Z805 Lumbar puncture - with instillation of medication or other therapeutic agent

The Section requested,

1. an increase for Z804 from $74.35 to $150.00 (by 101.7%)
2. Z804 descriptor be revised to “Lumbar puncture without image guidance”.
3. Z805 be delisted

The Section put forward the following in support of their request:

- Fees for Lumbar puncture are grossly inadequate when compared to the benchmark code for Neurology which itself is inadequate as is reflected by the relativity position of the specialty.
- The fee code has disincentivized performing this often necessary test with mounting anecdotal evidence to suggest patient harms due to omission/delay.
- This procedure can be billed as Z805 if medication instilled. We propose having a single code that would replace Z804 and Z805.
- Approximately 7500 lumbar punctures were performed in the FY2018/19 based upon fee for service OHIP claims. Of this approximately 1/6 were performed by Neurology section.

The Committee noted the following.

- In response to the committee, the Section provided the following additional information in support of their submission:
  - An appropriate comparator code would be G246 Lumbar percutaneous epidural injection at $150.00
  - Average total time to complete the procedure by a trained neurologist is 60 minutes.
- Other Sections need to be consulted prior to making any changes.

Committee Comments:

- The OMSPC supports in principle.

30.14 Exxx Chronic CNS disorders premium

The Section requested a new Exxx Chronic CNS disorders at 50%. The premium is modelled after E078 Chronic disease assessment premium and would have similar payment rules and requirements as follows,

Chronic CNS disorder premium is payable in addition to the amount payable for an assessment when all of the following criteria are met:

(a) The assessment is a:
  i. medical specific assessment;
  ii. medical specific re-assessment;
  iii. complex medical specific re-assessment;
  iv. partial assessment; or
  v. level 2 paediatric assessment

(b) The service is rendered by a physician registered with OHIP as having one of the following specialty designations: 18(Neurology), 26(Paediatrics),

(c) The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.
[Commentary: The chronic disease assessment premium is not payable for assessments rendered to in-patients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

(d) The patient has an established diagnosis of a chronic CNS disease, documented in the patient's medical record.

And the addition of the following Neurology specific list of chronic Neurologic conditions (OHIP codes). That would include the current allowable disorders: Epilepsy, Senile presenile dementia,

Parkinson's, Multiple sclerosis, and add the following conditions in the order of suggested priority:

- 346 Chronic Migraine
- 350 trigeminal neuralgia
- 432 haemorrhage intracranial (currently billed under other haemorrhagic conditions)
- 436 Stroke
- 349 Huntington's chorea

The Section put forward the following in support of their request:

- A substantial proportion of Neurologic practice deals with management of complex Neurologic disorders on an ongoing basis.
- Typically, the patients seen in regular follow-up have severe disease that often necessitates prolonged follow-up visits in specialized centres.
- The proposed addition to the list of allowable conditions represents some of the most challenging chronic patient populations seen by Neurologists.
- It is our position that the omission of these chronic conditions is arbitrary and an update would serve to provide appropriate ongoing follow-up care to patients (currently disincentivized) which is vital to prevent deterioration and subsequent admissions to acute care hospitals.
- There are multiple lines of evidence to suggest that access to appropriate specialists and ongoing follow-up for chronic conditions results in fewer hospitalizations and a decrease in overall healthcare utilization, and positively impacts economy by reducing missed time of work.
- Currently intra-sectional relativity within Neurology is severely (50% difference in incomes from follow-up visits) affected between sub-specialist that provide ongoing neurologic follow-ups to neurologic conditions with or without chronic code modifier.
- Currently E078 premium is payable on an arbitrary list of Chronic Neurologic conditions at the exclusion of other conditions of similar complexity.

The Committee noted the following.

- As an alternative, the Section may wish to pursue creating a new assessment code that accounts for the increased complexity of these patients.

Committee Comments:

- The OMSPC supports in principle.

30.15 A180 Special Neurology Consultation

The Section requested an increase A180 from $300.70 to $350.00 (by 16.4%) and revise the descriptor as follows:

> **Complex ~~Special~~ neurology consultation**
> Complex ~~Special~~ neurology consultation is a consultation in which the physician provides all the elements of a consultation (A185) and spends a minimum of 75 minutes of direct or indirect contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient or is called to the Emergency department or Acute inpatient unit to render a time critical service which requires attendance within 15 min of request being rendered.

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- On Average Complex neurologic assessments require a mean of 75 min to complete.
- The typical disorders that require this service include but are not limited to Dementia assessments, Evaluation for brain death/severe anoxic injury and prognostication, refractory status epilepticus, autoimmune encephalopathies, patients admitted to ICU/stepdown units with complex medical comorbidities and psychogenic disorders. The overall acuity, and medico legal risk, and nature of disorders being evaluated justify the proposed increase.
- Simplistically on average a neurologist could reasonably complete two standard consultations in the time it would take to complete one complex assessment and incur far less medicolegal risk, administrative burden, less emotional burden.
- There are no other codes that are routinely billed with this service. A E082 modifier may apply if the patient is admitted by the Neurology service which is a rare occurrence for a specialty which is primarily consultative in nature. Admission premiums claimed by ICU/Medicine.

Committee Comments:

- The OMSPC supports in principle.

30.16 A185 Consultation

The Section requested an increase for A185 from $178.60 to $195.00 (by 9.2%) and revise the fee descriptor to “Neurology Consultation first 60 minutes”.

The Section put forward the following in support of their request:

- A general Neurology consultation continues to take a substantial time and intensity due to the continued reliance on detailed histories and comprehensive physical examinations.
- In Alberta and BC, a neurology consultation base rate is $200.00 and is defined as lasting the initial 30 min.
- In Ontario this results in the general consult code being severely undervalued as any consultation that does not last a full 75 min continues to be billed as a A185.

The Committee noted the following

- The purpose of including “first 60 minutes” is not clear to the committee.

Committee Comments:

- The OMSPC supports in principle the proposed fee increase and does not support the proposed descriptor revision.

30.17 Gxx1 Transcranial Doppler Ultrasound – Complete Study (60 minutes)

The Section requested new fees for Transcranial doppler ultrasound as follows:

Fee Code	Descriptor	Fee

Gxx1	Transcranial Doppler Ultrasound – Complete Study (60 minutes) – professional component	$150.00
Gxx2	Transcranial Doppler Ultrasound – Complete Study (60 minutes) – technical component	$190.00
Gxx3	Transcranial Doppler Ultrasound – Limited Study (30 minutes)– professional component	$100.00
Gxx4	Transcranial Doppler Ultrasound – Limited Study (30 minutes) – technical component	$80.00

The indications are as follows:

Transcranial Doppler Ultrasound – Complete Study (60 minutes)

- Vasospasm detection – baseline study or complete reassessment (temporal window, transorbital window, foramen magnum window, submandibular window), must include bilateral MCA / TICA / ACA / PCA / VA / Basilar
- Stroke risk stratification in sickle cell disease
- Emboli detection without microbubbles for carotid disease or cardioembolism
- Emboli detection with microbubbles for PFO detection … add $25.00 to professional fee
- Cerebral vasoreactivity study or autonomic testing including provocative manoeuvres such as breath-holding, tilt table, etc … add $40.00 to professional fee
- Other indications (e.g. evaluation of cerebral collateral circulation, post reperfusion therapy for large vessel stroke)

Transcranial Doppler Ultrasound – Limited Study (30 minutes)

- Vasospasm detection – subsequent study (temporal window and submandibular window only), must include bilateral MCA / ACA / PCA.

The Section put forward the following in support of their request:

- Transcranial doppler ultrasound (TCD) is a non-invasive method to assess cerebral circulation both qualitatively and quantitatively and can be performed at the bedside.
- TCD has been validated for the detection of cerebral vasospasm following subarachnoid haemorrhage (SAH) and is part of the American Heart Association / American Stroke Association guidelines for the management of aneurysmal SAH (class 2b recommendation, level II evidence).
- TCD-guided prophylactic transfusion in sickle cell disease (SCD) has been shown to be effective in stroke prevention in a large randomised controlled trial. The American Society of Haematology 2020 guidelines for SCD recommend annual screening with TCD (strong recommendation).
- TCD acquisition and interpretation should be performed by technologists and physicians who have been specifically trained in this modality. Vascular surgery, radiology, and neurology residencies do not provide any training in TCD. In North America, TCD training is usually only acquired through select vascular neurology fellowship programs or a small number of CME courses in the USA.
- Due to the current low reimbursement for TCD, the test is underutilized especially in the routine care of patients with aneurysmal SAH and cryptogenic stroke. Instead, for vasospasm detection currently, patients are exposed more frequently to CT angiograms which carry additional risk from radiation and iodinated contrast.

- This is currently being billed as: J189, J186, J187, J188 Transcranial doppler assessment of intracranial circulation.
- Comparable fee codes are: G471 Needle Electromyography and Nerve Conduction Studies technical component at $28.35 and G473 professional component at $275.00.
- We estimate that complete and limited TCDs will be performed 700 times per year, each.

Committee Comments:

- Submissions related to technical fees are outside scope of the OMA-MSPC and will not be considered.

30.18 G545 Prolonged EEG monitoring

The Section requested an increase to the maximum number of units for G545 Prolonged EEG monitoring from 12 to 18 units.

The following fee descriptor was proposed: Videotape recording of clinical signs in association with spontaneous EEG. Unit means 1⁄4 hour or major part thereof. See General Preamble GP6 for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG. G545 is limited to a maximum of 18 units.

The Section put forward the following in support of their request:

- Prolonged EEG monitoring that is performed in epilepsy monitoring units and intensive care units remains significantly undervalued.
- The amount of work required to interpret and report 24 hours of EEG is many times greater than a routine 20-minute EEG, however for the maximum of 12 units per day G545 is currently reimbursed at $14.70x12 units=$176.40, compared to the current $50 paid for a routine EEG interpretation of only 20 minutes' duration (G418).
- In order to address this significant undervaluation of prolonged EEG monitoring, we propose an increase in the total number of billable units (increase from 12 to 18).
- Increasing the limit from a maximum of 12 units to a maximum of 18 units would change the total cost from $14.70 x 12 units = $176.40 to $14.70 x 18 units = $264.60.

Committee Comments:

- The OMSPC supports in principle to increase the maximum number of units from 12 to 18 for G545.
- Submissions related to technical fees are outside scope of the OMA-MSPC and will not be considered. As such, the maximum limit for G540 would remain at 12 units.

31 Neurosurgery

31.1 Axxx Neurosurgical Telephone Consultation (CritiCall)

The Section requested a new code Axxx Neurosurgical telephone consultation (CritiCall) at $121.00 with the following payment rules:

The physician must review and interpret all relevant imaging, obtain pertinent history and physical exam information from referring specialist and then provide a concise management plan.

The Section put forward the following in support of their request:

- CritiCall access to Neurosurgical consultation has been growing exponentially since inception. Currently, there are over 17,000 calls per annum (roughly 2,000 calls at launch) for this service which amounts to more than all other specialities combined plus a large margin.
- Access to this service is available 24/7 with the vast majority of calls occurring between 2pm and midnight.
- This new code for CritiCall would only apply to Neurosurgical Consultation.
- This service entails reviewing patient history and exam findings with the referring physician, interpreting neuro imaging and then providing an assessment and plan of action for the patient in question.
- Each call must be answered within 15 minutes. It requires that the specialist log onto the ENITS imaging platform after collecting the patient's information to review pertinent images while obtaining a history and physical from the emergency physician. This process alone can be 15-20 minutes in length.
- Once a plan has been formulated, the physician must then contact the hospital flow coordinator to arrange a bed if transfer is necessary. Once this is confirmed, the physician must then call the ward that the patient is going to and provide a brief history to charge nurse. The physician must then call CritiCall back to provide them with logistics of where to send the patient.
- The vast majority of patients transferred are quite sick with roughly 10% of them being deemed "life or limb."
- The complexity of medical management, the medical legal liability, and time commitment need to be adequately addressed with the new proposed code.
- This process is quite comparable to a telephone consultation for a new patient which is currently associated with a reimbursement of $121.
- Currently billing K737 CritiCall telephone consultation - Consultant physician at $40.45.

Committee Comments:

- The OMSPC supports in principle, however the committee is of the opinion the new fee code should be established as an assessment fee rather than a consultation fee to avoid limiting aspects associated with a consultation.
- The Section on Cardiac Surgery supports the proposal and requested a similar fee, which the committee supports in principle.

31.2 Nxxx Endovascular Mechanical Thrombectomy for Embolic Stroke

The Section requested a new code Nxxx Endovascular Mechanical Thrombectomy for embolic stroke at $2,000.00 with the payment rule that the physicians must attempt to re-establish cerebral blood flow in patients deemed as suitable candidates for EVT.

The Section put forward the following in support of their request:

- Currently, most centres performing EVT utilize the N107 (Endovascular approach to include balloon catheter or embolization techniques for arteriovenous malformation - $1,456.95) billing code, which is the code for arteriovenous malformation embolization.
- Intracranial clot retrieval requires the physician to navigate a triaxial system into the most delicate and vital vasculature within the brain. Simply gaining access into these vessels is a very demanding and specific skillset possessed by only a small number of specialists in the province.
- Complications often result in catastrophic outcomes and death. The procedure is further complicated by the time pressures as each minute that passes results in billions of neurons dying.
- These procedures are extremely intense and time sensitive carrying huge medical legal liability. In addition, the technology continues to change with new techniques and devices emerging constantly requiring the physicians to constantly engage in education.

The Committee noted the following.

- Given the information provided, the committee was unable to determine if the proposed fee was appropriate based on time, intensity and fee relativity with comparable procedures.
- Consultation with Neurology, Diagnostic Radiology and Neurosurgery could help establish an appropriate fee value.

Committee Comments:

- The OMSPC supports in principle the creation of a new fee, however the committee requests the Sections on Neurology, Neuroradiology and Diagnostic Imaging to bring forward an appropriate fee value.
- Decision deferred. The OMSPC recommends continuing to develop this code in consultation with the affected sections. In particular, appropriate comparators will be needed with respect time and intensity.

31.3 Exxx Fluorescence-guided neurosurgery (E-code)

The Section requested a new code Exxx Intraoperative use of fluorescence-guided modalities at $559.00 with the following payment rules:

> E-code for any neurosurgical procedure during which intraoperative fluorscence-guidance is used as an adjunct to the procedure. This may include the use of 5-aminolevulinic acid (5-ALA), indocynanine green (ICG), fluorescein, or other fluorophore, in order to optimize the efficacy and/or safety of the operative procedure.

The Section put forward the following in support of their request:

- A comparable fee code is N123 Stereotaxis – intracranial (to include ventriculography) which pays $559.60.
- The N123 fee code for intraoperative stereotaxy requires the neurosurgeon to apply advanced imaging technology as well as real-time application of imaging and anatomic data to execute safer, more effective neurosurgical procedures.
- Fluorescence as an adjunct to neurosurgery has begun to gain momentum and is slowly working its way into mainstream use. Costs associated with the dye and the technology required to visualize the dye are currently the limiting factors to full implementation. This technology ideally

would be used as an adjunct to all glioma resections in the future. Pre-treatment with the dye, intraoperative interpretation of the imaging, and how it would impact operative resection all certainly will add time to the procedure.

- Fluorescence is currently regularly utilized in vascular neurosurgery to assess for distal vessel compromise, aneurysm or AVM residuals etc. The medications are administered intra-operatively by the anaesthesiologist, time is allowed to pass until the dye is considered systemic, and then imaging obtained. The imaging is then obtained and action taken if necessary. This process may be repeated several times in a single procedure.
- While this technology is new to Canada (Health Canada approval in September 2020 for 5-aminolevulinic acid (5-ALA) for example), the application of fluorescent-guidance in neurosurgical procedures has become a standard of care in many other jurisdictions.

Committee Comments:

- The OMSPC supports in principle, however the committee requires additional information to support the proposed fee value based on time, intensity and fee relativity with comparable procedures.

31.4 Exxx Intraoperative neurophysiologic monitoring

The Section requested a new code Exxx Intraoperative neurophysiologic monitoring at $400.00 with the following payment rules:

> E-code for any neurosurgical procedure during which intraoperative neurophysiologic monitoring (SSEP, phase reversal, MEP, ECOG, EMG, BAEP, direct cortical/subcortical stimulation, cranial nerve monitoring) is used as an adjunct to the procedure. This may be done with the patient under general anaesthesia or under conscious sedation/awake surgical techniques.

The Section put forward the following in support of their request:

- The proposed fee of $400 is in-line with similar operative adjuncts, such as E896 for microelectrode recording with stereotaxis
- The use of a specific neurophysiologic modality of testing must be dictated in the operative note, along with an indication for its use. Technicians overseeing the process also document and interpret results intraoperatively.
- The E896 fee code for microelectrode recording is one comparable fee code, requiring the neurosurgeon to apply advanced understanding of patient-derived real-time neurophysiologic data to execute safer, more effective neurosurgical procedures.
- While these technologies have long been available, the lack of compensation and the additional expense for neurosurgical centres to employ dedicated neurophysiology team members have served as barriers to widespread implementation of such strategies that serve to optimize outcomes and patient safety.
- Intraoperative neuromonitoring is carried out by a neurophysiologist. They require setup time prior to the commencement of the case and this can vary in length depending on what exactly is being monitored. They provide feedback to the surgeon and provide updates as the case progresses.

- Surgeons may stimulate certain parts of the brain, cranial nerves, peripheral nerves or spinal cord intra operatively and receive feedback from the technician.
- Because the interpretation of the data is done by someone else, we felt it only fair to propose a fee that is lower than FGN.

The Committee noted the following.

- Additional information on direct physician time would be helpful to evaluate the proposed fee value.
- Comparator codes from other provinces may be helpful in establishing an appropriate relative value with other comparable services.

Committee Comments:

- The OMSPC supports in principle, however the committee requires additional information to support the proposed fee value based on time, intensity and fee relativity with comparable procedures.

31.5 Exxx Geriatric Neurosurgery (70-79 years)

31.6 Exxx Geriatric Neurosurgery (80+)

The Section is requesting two new Geriatric Neurosurgery premiums,

1. a 25% premium applicable to any neurosurgical base procedure fee (i.e., “N” code) performed for patients aged 70-79 years.
2. a 50% premium applicable to any neurosurgical base procedure fee (i.e., “N” code) performed for patients aged 80 years or greater.

The Section put forward the following in support of their request:

- The incidence of elderly patients requiring neurosurgical interventions is steadily increasing, reflecting the general aging of our population.
- The overall risk, perioperative morbidity, surgical complexity, length of stay and risk of readmission increases concordant with patient age.
- The E420 trauma premium fee code (add 50%) reflects the increasing morbidity associated with a patient population deemed a priori to be at risk of multiple potential trauma-related comorbidities, and as a result requiring more intensive medical/surgical intervention plus increased length of stay.
- The added perioperative considerations, medical risk, and surgical risk inherent in the surgical management of patients in the geriatric age-range warrant specific consideration and remuneration.
- From a neurosurgical standpoint, these patients tend to require an extensive amount of perioperative care as the majority are unable to actively partake in their own care due to their underlying pathology.
- Complications intraoperatively and postoperatively are also significantly higher.
- Your suggestions of unbundling post-operative care from the surgical fee via a geriatric visit premium would be a fair compromise as long as the premium factors in the prolonged lengths of stay, the increased demands of family communication, the often required collaboration required with consultation services to manage care.

The Committee noted the following.

- The Section is open to the concept of unbundling post-operative care from the surgical fee and/or creating of a geriatric visit premium would be a fair compromise to the proposed geriatrics neurosurgery premium.

Committee Comments:

- The OMSPC does not support. The committee believes the desired correction would be achieved through unbundling pre- and post-operative care. See Section on General Surgery item #17.5.

31.7 Exxx Microsurgical dissection around critical intracranial arteries/veins

31.8 Exxx Resection from eloquent brain

The Section requested two new add-on premiums,

1. Exxx Microsurgical dissection around critical intracranial arteries/veins at 40% with the following descriptor and payment rules:

   Dissection of tumours, vascular structures and lesions from critical intracranial arteries or veins to basic fee for tumour excision, aneurysm repair, or foreign body removal when using operating microscope/exoscope/endoscope, add 40%

   Note: Physician must attempt to dissect lesions away from eloquent vessels, which if lost would lead to significant neurological deficits.

2. Exxx Resection from eloquent brain at 40% with the following descriptor and payment rules:

   Dissection of tumours, vascular structures and lesions from cranial nerves (neurolysis), brainstem, hypothalamus, speech, motor or sensory brain areas to basic fee for tumour excision, aneurysm repair, or foreign body removal when using operating microscope/exoscope/endoscope, add 40%

The Section put forward the following in support of their request:

- Similar principle to E906 (to basic fee for neurolysis, tumour excision, nerve suture or graft when using operating microscope, add 40%); the amount works out to what is similar for E889 (complex endonasal endoscopic resection from cranial nerves, to N114 or N116 add $520.00)) which will be reinstated to $800.
- Given the fact that these procedures take hours to perform and the procedures often last 10+ hours in duration, they are not compensated for adequately in comparison to fee codes in our own section or when we compare to other sections when we can only bill codes such as N153/N105/N154 alone. N153 does not capture the complexity of these very long cases.
- We feel that this procedure requires an E billing code and fair compensation.
- The procedure is being done and subsumed under N153 and sometimes N105/N154. N153 does not capture the complexity of these very long cases.

- Brain tumours, whether malignant or benign, and vascular lesions like aneurysms may involve highly eloquent regions. Surgeons may spend hours dissecting these high risk areas in order to relieve neurological deficits or pain.
- Achieving total or near total resections in almost every tumour studied provides longer progression free and overall survival. In benign lesions it obviates the need for further treatment such as radiation therapy.
- In general, these are rare cases but when encountered, surgeries can last 8+ hours. The importance of this procedure both from a patient care standpoint and societal cost perspective is undeniable.
- Currently, estimates indicate we are doing 150-300 cases per year within the province of Ontario.

The Committee noted the following.

- The Section is open to a time-based fee that could start after the first 5 hours have passed and would be happy to work with the committee to determine what a fair compensation would be.

Committee Comments:

- The OMSPC supports in principle to creating a time-based surgical code for extended complex surgical procedures. The committee requests the Section to provide a list of codes these premiums would apply to.

31.9 Nxxx Resection of lesion from infratemporal fossa

The Section requested a new code Nxxx Resection of lesion from infratemporal fossa at $2,500.00 with the following descriptor and payment rules:

> Dissection of tumours, vascular structures and lesions from the infratemporal fossa.
>
> Note: Physicians must enter the infratemporal fossa and resect lesions such as tumours from this eloquent area.

The Section put forward the following in support of their request:

- The procedure is being done and subsumed under N153 (Meningioma and other tumorous lesions, including pituitary tumours, infratentorial or basal - $2,529.80) and sometimes N105 (Carotid circulation -per vessel - $2,477.45) and N154 (Vertebrobasilar circulation, including aneurysm of vein of Galen - $2,477.45).
- N153 alone does not capture the complexity of these very long and complicated cases.
- Tumours may extend intracranially as well.
- Given the fact that these procedures take hours to perform and the procedures often last 8+ hours in duration, they are not compensated for adequately in comparison to fee codes in our own section or when we compare to other sections when we can only bill codes such as N153 alone.
- We feel that this procedure requires an E billing code and fair compensation.

The Committee noted the following.

- The Section is open to a time based fee that could start after the first 5 hours have passed and would be would be happy to work with the committee to determine what a fair compensation would be.

Committee Comments:

- The OMSPC supports in principle to creating a time-based surgical code for extended complex surgical procedures.

31.10 A045 Consultation

The Section requested an increase for A045 from $121.10 to $169.00 (by 39.7%)

The Section put forward the following in support of their request:

- The Intra-Sectional Relativity (ISR) survey results supports the proposed increase.

The Committee noted the following.

- The proposed fee increase would put A/C935 Special surgical consultation ($160.00) out of relativity.

Committee Comments:

- The OMSPC supports in principle to a fee increase and notes that A/C935 Special surgical consultation fee would need to be increased to maintain fee relativity.

31.11 Exxx BMI Premium

The Section requested a new BMI Premium at 30% applicable to patients with a BMI recorded as >35 undergoing surgical intervention.

The Section put forward the following in support of their request:

- Elevated BMI increases pre-operative, intra-operative, and post-operative care complexity. Other specialities including anaesthesia and general surgery are compensated for these factors.
- The level of complexity added is similar to a revision procedure.
- Positioning patients prone or in a lateral decubitus can be time consuming and challenging. In fact, there are times when the ideal surgical approach is abandoned for a less favourable or more complex approach simply do to size.
- Even in the supine position, with the patient's head in pins, certain head-of-bed elevations are not possible and other creative solutions conjured.
- Post operatively, mobilizing these patients and getting them home is also challenging and adds to length of hospital stay.
- For spine patients, the technical difficulties of working in deep incisions, poor wound healing, and mobilization issues post operatively add to the complexity of delivering care.
- Anaesthesia receives extra Units and other surgical specialities receive 25% premium (E676).

Committee Comments:

- The OMSPC supports in principle a BMI premium rate equal to E676 at 25%.

- The Section on Cardiac Surgery supports the proposal and requested that the BMI premium also be applicable to cardiac surgery procedures; the committee supports in principle.

32 Nuclear Medicine

32.1 A/C635 Consultation for radionuclide therapy

32.2 A/C835 Comprehensive nuclear medicine consultation for radionuclide therapy

The Section requested a revision to the descriptor of A/C635 and A/C835 as follows:

> A/C635 Consultation ~~for radionuclide therapy~~
> A/C835 Comprehensive nuclear medicine consultation ~~for radionuclide therapy~~
>
> (Deletions ~~strikethrough~~)

The following was put forward to support their request:

- The radionuclide therapy wording was added by the MSPC in the last round of negotiations when we asked that the fee be raised to a similar level as consultations in other specialties.
- Subsequently, section members have pointed out that there are other potential scenarios in which we perform a consultation such as counselling patients with radiation exposures or radiation phobias. These rare but valid consultations would technically no longer meet the criteria for a consultation.
- A comprehensive nuclear medicine consultation is a consultation rendered by a specialist in nuclear medicine who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

Committee Comments:

- The OMSPC supports in principle.

32.3 Axxx Diagnostic consultation (PET)

The Section requested a new code Axxx Diagnostic consultation (PET) at a fee based on Section allocation, with the following descriptor and payment rules:

> A diagnostic Nuclear Medicine consultation (PET) is the service rendered when a PET study performed at one institution or facility is referred to a Nuclear Medicine specialist in a different institution or facility for a written opinion.
>
> A diagnostic Nuclear Medicine consultation (PET) is not eligible for payment when studies rendered in a different institution or facility are used for comparison purposes with studies rendered in the consultant's institution or facility. This fee code is only eligible for payment to physicians from Nuclear Medicine (63).

The Section put forward the following in support of their request:

- PET studies tend to be far more time- and labour-intensive to interpret than general Nuclear Medicine exams.
- The section feels these diagnostic consultations should be remunerated at a higher rate than the existing A735, which would be used for non-PET diagnostic consultations going forward.
- This is currently being billed as A735.
- Comparable services include:
    - A330 Radiology second opinion of CT study, per study - $89.50
    - A332 Radiology second opinion of MRI study, per study - $199.70

Committee Comments:

- The OMSPC supports in principle.

32.4 A735 Diagnostic consultation

The Section requested a revision of the A735 fee descriptor as follows:

> **Diagnostic consultation**
> A diagnostic nuclear medicine consultation is the service rendered:
> a. when <u>non-PET</u> nuclear medicine studies rendered at one institution or facility are referred to a nuclear medicine specialist in a different institution or facility for a written opinion. ~~In this case, the specific elements are the same as the nuclear medicine professional component (see page B1)~~; or
> b. b. when a nuclear medicine specialist is required to make a special visit at evening or night (17:00h to 07:00h) or on a Saturday, Sunday, or holiday to consult on the advisability of performing a nuclear medicine procedure, which eventually is not done. In this case, the specific elements are the same as for consultations (see page GP16).
>
> (Revisions <u>underlined</u>, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- PET studies tend to be far more time- and labour-intensive to interpret than general Nuclear Medicine exams.
- The section feels that PET diagnostic consultations should be remunerated at a higher rate than the existing A735.
- We would like to make A735 the code for non-PET diagnostic consultations and create a new PET diagnostic consultation code.

Committee Comments:

- The OMSPC supports in principle.

32.5 Kxxx MCC Nuclear Medicine Participant, per patient

The Section requested a new code Kxxx multidisciplinary cancer conference (MCC) Nuclear Medicine Participant, per patient at $31.35.

The Section put forward the following in support of their request:

- Nuclear Medicine does not have a specific MCC code like Diagnostic Radiology and must bill the generic K708.
- Nuclear Medicine physicians historically did not attend MCCs. With the increasing use of PET, we are now frequently asked to attend rounds to review imaging.
- Given the complexity of the PET cases we are now presenting, the section would like to consider increasing the fee at some point in the future.
- We would like to introduce our own code now for tracking purposes without any change in value in this round of allocation.
- Since the existing K708 MCC Participant, per patient code is limited to a maximum of 5 services, our members have encountered cases where the number of surgeons, oncologists, etc. billing the code exceeds this cap, and our members have not been paid.
- While oncologists, surgeons, radiologists, etc. typically attend no more than one MCC per day, the small number of Nuclear Medicine physicians at a given institution frequently requires a single person to cover multiple MCCs, thus exceeding the daily limit.
- As we perform a similar role to radiologists at these rounds, an alternative to creating a new code would be to amend K710 MCC Radiologist Participant, per patient to allow our section to also bill that code.
- Billing a combination of K708 and K710 would cover those individuals who need to attend more than one MCC per day.
- K708 was billed 1,426 times by Nuclear Medicine physicians in 2019 according to OMA data.

Committee Comments:

- The OMSPC supports in principle.

32.6 J866 Application of (SPECT), maximum one per Nuclear Medicine examination
32.7 Jxx1 Subsequent tomographic (SPECT) sequence
32.8 Jxx2 First hybrid tomographic (SPECT/CT) sequence
32.9 Jxx3 - Subsequent hybrid tomographic (SPECT/CT) sequence
32.10 Jxx4 SPECT/CT

The Section is proposing modernization of the OHIP Schedule with respect to application of SPECT and hybrid SPECT/CT in a cost neutral manner as follows:

Application of Tomography (SPECT)~~, other than to J808 or J852~~ – (page B1)

FC	Descriptor	Technical	Professional	Details
J866	<u>First tomographic (SPECT) sequence (maximum 1)</u> ~~maximum one per Nuclear Medicine examination~~	$43.50	$23.65	Revise descriptor. No change in fee values.
Jxx1	Subsequent tomographic (SPECT) sequence	$0.00	$0.00	This code is being created for tracking purposes only, so $0 for both technical and professional fees.

Jxx2	First hybrid tomographic (SPECT/CT) sequence (maximum 1)	$43.50	$23.65	Currently billed as J866. Proposing same fee as J866
Jxx3	Subsequent hybrid tomographic (SPECT/CT) sequence	$0.00	$0.00	This code is being created for tracking purposes only, so $0 for both technical and professional fees.

Note:

1. J866 and Jxx1 cannot be billed with J807 or J808 as those codes already include the tomographic sequence.
2. Jxx1 can only be billed in conjunction with J866 or Jxx2.
3. Jxx2 is not eligible for payment with J807, J808, or J866.
4. Jxx2 and Jxx3 are only eligible for payment when performed on a dedicated hybrid SPECT/CT system; software fusion of SPECT data with diagnostic CT data sets is not eligible.
5. Jxx3 is not eligible for payment with J807 or J808
6. Jxx3 can only be billed in conjunction with J866 or Jxx2.
7. For gallium scintigraphy (J852 and J853), J819 should be used in place of J866.
8. For gallium scintigraphy (J852 and J853), Jxx4 should be used in place of Jxx2.

Application of tomography (SPECT) – (page B9)

FC	Descriptor	Technical	Professional	Details
J819	where each SPECT image represents a different organ or body area, to J852 or J853, maximum 3 images per examination	$43.50	$24.65	No change
Jxx4	SPECT/CT - where each data set represents a different body area, maximum 3 images per examination	$43.50	$24.65	Currently billed as J819. Proposing same fee as J819

Note:

1. J850 and J851 are not to be billed together. J804 may be claimed in addition to J850 or J851 for blood pool study.
2. Jxx4 is only billable in conjunction with J852 or J853.
3. The combined total number of SPECT and SPECT/CT procedures (J819 + Jxx4) allowed per exam is 3.

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- The Schedule needs to be tightened up and made consistent with proposed new codes for SPECT/CT and additional tomographic sequences.
- All existing SPECT codes (J866, J809, J819) are add-on codes which are billed in addition to the primary study code.

- The majority of codes in our section of the Schedule can have SPECT added depending on the study indication and protocol required.
- Our intent with these proposals is,
  a) to create a separate fee code for hybrid (SPECT/CT) imaging, and
  b) to create tracking codes for additional tomographic acquisitions in order to generate volume data, with the intention of proposing additional tomographic acquisitions be funded in a future allocation.
- As a patient could conceivably have multiple SPECTs, multiple SPECT/CTs, or a combination of SPECT and SPECT/CT, we figured we would need codes for the following:
  - First SPECT (J866)
  - Additional SPECT (Jxx1)
  - First SPECT/CT (Jxx2)
  - Additional SPECT/CT (Jxx3)
- The Section is asking that the existing J866 which is now used for both SPECT and SPECT/CT be split into separate codes (J866 and Jxx2) so the values can be adjusted independently in future.
- By reframing this as the splitting of an existing code rather than the creation of a new code, hopefully we can sidestep the technical fee issue.
- J866 would no longer be used for myocardial perfusion imaging under our proposed revisions of J807/J808.
- It is important to understand that SPECT/CT procedures are currently being billed using the existing SPECT codes.
- Our intention is that Jxx1 would replace J866 in applicable cases. As this is a direct substitution, Jxx2 should carry the same technical and professional fees as *J866* since this is a cost-neutral change.
- It is now the standard of care to perform multiple tomographic sequences on many studies due to the improved sensitivity/accuracy/contrast/etc. of tomographic imaging (cp. X-ray vs. CT).
- As the existing J866 code is limited to 1 per examination, additional SPECT acquisitions are currently neither paid nor tracked.
- We propose a $0 tracking fee for additional acquisitions to allow us to generate accurate volume data for these procedures. This data could then be used to fund these procedures in future allocations.
- Hybrid imaging with SPECT/CT is now the standard of care for many Nuclear Medicine procedures. This requires significantly more work from the physician than a standard SPECT but is currently billed using the same J866 fee code.

The Section put forward the following in support of the proposed new fee for Jxx4 SPECT/CT:

- Hybrid imaging with SPECT/CT is now the standard of care for many Nuclear Medicine procedures.
- This requires significantly more work from the physician than a standard SPECT but is currently billed using the same J819 fee code for gallium studies.
- We would like to introduce a new gallium SPECT/CT fee code which would replace J819 for SPECT/CT studies.
- This would pay the same as J819 (for both professional and technical fees) and thus be cost-neutral, but it would allow us to track SPECT vs. SPECT/CT volumes going forward so that increases could be applied selectively to SPECT/CT in future allocations.
- No change in overall volume.

Committee Comments:

- The OMSPC supports in principle and awaits a more comprehensive modernization of the Schedule by the Section.

32.11 J700 PET Solitary pulmonary nodule

32.12 Jxxx PET - Cardiology

32.13 Jxxx PET Neurology

32.14 Jxxx PET Other

The Section requested revising the current list of PET fee codes such that it is simpler, as follows

FC	Descriptor	Proposed
J700	PET - Solitary pulmonary nodule	$237.50
Jxx1	PET - Cardiology	$237.50
Jxx2	PET - Neurology	$237.50
Jxx3	PET - Other	$237.50

Note:

1. Jxx1 is only an insured service when performed for an approved cardiac indication.
2. Jxx2 is only an insured service when performed for an approved neurologic indication.
3. Jxx3 is only an insured service when performed for an approved indication.
4. The list of current approved indications is maintained by the PET Steering Committee of Cancer Care Ontario and can be accessed through the PET Scans Ontario website.

The Section put forward the following in support of their request:

- The Section on Nuclear Medicine and the Cancer Care Ontario PET Steering Committee (representing the OMA and Ontario Health, respectively) have come up with a joint proposal to implement a generic fee code for all approved cardiac PET procedures with associated commentary indicating that a procedure is only an insured service when that specific indication is on the approved list maintained by the PET Steering Committee of Cancer Care Ontario.
- Given the rapid pace of change in the PET world and the strained OMA-MOH relationship over the last 10 years, this is simply not a feasible mechanism for maintaining an up-to-date list of insured indications. Addition of new PET indications currently requires modification of the Schedule.
- The revised J700 code would replace J700 – J706 and J709 – J713; Payment rules and reporting requirements would be the same as for those codes.
- This revised Jxx1 code would replace J707 and J708.
- Fee value would remain the same for the purposes of this change, but a small increase will be requested depending on Section allocation.
- No change to overall volumes.

Committee Comments:

- The OMSPC supports in principle.

32.15 J807 Myocardial Perfusion Scintigraphy - resting, immediate post stress

32.16 J808 Myocardial Perfusion Scintigraphy - delayed

32.17 J809 - Application of (SPECT), maximum two per examination, to J808

32.18 J810 - Myocardial scintigraphy - acute infarction, injury

32.19 Jxxx Myocardial Perfusion Scintigraphy - wall motion assessment - first analysis (maximum of 1 per exam)

32.20 Jxxx Myocardial Perfusion Scintigraphy - wall motion assessment - subsequent analysis (maximum of 1 per exam)

The Section is proposing modernization of the OHIP Schedule with respect to cardiac Nuclear Medicine studies on page B4 as follows:

Myocardial Perfusion Scintigraphy

		Technical Fee		Professional Fee		
FC	Descriptor	Current	Proposed	Current	Proposed	Details
J807	First sequence (rest of post-stress) ~~- resting, immediate post stress~~	$217.55	$261.05	$38.10	$61.75	Combine J807 and J866.
~~J866~~	~~application of SPECT (maximum 1 per examination), to J807~~	~~$43.50~~		~~$23.65~~		Delist and combine into J807 on cost neutral basis.
J900	application of Rubidium PET for cardiac perfusion (maximum 1 per examination), to J807	$43.50		$23.65		No change
J808	Subsequent sequence (rest or post-stress), maximum of 2 per exam ~~- delayed~~	$80.10	$123.60	$20.90	$44.55	Combine J808 and J809.
~~J809~~	~~Application of (SPECT), maximum two per examination, to J808~~	~~$43.50~~		~~$23.65~~		Delist and combine into J808 on cost neutral basis.
J901	application of Rubidium PET for cardiac perfusion (maximum 1 per examination), to J808	$43.50		$23.65		No change

Note:

1. J807 is used for the first scintigraphic sequence performed in a myocardial perfusion study, regardless of
    a. whether it is a rest or post-stress sequence and
    b. whether a 1-day or 2-day protocol is used.
2. J807 includes the application of tomography where applicable.

3. J808 is used for subsequent scintigraphic sequences performed in a myocardial perfusion study, regardless of
    a. whether they are rest or post-stress sequences and (
    b. whether a 1-day or 2-day protocol is used.
4. J808 includes the application of tomography where applicable.

Myocardial scintigraphy

		Technical Fee		Professional Fee		
FC	Descriptor	Current	Proposed	Current	Proposed	Details
J810	Myocardial scintigraphy - ~~acute infarction, injury~~ including infarction, injury, inflammation, infiltration	$88.25	No change	$37.90	No change	Descriptor revisions. No impact on utilization.
Jxx1	Myocardial Perfusion Scintigraphy - wall motion assessment - first analysis (maximum of 1 per exam)	$135.15	$135.15	$62.50	$43.25	Professional fee currently billed as J813 at $62.50. No change in tech fee.
Jxx2	Myocardial Perfusion Scintigraphy - wall motion assessment - subsequent analysis (maximum of 1 per exam)	$48.15	$48.15	$33.00	$20.90	Professional fee currently billed as J814 at $33.00. No change in tech fee.

Note:

1. Jxx1 is the used when analysis of cardiac wall motion is performed as part of a myocardial perfusion study.
2. Jxx1 is used for the first wall motion assessment performed in a myocardial perfusion study, regardless of,
    a. whether it is on a rest or post-stress sequence, and
    b. whether a 1-day or 2-day protocol is used.
3. Jxx1 must be billed with either J807 or J808.
4. Jxx1 cannot be billed in conjunction with J811, J812, J813, or J814.
5. Jxx2 is the used when analysis of cardiac wall motion is performed as part of a myocardial perfusion study.
6. Jxx2 is used for a subsequent wall motion assessment performed in a myocardial perfusion study, regardless of
    a. whether it is on a rest or post-stress sequence, and
    b. whether a 1-day or 2-day protocol is used.
7. Jxx2 must be billed with J808.
8. Jxx2 cannot be billed in conjunction with J811, J812, J813, or J814.

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request for J807 and J866 revisions:

- The terminology used in the Schedule is outdated and pertains primarily to the original thallium studies rather than the technetium protocols used today.

- Tomography is now used in essentially all studies, making the need for separate tomographic codes moot. As Such, the Section proposes to add the professional and technical values of the J866 to the J807 to create a single streamlined code.
- In addition, we have updated the wording to clarify when J807 should be used vs. J808
- This will be cost-neutral and no change to overall volumes.

The Section put forward the following in support of their request relating to J808 and J809:

- The terminology used in the Schedule of Benefits is outdated and pertains primarily to the original thallium studies rather than the technetium protocols used today.
- Tomography is now used in essentially all studies, making the need for separate tomographic codes moot. As Such, the Section proposes to add the professional and technical values of the J809 to the J808 to create a single streamlined code.
- In addition, we have updated the wording to clarify when J808 should be used vs. J807
- This will be cost-neutral and no change to overall volumes.

The Section put forward the following in support of their request for J810 revision:

- The terminology used in the Schedule of Benefits outdated and pertains primarily to the old infarction test rather than the amyloid and other myocardial injury studies performed today.
- No change to overall volumes.

The Section put forward the following in support of their request for new Myocardial Perfusion Scintigraphy wall motion assessment fees:

- We are requesting that the existing J813 and J814 codes which are currently used for both myocardial perfusion imaging and MUGA studies be split into separate codes for each. This will allow them to be independently adjusted in future to improve intra-sectional relativity.
- Assessment of wall motion is currently billed with the same codes (primarily J813 and J814) regardless of whether it is done as part of a myocardial perfusion imaging (MPI) study or the more complex radionuclide angiography (MUGA) exam.
- For this reason, the fees for these 2 different types of wall motion assessments cannot be adjusted independently.
- We would essentially like to split wall motion into separate MPI and MUGA codes.
- As we cannot adjust T-fees through the MSPC process, we would like to maintain the current J813 and J814 T-fees for the new codes but use a lower P-fee for the new MPI wall motion codes to reflect the lower workload involved.
- The savings would be redistributed to other Nuclear Medicine codes during the allocation process to improve intra-sectional relativity.

The Committee noted the following.

- The Section needs to consult with other Sections that might be impacted.

Committee Comments:

- The OMSPC supports in principle.

32.21 J820 Parathyroid scintigraphy - dual isotope technique with T1201 and Tc99m Iodine
32.22 J857 - CSF circulation - with Tc99m or I-131 HSA
32.23 J858 - CSF circulation - Brain scintigraphy
32.24 J860 - Perfusion and ventilation scintigraphy - same day
32.25 J865 - Total body counting
32.26 J869 - Adrenal scintigraphy - with MIBG
32.27 J830 - Abdominal scintigraphy - for gastrointestinal bleed - Tc99m sulphur colloid or Tc04
32.28 J878 - Abdominal scintigraphy - for gastrointestinal bleed - labelled RBCs

The Section requested descriptor revisions of the following fee codes to reflect modern day practice:

FC	Descriptor	Current	Proposed	Details
J820	Parathyroid scintigraphy ~~- dual isotope technique with T1201 and Tc99m Iodine~~	$55.30	$55.30	Revision
J857	CSF circulation - with Tc99m ~~or I-131 HSA~~	$45.75	$45.75	Revision
J858	CSF circulation - Brain scintigraphy (except cerebral perfusion)	$40.30	$40.30	Revision
J860	Ventilation and perfusion (V/Q) scintigraphy - same day ~~Perfusion and ventilation scintigraphy - same day~~	$49.70	$72.10	Value Change and Revision
J865	Total body counting including dosimetry	$49.70	$49.70	Revision
J869	Adrenal scintigraphy ~~- with MIBG~~	$49.70	$49.70	Revision
J830	Abdominal scintigraphy - for gastrointestinal bleed - Tc99m sulphur colloid or pertechnetate ~~Tc04~~	$40.30	$40.30	Revision
J878	Abdominal scintigraphy - RBC scintigraphy ~~for gastrointestinal bleed - labelled RBCs~~	$40.30	$40.30	Revision

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request for revision to J820:

- The wording in the Schedule is outdated and refers to old techniques no longer used. As modern parathyroid scans essentially all use a similar technique, there is no need for a descriptor after the fee code.
- Indications for parathyroid scanning include workup of hyperparathyroidism with biochemical evidence (i.e., elevated serum PTH) or, in rare circumstance, inappropriately normal PTH with evidence of elevated normalized serum calcium or ionized calcium.
- As normal parathyroid tissue is typically not visualized on parathyroid scintigraphy, evaluation of an incidental nodule found on anatomic imaging (e.g. ultrasound, CT, MRI) in the absence of a biochemical abnormality is not generally an appropriate indication for this study.
- No change in overall volume.

The Section put forward the following in support of their request for revision to J857:

- I-131 HSA is no longer used or even available
- No change in overall volume.

The Section put forward the following in support of their request for revision and fee increase to J860:

- The proposed descriptor has a change of order – This was done on purpose to align with V and Q.
- Increased fee value is the sum of J859 and J887.
- Ventilation and perfusion studies done on the same day actually require more work than the separate exams as both components must be interpreted and then also compared.
- The current J860 value thus undercompensates physicians for this service.
- No change to overall volume.

The Section put forward the following in support of their request for revision to J869:

- The wording in the Schedule is outdated, as this procedure has been performed with multiple other agents besides MIBG for many years now.
- These are now broadly referred to as "theranostic" agents in the literature and daily practice.
- No change in overall volume.

The Section put forward the following in support of their request J830:

- This entire section of page B6 should be relabelled "Abdominal scintigraphy" as J878 is the only code that involves gastrointestinal bleed imaging.
- J830 is actually the code for a Meckel's diverticulum scan, while J879 is for LeVeen shunt patency as noted.
- No change in overall volume.

The Section put forward the following in support of their request J878:

- J878 should perhaps be moved to page B11 as it is used for bleeding imaging in general, not just in the abdomen.
- Note that J830 and J879 are not really GI bleed imaging, making the "Abdominal scintigraphy – for gastrointestinal bleed" heading on page B6 inaccurate.
- No change in overall volume.

The Committee noted the following.

- The Section needs to consult with other Sections that might be impacted.

Committee Comments:

- The OMSPC supports in principle.

32.29 Jxxx CSF circulation - Brain scintigraphy - Cerebral perfusion

32.30 J858 CSF circulation - Brain scintigraphy

The Section requested a new code Jxxx Brain scintigraphy - Cerebral perfusion at $40.30 and revision to fee code descriptor J858 to the following CSF circulation - Brain scintigraphy (except cerebral perfusion).

The Section put forward the following in support of their request:

- Cerebral perfusion studies require significantly more time and effort to interpret than other types of brain scans.
- By separating perfusion studies out, we can increase their value without affecting other types of brain scans.
- Increase in Jxxx proposed fee value depending on Section allocation.
- No change to overall volumes as all of these procedures are currently being billed as J858

The Committee noted the following.

- The Section needs to consult with other Sections that might be impacted.

Committee Comments:

- The OMSPC supports in principle.

32.31 X326 Thyroid malignancy
32.32 X327 Hyperthyroidism
32.33 X336 Prostate malignancy
32.34 X328 Polycythemia
32.35 X329 Metastatic disease of bone
32.36 X330 Ascites and/or pleural effusion(s) due to malignancy

The Section requested modernization of the Radioisotopes section of the OHIP Schedule (page C6) as follows:

FC	Descriptor	Current	Proposed	$ Increase	% Increase	Details
X326	Radionuclide therapy for malignancy ~~Thyroid malignancy~~	$85.30	$100.00	$14.70	17.2%	Value Change and Revision
X327	Radionuclide therapy for non-malignany indications ~~Hyperthyroidism~~	$77.80	$80.00	$2.20	2.8%	Value Change and Revision
~~X335~~	~~Induction of hypothyroidism~~	~~$75.9~~	~~$0.00~~			~~Delist~~
~~X336~~	~~Prostate malignancy~~	~~$75.90~~	~~$0.00~~			~~Delist~~
~~X328~~	~~Polycythemia~~	~~$45.35~~	~~$0.00~~			~~Delist~~
~~X329~~	~~Metastatic disease of bone~~	~~$70.55~~	~~$0.00~~			~~Delist~~
~~X330~~	~~Ascites and/or pleural effusion(s) due to malignancy~~	~~$54.00~~	~~$0.00~~			~~Delist~~
~~X332~~	~~Arthritis–single or multiple site~~	~~$36.45~~	~~$0.00~~			~~Delist~~

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- All codes in this section of the Schedule (page C6) are underpaid.

- As the actual procedure is nearly identical for each therapy, we propose merging X326, X336, X328, X329, and X330 into a single "Radionuclide therapy for malignancy" code and raising its value to $100.
- X327, X335, and X332 would be merged into a single "Radionuclide therapy for non-malignancy indications" code and raising its value to $80.
- Note that codes X336, X328, X329, X330, X335 and X332 would be eliminated under this proposal.
- No change in overall volume.
- We would like the entire radioisotope therapy section (page C6) moved into the Nuclear Medicine section of the Schedule as these are really Nuclear Medicine procedures, not part of Radiation Oncology.

The Committee noted the following.

- The Section needs to consult with other Sections that might be impacted.

Committee Comments:

- The OMSPC supports in principle.

33 Obstetrics & Gynaecology

33.1 Proposed Intrasectional Relativity Adjustments

The section requested intra-sectional relativity adjustment to their visit and procedural fees. See **Appendix III** for complete list of proposed fee increases.

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results supports the proposed increases and additional analysis suggests inter-sectional differences are the greatest driver of the Gender Pay Gap experienced in OB-GYN
- Female surgeons make significantly lower per-hour fees compared to males across all surgical specialties. In Gynaecology, the intra-sectional gap is narrower, because the number of codes that can be billed are limited.
- However, we are doubly disadvantaged, because GYN surgical codes are reimbursed >30% less than comparable surgical codes. There is no other reasonable explanation, other than systemic bias that procedures done exclusively on women pay substantially less than those performed by surgeons who work on both genders.
- In evaluating appropriate OB/GYN surgical fee relativity, comparison was made to BC, Alberta & Quebec fee schedules and to General Surgery & Urology fee codes with similar time & intensity
- In support of the diagnostic and therapeutic procedure fee increases, the Section noted
    - These are procedural office codes. In general all OB-GYN office codes are underfunded. That leaves those OB-GYN who only do office OB-GYN at a significant disadvantage. In particular those procedural codes that are disproportionally used for adolescent or elderly GYN patients are underfunded.
    - In the past IUDs were mainly used by multiparous patients. However, now they are very popular with young nulliparous patients. These insertions can be quite challenging and time consuming.

- The fees are higher in Alberta, BC & PQ reflecting the work done

Committee Comments:

- The OMSPC supports in principle and recommends that increases be targeted to the codes identified as being most underfunded.
- The Section is asked to prioritize their requests.
- Alternatively, the OMSPC would support a revenue neutral Intrasectional adjustment, allowing for allocation to be applied across-the-board.
- Please review Section on General and Family Practice and Emergency Medicine for common submission.

33.2 P005 Antenatal preventive health assessment.

In addition to the proposed fee increase to P005 listed in the proposed intra-sectional relativity adjustments, the Section requested that the payment rules for P005 be tightened, such that P005 can be billed only by the physician providing ongoing antenatal care and risk assessment.

The Section put forward the following in support of their request:

- The Section is aware that many OB-GYNs (and FM-OB), who actually provide the bulk of prenatal care and who perform and document the actual risk assessment are unable to bill the code, because it has been billed by a referring provider who has diagnosed the pregnancy only

Committee Comments:

- Decision deferred until feedback from Section on General and Family Practice is obtained
- Please review Section on General and Family Practice for common submission.

33.3 Axxx Consultation - child less than or equal to 16 years

The Section requested a new code Axxx Consultation - child less than or equal to 16 years at $160.00 with the following payment rules:

> Consultation for a child or adolescent for a reproductive endocrinology concern. Examples: Precocious puberty, PCOS, amenorrhea, dysmenorrhea, abnormal bleeding, pelvic pain, contraception, vulvar dermatology, etc.

The Section put forward the following in support of their request:

- OB-GYN also is a specialty in Reproductive Endocrinology & Infertility. As such, medical consults are most similar to those billed by endocrinology; code for seeing adolescent for gynaecology is comparable to Endocrinology code A765 ($165.50).
- This service is currently billed as A205 = $150.00, new medical consultation lasting 50 minutes or more = $200.00

The Committee discussed the following issues:

- This presumes an increase in A205 to a value of $150.

Committee Comments:

- The OMSPC supports in principle and asks the Section to prioritize their requests.

33.4 Axxx Reproductive Endocrinology Medical specific reassessment

The Section requested a new code Axxx Reproductive Endocrinology Medical specific reassessment at $67.75 with the following descriptor and payment rules,

> Axxx Reassessment after 6 months or more for a reproductive endocrinology problem.
>
> Note:
> Medical Specific Reassessment of a patient with a reproductive endocrinology condition.

The Section put forward the following in support of their request:

- The service includes updating condition, responses to medication prescribed, update medical & surgical history, update medications for interactions, education or counselling on disease or medications. May include a physical exam.
- Intra-Sectional Relativity (ISR) survey results supports the proposed fee: minimum time 20 minutes and average intensity is 3/5.
- Comparable services are K013 or K033 (Educational counselling) billed in lieu of an appropriate code.
- Patients are often elderly with co-morbidities and cognitive issues.
- This service is currently billed as K013.

Committee Comments:

- The OMSPC supports in principle and asks the Section to prioritize their requests.

33.5 Axx1 Medical Obstetrics & Gynaecologic Consultation lasting >=50 min

33.6 Axx2 Complex Medical Obstetrics & Gynaecologic Consultation lasting >=75 min

The Section requested two new Medical Obstetrics & Gynaecologic Consultation fees,

1. Axxx Medical Obstetrics & Gynaecologic Consultation lasting a minimum of 50 minutes at $200.00
2. Medical Obstetrics & Gynaecologic Consultation lasting a minimum of 75 minutes at $300.00

These fees would be payable to a specialist in OB-GYN who provides all the elements of a consultation and due to the complexity of the medical condition, impact on the patient's co-morbidities and/or education of patient and family. A pap smear G365/G394 + E430/431, and/or removal of cervical polyp code + E542 may be billed if performed.

The Section put forward the following in support of their request:

- In the past, a routine consultation used to take 15-25 minutes to perform, including documentation.
- The Intra-Sectional Relativity (ISR) survey results indicates that the average consultation is 44 minutes, so a substantial number of OB-GYNs already are spending 50 minutes or more to do a consult. They should be compensated appropriately for the time and intensity, knowledge & judgement.

- OB/GYN has evolved to encompass more complex elements of Reproductive Endocrinology. We feel that when the service is provided it should be paid at an equivalent to an Endocrinology Consultation (A155 - $162.65).
- An A935 is for at least 50 minutes with the patient. If more than an hour is spent with the patient providing direct care and education, it should be compensated.
- These services is currently billed as A205, A935 codes.

Committee Comments:

- The OMSPC supports in principle and asks the Section to prioritize their requests.

33.7 Axxx Intrapartum assessment by an obstetrical consultant at the request of a primary care physician or midwife

The Section requested a new code Axxx Intrapartum assessment by an obstetrical consultant at the request of a primary care physician or midwife at $100.00 with the following payment rules:

a) Payable only subsequent to obstetrician's consultation provided at least 30 minutes have elapsed between consultation and repeat evaluation and must be a separate event (i.e. time/situation).
b) Delivery fee codes payable in addition.

The Section put forward the following in support of their request:

- A consultation may have been provided early in a pregnancy for an entirely different reason than that requested by the midwife during intrapartum care.
- These may be uncompensated urgent or emergent consultations that require substantial time commitment & ongoing surveillance in labour.
- Despite scope of practice guidelines, these patients are often referred late, and decisions may have to be made under difficult conditions that would not be present if the OB were the most responsible care provider for the labour.
- Requires repeat assessment of the fetus and mother, placement of specialized fetal monitoring equipment, a period of observation, and often a recommendation to transfer care to the obstetrical service, or the need to do an emergent delivery under less than ideal conditions.
- Often a high intensity encounter 5/5, requiring expert communication, interpersonal skills, knowledge translation at an understandable level for the patient, where both the patient and physician are experiencing stress.
- Obstetricians have to respond to these requests multiple times during their call. It interferes with their ability to plan their day, and their ability to balance the needs of the other patients on the unit. The stress that this creates for the physician and nursing staff, particularly during the pandemic, is a cause of the high rate of burnout.
- Intensity 3-4. Requires repeat communication and use of interpersonal skill, knowledge & judgement, and ensuring comprehension and compliance with medications.

Committee Comments:

- The OMSPC supports in principle but recommends the fee value be set in accordance with other re-assessment fees.
- The Section is asked to provide details on indications and limits on billing.

- Alternatively, the Section could consider unbundling of associated services.

33.8 Gxxx Pessary assessment

The Section requested a new add-on code Gxxx Pessary assessment at $45.00 to a maximum of 6 times per year.

The Section put forward the following in support of their request:

- To be billed for reassessment of patient with a pessary in the vagina.
- Requires medical assessment, review of medications, removal, disinfection & washing, then vaginal replacement.
- Comparator service is G398 Initial & recurrent pessary fitting, 1 per year ($61.30); the intensity of removing, cleaning and replacement of a pessary is no less than the initial fitting & insertion.
- Patients typically come for assessment, pessary fitting, and then when the pessary comes in, a couple of exams, assessment, treatment of bleeding or discharge; these patients are often quite elderly, with multiple co-morbidities and declining mobility.
- The proposed relative value of the comparator code is approximately 50% of the proposed new fee for G398 (from $61.30 to $100).
- This service is currently billed as A204.
- Pessary assessments often take 30 minutes in the room and 10-15 minutes to change and leave the room.
- It is entirely reasonable for these patients to come in every 2-3 months.

The Committee discussed the following issues:

- The proposed value is based on a proposed increase to G398.

Committee Comments:

- The OMSPC supports in principle and would anchor the value relative to G398.

33.9 Zxxx Chemical treatment of genital condyloma or granulation tissue

33.10 Z733 Chemical treatment of genital condyloma or granulation tissue

33.11 Z736 Treatment of genital condyloma, any ablative procedure

The Section requested,

1. a new code Zxxx Chemical treatment of genital condyloma or granulation tissue, 4-15 lesions at $15.05.
2. Z733 ($11.05) descriptor be revised to Chemical treatment of genital condyloma or granulation tissue, first three lesions
3. Z736 descriptor be revied to Treatment of genital condyloma, any ablative procedure: Chemical, electrodesiccation, CO2 Laser ablation or surgical excision +/- local anaesthetic
4. Z736 fee be increase from $26.85 to $30.95.

[Commentary:
Zxxx and Z733 are to include application of TCA, AgN03 or other ablative chemical]

The Section put forward the following in support of their request:

- Currently the service is billed as Z733 chemical treatments for low grade squamous intraepithelial bleeding at $11.05.
- Z733 is very low and assumes treatment of <+3 lesions. A new code is needed, because vulvar condyloma are often more extensive than 3
- Comparable codes include:
    - Z733 GYN Treatment of condyloma (single or multiple) = $11.05
    - Z736 Condylomata - surgical excision or electrodesiccation or CO2 laser – local anaesthetic = $26.85
    - Z549 Fulgration of condyloma – local anaesthetic (General Surgery) = $30.95
    - Z701 Excision Penile condyloma – local anaesthetic = $32.60
    - These are all ablative procedures, yet the GYN procedures are paid less than ablative procedures performed by other specialties. It is an example of Gender Pay Gap affecting OB-GYN

The Committee noted the following.

- The Section provided requested information on revising the existing Condylomata fee codes listed on page V2 (Z733, Z736, and Z769) to include more clinical indications for their use

Committee Comments:

- The OMSPC supports in principle.

33.12 Zxxx Removal of intrauterine device & reimplantation

The Section requested a new code Zxxx Removal of Intrauterine device at $25.00.

The Section put forward the following in support of their request:

- There is no fee for providing this service and is currently included in the visit fee.
- BC and PQ both have codes, that are over $30.

Committee Comments:

- The OMSPC supports in principle and recommends the Section coordinate with SGFP on code details and fee value.
- Please review Section on General and Family Practice for common submission

33.13 Zxxx Complicated removal of IUD

The Section requested a new code Zxxx Complicated removal of IUD at $65.00, with the fee descriptor "Complicated removal of IUD - for retained IUD requiring the use of dilators, or other devices to extract the IUD." E542 would be eligible for payment with Zxxx.

The Section put forward the following in support of their request:

- May require the use of local anaesthetics, sterilized instruments, including dilators, a tenaculum, ring forceps, a Novak curette, Uterine packing forceps, IUD hook or other instrument to capture the IUD.
- Procedure may take 35-45 mins to successful or realize that it may not be successful.
- We have been providing the service without compensation for decades.

Committee Comments:

- The OMSPC supports in principle

33.14 Zxx1 Removal of Foreign Body from the Vagina – local anaesthesia

33.15 Zxx2 Removal of Foreign Body from the Vagina - requiring general anaesthesia

The Section requested two new fees for removal of foreign body from the vagina,

1. Zxx1 when rendered under local anaesthesia at $40.00; and
2. Zxx2 when rendered under general anaesthesia at $100.00 plus $25/15 min after the first 30 minutes

Both codes would be eligible for payment with a consultation and E542 ($11.55).

The Section put forward the following in support of their request:

- Comparator services are Z114 Foreign body removal billed ($25.25) with E542, and Z756 Fecal disimpaction ($36.80)
- There is currently no code for removing a foreign body from the vagina. Many are removed relatively easily, but other are challenging and may cause injury to the physician and the patient.
- Zxx1 is not to be used for simple retrieval of tampon
- Zxx2 is for failed removal under local anaesthetic, or inappropriate for local anaesthetic. Foreign bodies may be penetrating, scarring or infected

The Committee discussed the following issues:

- The creation of a code for complicated removal of a foreign body with a time requirement could satisfy this request (for patients either under general anaesthetic or not).
- Time and base units are used in anaesthesia billing, and procedural codes do not follow this model.

Committee Comments:

- The OMSPC supports in principle the creation of new fee for removal of foreign body from the vagina – local anaesthesia.
- The OMSPC requests additional information in support of the removal of foreign body from the vagina (general anaesthesia) request, including a comparator code for reference.
- The OMSPC recommends that the Section choose between a time-based surgical fee (for example, modelled after R226) or a flat fee for the service accounting for typical average time and intensity.

33.16 Zxxx Removal/excision cervical polyp

The Section requested a new code Zxxx Removal/excision cervical polyp at $20.00. Zxxx would be eligible for payment with a consultation, assessment and E542.

The Section put forward the following in support of their request:

- This is a procedure that requires extra instrumentation, skill and preparation with submission of the specimen to pathology.

- We have not had a pre-existing code.
- Comparable to General Surgery rectal biopsies fee Z536 ($44.65) or biopsy benign anal lesion Z757 ($47.15).

The Committee noted the following.

- The Section agreed for the fee to be linked to Z720 ($20.00).

Committee Comments:

- The OSMPC supports in principle and proposes that the fee be set equal to cervical biopsy (Z720).

33.17 E861 - paracervical block - add

The Section requested an increase for E861 from $9.00 to $20.00 (by 122.2%).

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results supports the proposed increases
- Is always performed bilaterally.
- Current description restricts use for management of pain.
- The use of local anaesthetic takes longer, there is a delay until it becomes effective & patients need monitoring & support. The new fee of $20 is more reasonable.
- This is poor care and gender biased.

Committee Comments:

- The OMSPC supports in principle

33.18 E542 Tray fee - when performed outside hospital

The Section requested an increase for E542 from $11.55 to $15.00 (by 29.9%).

The Section put forward the following in support of their request:

- Intra-Sectional Relativity (ISR) survey results supports the proposed increases
- Should be payable for more than one procedure performed at the same time out of hospital. Tray requirements are different, and currently the physician funds the cost of additional trays. Alternative is bringing the patient back for the second procedure.

The Committee discussed the following issues:

- This has implications for multiple Specialties.
- The Section acknowledged deferral of this item.

Committee Comments:

- The OMSPC holds the opinion that all tray fees should compensate for the cost of the tray.
- The decision is deferred until a more robust methodology for evaluating tray fees can be established.

33.19 Exx1 Add on to Hysteroscopy procedural codes when rendered in a private office (Z582, z583, Z585, Z586, Z587)

33.20 Exx2 Add on to Colposcopy procedure codes when performed in a private office (Z731, Z787, Z730)

The Section requested two new add-on fees,

1. Exx1 Add on to Hysteroscopy procedural codes when rendered in a private office (Z582, z583, Z585, Z586, Z587) at $22.35
2. Exx2 Add on to Colposcopy procedure codes when performed in a private office (Z731, Z787, Z730) at $22.35

The Section put forward the following in support of their request:

- There are multiple comparators in other surgical specialties such as General Surgery for colonoscopies and gastroscopies, similar for gastroenterology.
- These are all procedures that can be performed outside of hospital.
- It will save money at the hospital level because independent practitioners are currently doing this at their own cost and deserve a new procedural code.
- The new add-on fees are to be linked to E749.

Committee Comments:

- The OMSPC supports in principle.

33.21 E676 - Morbidly obese patient, surgeon, to procedural fee(s)

The Section put forward the following support their requested revision:

- Current fee is under-valued. We propose to add:
    - 25% if BMI 40-45,
    - 30% if BMI 45-55,
    - 35% if BMI 55-60,
    - 40% if BMI 60-70,
    - 50% if BMI >70"

The Committee noted the following:

- The Section acknowledged deferral of this item.

Committee Comments:

- The OMSPC does not support the request based on lack of evidence provided by the Section to justify the request.

33.22 Z463 Removal of Norplant

The Section requested that the descriptor of Z463 be revised from “Removal of Norplant” to “Removal of Hormone Pellet”.

The Section put forward the following in support of their request:

- Norplant is a trade name that is no longer available.

- Trade names used in the Schedule of Benefits create future limitations if a similar medication becomes available or the original brand is removed from the market.

Committee Comments:

- The OMSPC is supportive in principle.

33.23 P023 Oxytocin infusion for induction or augmentation of labour

33.24 Pxxx Maintenance of oxytocin use for induction or augmentation of labour, per hour

The Section requested,

1. P023 be revised to the initiation of oxytocin infusion for induction or augmentation of labour to include the first hour of monitoring and maintenance; and
2. A new fee Pxxx for maintenance of oxytocin use for induction or augmentation of labour at $25 for each additional hour.

The Section put forward the following in support of their request:

- British Columbia has a time based codes.

The Committee discussed the following issues:

- Additional clarity is needed as to whether there is ongoing 1-1 monitoring for oxytocin infusion for augmentation of labour, or rather a re-assessment at an interval of time.
- An alternative opinion is that rather than a time-based code, the code could be revised to $67.00 per first procedure and $25 for each additional procedure (e.g., creation of E add-on code); the Section was in agreement with this approach. However, the committee requires additional information on the descriptor and payment rules.
- Further consideration should be given to the concept of being paid only for delivery and not for the ongoing monitoring of labour.

Committee Comments:

- The committee supports in principle the idea of unbundling the infusion and monitoring service components.
- The committee requests the Section to provide additional information on the descriptor and payment rules

34 Occupational & Environmental Medicine

The Section is requesting a new consultation and visits menu of fees for Occupational & Environmental Medicine, as follows:

FC	Descriptor	Proposed
Fee code listing restricted to Occupational Medicine specialists (Fee values set equal to Internal Medicine)		
Axx1	Consultation	$157.00
Axx2	Comprehensive occupational medicine consultation	$300.70
Axx3	Extended special occupational medicine consultation	$401.30
Axx4	Limited consultation	$105.25
Axx5	Repeat consultation	$105.25
Axx6	Medical specific assessment	$79.85
Axx7	Medical specific re-assessment	$61.25
Axx8	Complex medical specific re-assessment	$70.90
Axx9	Partial assessment	$38.05
Fee code listing under Family Practice & Practice in General		
Ax10	Special occupational/environmental health consultation	$159.20
Ax11	Occupational/environmental health counselling	$72.15
Exxx	Collection of occupational/environmental history Payment rules: 1. Collection of occupational/environmental history fee is only eligible for payment when rendered in conjunction with one of the following services: Axx5 – Axx9, A001, A003, A004, A005, A006, A007, A130, A131, A133, A134, A135, A136, A905, C003, C004, C005, C006, C905, K005, K007, K013, K017, K130, K131, K132, P003, P004, P005, P008, H065, H055. 2. Collection of occupational/environmental history fee is limited to a maximum of one service per patient per 12-month period.	$15.55

The Section put forward the following in support of their request:

- We propose to create a new OHIP code unique to Occupational Medicine (instead of lumping Occupational Medicine together with Internal Medicine under the code '13').
- Occupational Medicine is the only subspecialty that does not have its own codes and is combined together with Internal Medicine.
- The proposed fee is the same as that for Internal Medicine.
- The main change here is to have an Occupational Medicine – specific fee codes Axx3, Ax10 and Ax11.
- Creation of a specialty-specific fee code will enable a means to analyse provision of occupational medicine assessments (e.g., for future relativity analyses, understand practice patterns, identify gaps in care such as geographic patterns and targeting educational supports).
- Axx3 Extended special occupational medicine consultation proposed fee is the same as that for Neurology.
    - Occupational medicine consultations frequently extend beyond 90 minutes as they include a lengthy occupational history taking, review of hazards and exposures, review of safety data sheets, a general health review to assess alternative causes for signs/symptoms, a comprehensive physical examination, and a detailed risk communication and recommendations to the patient.
    - This service is currently billed as A130 at $300.70, which assumes the 75-minute minimum time.
    - Currently, there are no fee codes available for significantly longer visits.
    - Given a very lengthy nature of patient visits in our specialty, we request to have a fee code for visits longer than 90 minutes similar to A682 Extended special neurology consultation - $401.30
- For Ax10 Special occupational/environmental health consultation is currently billed as A912 Comprehensive family and general practice consultation at $217.15.
    - Current available fee codes for our Section create huge disparity and do not reflect the amount of work and time involved in an occupational/environmental consultation. As a result, those few who practice fee-for-service occupational and environmental medicine are underpaid for their unique expertise, time, and work intensity.
    - The consultation is not a third-party request and is not covered by WSIB.
    - Such consultation implies that the family physician is comfortable providing occupational/environmental assessment through experience, a special interest, or other qualifications (for example through a Canadian Board in Occupational Medicine).
    - Another aspect of occupational medicine is fitness for duty assessment for those with various medical conditions as well as return to work planning. Some of these assessments are done as a part of a third-party payment process.
    - However, a significant proportion of Ontario workers are employed by small businesses that do not have occupational health departments that would pay for such assessments. The task of ensuring safe return to work for this population, by default, falls within the fee-for-service system.
    - Current lack of appropriate fees to cover these assessments results in the general reluctance of physicians to spend the necessary time for these visits.
    - Workplace-health interaction is present in 50% of clinic visits and requires more attention from physicians according to Huber et al.

- Currently, there is no added fee for collection of occupational/environmental history. Such collection is frequently neglected and overlooked or reduced to simply stating the patient's job title.
    - Workplace-health interaction is present in 50% of clinic visits and requires more attention from physicians according to Huber et al. However, taking occupational/environmental history is frequently neglected. Physicians are reluctant to spend the necessary time due to the lack of incentives.

The Committee noted the following

- The committee requires the Section to provide additional information on how to identify family medicine physicians practicing in occupation and environmental medicine within the OHIP claims data and training/experience required in order to bill these proposed codes.
- The committee does not support the proposed Exxx fee, as this is currently a defined element of existing assessment codes.

Committee Comments:

- The OMSPC supports in principle the request to create a new fee code listing restricted to Occupational Medicine specialists where fees are set equal to Internal Medicine.
- The OMSPC supports in principle the request to create new fee codes Ax10 and Ax11 under the general listings for Family Practice & Practice in General. The Section is requested to provide appliable payment rules and requirements to be eligible to bill the proposed fees (e.g., details on required training and/or experience).
- The OMSPC does not support the creation of Exxx Collection of occupational/environmental history for the reasons noted above.

35 Ophthalmology/Eye Surgeons of Ontario

35.1 E159 Strabismus procedure one muscle one or both eyes
35.2 Exxx Strabismus surgery supplement for each additional horizontal or vertical rectus muscle operated on (maximum 8 muscles)
35.3 E158 Strabismus procedure – two muscles, one or both eyes
35.4 E162 Strabismus procedure – three or more muscles, one or both eyes
35.5 Exxx Surgery on the inferior oblique muscle
35.6 Exxx Surgery on the superior oblique muscle
35.7 Exxx Supplemental for an additional superior or inferior oblique muscle surgery
35.8 E949 - for adjustable suture
35.9 E952 Repeat operation on a previously operated eye muscle. Current Descriptor: Strabismus procedures - repeat strabismus procedure
35.10 Exxx Transposition of extraocular muscles

The Section is requesting modernization to strabismus procedure fee code listing as follows,

Repair
Strabismus procedures

Fee code	Descriptor	Current Fee	New Fee
E159	Strabismus surgery on one horizontal or vertical rectus muscle ~~procedure one muscle one or both eyes~~	$369.00	$525.15
Exx1	Strabismus surgery supplement for each additional horizontal or vertical rectus muscle operated on (maximum 8 muscles)		$446.38
~~E158~~	~~Strabismus procedure - two muscles, one or both eyes~~	~~$460.00~~	delisted
~~E162~~	~~Strabismus procedure - three or more muscles, one or both eyes~~	~~$542.00~~	delisted
Exx2	Strabismus surgery performed on one of the inferior oblique muscles		$543.65
Exx3	Strabismus surgery performed on one of the superior oblique muscles		$600.00
Exx4	Surgery performed on a second superior or inferior oblique muscle on the second eye in the same surgical session		85%
E949	*For adjustable suture placed on an extraocular eye muscle for adjustment at the time of surgery or post-operatively.* Payment Rule: *For each adjustable suture placed on an extraocular eye muscle.*	$100.00	$180.00
E952	Repeat ~~strabismus procedure~~ operation on any previously operated muscle. Addition per muscle (maximum 11 muscles) NOTE: Re-operation code supplements are applicable to cases of dysthyroid eye disease, when a retinal buckle is or has been present, post trauma involving or very close to an eye muscle affecting its attachments, or orbital fracture affecting orbital contents.	$175.00	$219.10
Exx5	*Transposition of extraocular muscle to treat paretic or lost, damaged eye muscles*		$600.00

(Revisions underlined, deletions ~~strikethrough~~)

The Committee noted the following with respect to the Section's overall submission.

- These procedures are primarily provided to paediatric patients
- The Section is attempting to address intra-sectional relativity, noting that these fees have been reviewed in many years.
- The section does not support a time-based surgical add-on for services that run longer than a typical duration because this would not encourage physician efficiency and does not recognize expertise. This may lead to cases taking longer than absolutely necessary, which is not good for patient care particularly for paediatric patients.

The Section put forward the following in support of their request to change E159 and deletion of E158 and E162 with the creation of a new fee in their place:

- Strabismus surgery requires painstaking care for accuracy of muscle positioning, and prevention of globe damage.
- This procedure is carried out for patients who are often young children and infants or adults with diplopia secondary to misalignment of the eyes. Patient safety has demonstrated significant adverse effects in the range or 1:50,000 procedures and success to re-align the eyes within 3-5 degrees of orthophoria is over 80%.
- Currently paediatric ophthalmology manpower is extremely limited, with little ability to attract new surgeons leading to a scarcity of care, and increasingly long waits for patients, often leading to permanent loss of vision.
- Current fees have made it extremely difficult if not impossible to run a paediatric ophthalmology and strabismus surgical practice outside a major University centre in a revenue positive fashion.
- Typical patients are in 3 categories. Infants and young children 9 months to 4 years are the most critical and at risk for permanent visual loss. Children 4-17 remain extremely important as they lose binocularity, vision that leads to learning delays, functional delays, and psychological problems. Adults often have intractable double vision and are unable to work and function in society and are at increased risk of falls.
- The procedure is moderately intense with risk of damaging the eye, leading to blindness, malposition or loss of an extraocular muscle leading to misalignment of the eyes and constant double vision.
- The procedure is microsurgical requiring magnification and use of micro instruments, along with all care and expertise required to perform the service.
- Technical skill is moderate to high to perform this procedure. The complexity is increased as the procedure involves multiple extraocular muscles on one or both eyes.
- Comparable fee code is E152 Scleral bucking procedure $700
- Frequency of Procedure or Service is between 2000-2300 cases for strabismus of all forms in total.
- Ontario has close to the lowest compensation for this procedure in Canada, as a result few surgeons are willing to perform this complex procedure affecting children's development and leaving adults with intractable double vision.
- We suggest that the fee be adjusted to be equal or above those currently active in Quebec (which remains lower than other provinces).

The Committee noted the following

- Each additional muscle can take 15-30 minutes depending on the complexity and risk.

The Section put forward the following in support of their request for the new inferior and superior muscle repair fees:

- Strabismus surgery requires painstaking care for accuracy of muscle positioning, and prevention of globe damage. The inferior oblique muscle affects both position as well as torsion.
- Treatment is complex and requires expertise typically gained through fellowship training, or additional training post residency.
- Damage or mishandling of the muscle can lead to worsening of eye position and diplopia.

- This procedure is carried out for patients who are often young children and infants or adults with diplopia secondary to misalignment of the eyes.
- Patient safety has demonstrated significant adverse effects in the range or 1:50,000 procedures and success to re-align the eyes within 3-5 degrees of orthophoria in vertical, horizontal and torsional positions is over 75%.
- Current payment is amongst the lowest in Canada. Currently paediatric ophthalmology manpower is extremely limited, with little ability to attract new surgeons leading to a scarcity of care, and increasingly long waits for patients, often leading to permanent loss of vision
- Typical patients have suffered from either a congenital or traumatic IV nerve palsy (although other causes do occur).
- Patients requiring treatment range from Infants and young children 9 months to 4 years being the most critical and at risk for permanent visual loss. Children 4-17 remain extremely important as they suffer from new onset double vision, loose binocularity, which together can lead to learning delays, functional delays, and psychological problems. Adults often have intractable double vision and are unable to drive, work and function in society and are at increased risk of falls.
- The procedure is moderately intense with risk of damaging the eye, leading to blindness, malposition or loss of an extraocular muscle leading to misalignment of the eyes and constant double vision.
- The procedure is microsurgical requiring magnification and use of micro instruments, along with all care and expertise required to perform the service.
- Technical skill is moderate to high to perform this procedure, in addition to rectus muscles the oblique is more difficult to access and handle and requires manipulation of 2 rectus muscle to access it.
- Comparable fee code is E152 Scleral bucking procedure $700
- Currently billed under: E159 or E162 (both to be replaced)

The Committee noted the following.

- The procedure is different than E159 in that these muscles are located under other muscles and effect both rotation and torsion of the globe; they are much more difficult to reach and treat.
- The risk of diplopia post op along with bad outcomes is far greater in these cases.
- These surgeries require additional expertise and are only performed by fellowship trained paediatric and strabismus experts.
- The section's intention is to have two Exxx, Surgery on the superior and inferior oblique muscle that would replace E159.

The Section put forward the following in support of their request for E949 fee increase and descriptor revision:

- Strabismus surgery requires painstaking care for accuracy of muscle positioning, and prevention of globe damage.
- Operating on previously operated muscles is extremely complex
- Adjustable sutures allow the surgeon to adjust the eye muscle position intraoperatively or post operatively to attain the best eye position result.
- The use of adjustable sutures is complex and requires expertise typically gained through fellowship training, or additional training post residency.

- This procedure is carried out for patients' children and adults often with diplopia secondary to misalignment of the eyes. Patient safety has demonstrated significant adverse effects in the range or 1:50,000 procedures and success to re-align the eyes within 3-5 degrees of orthophoria in vertical, horizontal and torsional positions is over 80%.
- Patients requiring treatment range from young children 4+ years of age to 17 years who have more complex strabismus and adults often have misalignment and often intractable double vision and are unable to drive, work and function in society and are at increased risk of falls.
- The procedure is moderately intense, due to the complexity of how to place the adjustable suture without causing further damage, isolating it and determining the appropriate procedure to perform to attain the best.
- The procedure is microsurgical requiring magnification and use of micro instruments, along with all care and expertise required to perform the service. Technical skill is moderate to perform this procedure.

The Section put forward the following in support of their request for E952 fee increase and descriptor revision:

- Strabismus surgery requires painstaking care for accuracy of muscle positioning, and prevention of globe damage.
- Operating on previously operated muscles is extremely complex secondary to scarring, possible fat adhesion altered muscle positions, complexity in identifying the correct muscle and determining appropriate treatment.
- Treatment is extremely complex and requires expertise typically gained through fellowship training, or additional training post residency.
- Damage or mishandling of the muscle can lead to worsening of eye position and diplopia.
- This procedure is carried out for patients who are often young children and infants or adults with diplopia secondary to misalignment of the eyes.
- Patient safety has demonstrated significant adverse effects in the range or 1:20,000 procedures and success to re-align the eyes within 3-5 degrees of orthophoria in vertical, horizontal and torsional positions is over 70%.
- These patients have had previous eye muscle surgery (or diseases such as Graves disease that alters the muscle significantly with scarring and restriction).
- Patients requiring treatment range from Infants and young children 2-3 years of age to 17 years who should be treated as they can suffer from blurred vision and new onset double vision. They can lose binocularity, which can lead to learning delays, functional delays, and psychological problems. Adults often have intractable double vision and are unable to drive, work and function in society and are at increased risk of falls.
- The procedure is intense, due to the complexity of identifying scarred muscle without causing further damage, isolating it and determining the appropriate procedure to perform to attain the best result.
- There is an increased risk of damaging the eye, leading to blindness, malposition or loss of an extraocular muscle leading to misalignment of the eyes and constant double vision.
- The procedure is microsurgical requiring magnification and use of micro instruments, along with all care and expertise required to perform the service.
- Technical skill is high to perform this procedure.

The Committee noted the following with regards to E949 and E952:

- The proposed fee increase addresses intra-sectional fee relativity.
- Multi-muscle procedures are quite common
- Not every muscle requires the same amount of time. The more scarred and difficult to reach and treat the muscle the more time it will take.
- The section does not support a time-based surgical add-on for services that run longer than a typical duration because this would not encourage physician efficiency and does not recognize expertise. This may lead to cases taking longer than absolutely necessary, which is not good for patient care particularly for paediatric patients.

The Section put forward the following in support of their request for a new transposition of extraocular muscles fee:

- Strabismus surgery requires painstaking care for accuracy of muscle positioning, and prevention of globe damage.
- Operating on one or multiple eye muscles when other eye muscles are paretic damaged, abnormal or lost requires complex procedures to isolate and move an extraocular muscle to a new position. This procedure risks damaging the eye and or worsening the eye movements.
- This is a very complex and time consuming procedure requiring great expertise to obtain a reasonable result.
- Expertise to perform this procedure is typically gained through fellowship training.
- This procedure is carried out for patients' children and adults often with diplopia secondary to a paretic muscle or muscle, malformations, genetic diseases, and trauma. These all lead to misalignment of the eyes. Patient safety has demonstrated significant adverse effects in the range or 1:40,000 procedures and success to re-align the eyes to an acceptable level allowing as a minimum some areas with single binocular vision.
- Patients requiring treatment range from young children 4+ years of age to 17 years who have more complex strabismus and adults often have misalignment and often intractable double vision and are unable to drive, work and function in society and are at increased risk of falls.
- The procedure is highly intense, due to the complexity of isolating and moving often multiple eye muscles without causing further damage to the globe or muscles. It is as well very complex determining the best procedure to employ in order to attain the best possible result.
- The procedure is microsurgical requiring magnification and use of micro instruments, along with all care and expertise required to perform the service. Technical skill is high to perform this procedure.
- Comparable fee code is E152 Scleral bucking procedure $700
- Currently being billed as E162.
- Performing adjustable suture technique is complex and time consuming and should have its code adjusted

The Committee noted the following regarding the proposed new fee for transposition of extraocular muscles:

- This fee would account for the transposition for one eye which is most common. It is rare to need to do this bilaterally in one sitting due to its complexity and time requirements.
- Each muscle takes the same amount of time. Each is equally as complex. Very posterior dissection is required with increased risk, and expertise to perform.
- Maximum of 2 extraocular muscles per eye; the second procedure would be paid at 85%.

- The section would be willing to consider creation of a time-based surgical add-on fee for this procedure, as at times, this procedure can run excessively long.

Committee Comments:

1. The OMSPC supports in principle a fee increase to E159
2. The OMSPC supports in principle to delist E158 and E162 and create a new of Exxx Strabismus surgery supplement fee
    - The Section is to provide payment rules guiding appropriate limits on the number of muscles under repair in Strabismus surgery and to ensure that total payment is in relativity with comparable services.
3. The OMSPC supports in principle the creation of new fees for inferior and superior oblique muscles
4. The OMSPC supports in principle the proposed fee increases and revisions to E949 and E952 with the following requirements proposed by the Section:
    - REPEAT PROCEDURE: strabismus repair being performed on a patient who has had previous strabismus surgery, or has had a retinal buckle procedure, Graves disease, trauma, or other procedure that has scarred or disrupted the extraocular muscles.
    - ADJUSTABLE SUTURE: When adjustable suture technique has been employed on one of more extraocular muscle during strabismus surgery.
5. The OMSPC supports in principle the creation of new fee for transposition of extraocular muscles

35.11 A233 Specific assessment

35.12 A234 Partial assessment

The section is requesting that,

1. A233 Specific assessment ($57.70) be allowed to be billed up to 4 times a year for paediatric patients, and
2. the paediatric premiums found on page GP64 be applied A233 Ophthalmology Specific assessment and A234 Partial assessment
3. A234 fee be increased from $28.95 to $30.50

The Section put forward the following in support of their request:

- Specific assessments in the case of paediatric patients are often required in excess of 2 visits per year.
- These examinations are often very complex taking 20+ minutes to complete due to difficulties secondary to cooperation and complexity.
- Incomplete or inaccurate examinations can lead to permanent loss of vision for these children.
- The A233 code should have attached the paediatric premiums to compensate for additional time, intensity, and risk.
- Partial assessments in the case of paediatric patients are often very complex in these cases taking significantly more time to complete than adult examinations due to difficulties secondary to cooperation and complexity.
- Review of Intra-Sectional Relativity (ISR) survey results demonstrated that most respondents felt A234 was undervalued.

- Increasing the value of the code is a first step in promoting both office-based care and the care of patients with chronic disease.

The Committee noted the following.

- The section is open to the creation of a new code that would apply to paediatric patents and allows for four (4) services per year.

Committee Comments:

- The OMSPC supports in principle.

35.13 Exxx Amblyopia (add on to A234 or A233)

The Section is requesting a new add on fee to A234 Partial assessment and A233 Specific assessment for Amblyopia at $50.00 with the following descriptor:

> *Exxx - for assessing a paediatric patient with amblyopia (low vision in one eye) undergoing active treatment through occlusion therapy, penalization, dichoptic therapy, refractive therapy or similar to maximize vision in the amblyopic eye(s), add $50.00*

The Section put forward the following in support of their request:

- The fee is for assessing a paediatric patient with amblyopia (low vision in one eye) undergoing active treatment through occlusion therapy, penalization, dichoptic therapy, refractive therapy or similar to maximize vision in the amblyopic eye(s).
- This add on code can be billed in addition to the A234 or A233 code when assessing and treating a patient 10 years of age or younger with amblyopia.
- Amblyopia is the single largest cause for low vision in one eye and is a leading cause of blindness. Treatment must be started at a young age to have the highest chance for success.
- Treatment requires ongoing therapy with frequent visits (every 3-4 months) and close observation of visual progress, and close attention to any factors that may further maximize visual gains (including refraction, eye movements- strabismus, ptosis, ocular disease that impacts on the clarity of the visual axis.
- Infants from birth who have any process that prevents an appropriate visual information from reaching the occipital cortex of the brain. Examples would be a child with strabismus and or a refractive error where one eye is neglected (lazy eye) leading to poor formation of the visual centres in the cortex.
- Professional activities associated with the performance of this procedure or service:
    - Full examination, with careful attention to vision must be performed using various techniques (depending on age).
    - Determination of treatment, and observation of success of treatment over time.
    - Detailed explanation to parents along with reinforcement of treatment techniques
    - Continued observation for any factors that may impede improvements including ocular (media and motility), and neurological issues.
- Moderate intensity as this relates often to the difference between blindness in an eye versus sight. There must be clear communication with the parents regarding the necessity of following the treatment plan, along with markers for success. The examination at each visit must be

thorough to ensure there are no changes that could limit the effect of treatment, including change to the eyeball, motility, optic nerve and cortex.

- Is this procedure/service is not currently being billed under another fee code.
- Frequency of Procedure or Service: 12,000/year.
- Due to the time and effort required to treat patients with amblyopia there are few providers comfortable and willing to take on the challenge; this can take 5-20 minutes to perform and is then added to other parts of the exam, and treatment planned. As a result, many children are missed or not treated and permanent loss of vision the result.
- This procedure is equivalent in intensity to a detailed anterior of posterior segment examination.
- Amblyopia treatment is critical for the young to maximize lifelong visual potential.

Committee Comments:

- The OMSPC supports in principle.

35.14 Exxx Extraction cataract all types of, by any procedure, bilateral and simultaneous, includes insertion of intraocular lens

The Section is requesting a new fee for extraction cataract all types of, by any procedure, bilateral and simultaneous, includes insertion of intraocular lens at $795.50 with the following descriptor and payment rule:

Proposed Descriptor:
Exxx Immediately sequential bilateral cataract surgery.

Proposed payment rule:
Simultaneous bilateral cataract surgery performed in the same surgical session.

The Section put forward the following in support of their request:

- Simultaneous bilateral cataract surgery (SBCS) will allow for direct and indirect health care savings.
- In addition, greater surgical efficiencies will aid in reducing the significant surgical backlog for cataract surgery.
- The current code results in a 15% reduction in the surgeon fee for the billing on the second eye, which acts as a dis-incentive for adoption.
- Comparable fee code: E140 at $397.75. Currently, billed E140 Cataract extraction x 2 with a 15% reduction on the second billing.
- New code would align with the ministry's recent increase in QBP hospital funding for BSCS.

The Committee noted the following.

- Surgical Preamble Payment rule #3 of the OHIP Schedule essentially states that when more than one procedure is carried during the same operation, the major procedure is paid in full and additional procedures are discounted by 15%; this payment rule also applies to bilateral procedures (see page SP3).
- The Section was requested to provide a rationale why the payment discount rule should not apply to cataract surgery in terms of time, intensity and intra-sectional fee relativity principles.

Committee Comments:

- The OMSPC supports in principle, but payment should be in accordance with Surgical Payment rule #3, as stated above.

35.15 Axxx Uveitis and ocular inflammatory diseases consultation

35.16 Cxxx Uveitis and ocular inflammatory diseases Consultation (Inpatient)

The section is requesting the creation of two new fee codes:

1. Axxx Uveitis and ocular inflammatory diseases consultation at $150.00
2. Cxxx Uveitis and ocular inflammatory diseases consultation (Inpatient) at $150.00

With the following payment rules and commentary:

1. A/C232 is only eligible for payment when the following are documented as part of the examination:
    a. Dilated examination of the fundus
    b. Analysis of pertinent laboratory testing and radiological studies performed for investigation of the patient's ocular inflammatory disease
    c. Analysis of pertinent ocular imaging studies performed for investigation of the patient's ocular inflammatory disease
2. A/C232 is only eligible for payment to an ophthalmologist with fellowship training in uveitis and ocular inflammatory diseases
3. A/C232 is only eligible for payment for the consultation of a patient with a uveitis, ocular inflammatory or orbital inflammatory disorder.

[Commentary: In circumstances where a uveitis specialist renders a consultation service to a patient who is not referred for a consultation for a uveitis, ocular or orbital inflammatory disorder or, where the patient does not have a uveitis, ocular or orbital inflammatory disorder, see general listings.]

The Section put forward the following in support of their request:

- An analysis of relativity from billing data assessed in the Section and the number and distribution of Ophthalmologists in the Section with training in this area shows that ophthalmologists with highly specialized training in ocular inflammatory diseases are caring for patients with complex ocular disease and multisystem inflammatory problems with a high intensity and duration for consultations and resulting follow up care.
- Consultations for patients with uveitis and ocular or orbital inflammation are longer than a general consultation due to patient data collection and patient education and require enduring communication with Rheumatologists and other medical specialists, as well as follow up on results of, and monitoring of laboratory testing and radiological or medical imaging.
- A patient with uveitis, ocular inflammatory disease or orbital inflammatory disease with an associated systemic or multisystem/multiorgan inflammatory or autoimmune disease.
- Generally, such patients would have an acute, sight-threatening ocular problem and require timely care with the need for multiple investigations to search for a cause of the ocular inflammation, which is often found after investigations to be linked with another potentially organ-threatening inflammatory disease. Both adult and paediatric patients present with uveitis and ocular inflammation.

- In addition to consulting with an ophthalmologist with this specialized training, other medical specialists, such as Rheumatologists, Internists, Respirologists, Nephrologists, Dermatologists and Infectious Disease specialists are consulted and regularly in the circle of care of these patients.
- A concise and detailed history including patient demographics, date of immigration if relevant, occupation, history of presentation and chief complaint, visual symptoms and duration, current/recent hospitalizations or illnesses, vaccination history, past medical history, past ocular history, past surgical history, family history (esp autoimmune diseases), social history including smoking history and occupational exposures, sexual history and orientation, TB exposures, sexually transmitted disease exposure or infection, potential infectious exposures, HIV history, travel history, history of current or past immunosuppression, cancer history and treatments, illicit or injected drug use, past use of corticosteroids, tolerance of past therapies/failed immune modulatory therapies, history of steroid associated eye pressure elevation and insurance coverage.
- Patient examination with dilation and complete fundus exam. Ocular imaging tests, generally optical coherence tomography and angiography, fundus photography, visual fields, but also not infrequently fluorescein angiography, indocyanine green angiography, ocular ultrasound, ultrasound biomicroscopy.
- Patients not infrequently undergo assessment of ocular fluids for infection or cancer. Laboratory testing and radiologic investigations such as chest x-ray, chest CT scan, neuroimaging are expected for such patients. Commonly, referrals to other medical and surgical specialists are requested and ongoing communication as the diagnosis and therapy for the patient evolve are essential.
- The service intensity for assessment of patients with ocular inflammatory diseases is a high intensity.
- Knowledge of immune modulating and biologic therapies, biosimilars, and other medical treatments is key.
- Specialization in this area requires maintaining a knowledge base specific to the above and to new and emerging therapies for uveitis and judgement of when and how best to apply these therapies.
- Communications at the time of consultation and enduring communication about the patient's course and effect of therapies requires a higher intensity and longer duration than a general consult in ophthalmology.
- Risk to patients of therapies applied for their ocular inflammatory disease, in terms of risk to the eye and systemic risk or risk to other organs is high. Communication with the patient and patient education about their disease, the implications for other organ systems and a patient-centered approach to both local eye and systemic therapy requires a high intensity during visits.
- Additional procedures, including ocular fluid analysis or laser are not infrequently done with an assessment of this type.
- Comparable fee codes A590 Comprehensive rheumatology consultation ($300.70)
- Estimated frequency of the Service is 950 per specialist annually, billed by 10-12 uveitis specialists in Ontario.
- The change is relevant to attracting new graduates to pursue fellowship training in this area of ophthalmology that is underserviced and higher intensity and as a result generates less clinical income than a general ophthalmologist and is therefore unattractive to new graduates.

The Committee noted the following.

- A935 Special surgical consultation could be billed for these consultations where time with patient meets 50 minutes duration requirement. However, the Section noted that many of the activities completed as part of the consultation are not patient-facing and would therefore not be included in the time required to bill an A935 code.
- An alternative approach would be to create a complex assessment code with appropriate descriptor and payment criteria, similar to codes such as A250 Retinopathy of prematurity assessment or A252 Initial vision rehabilitation assessment.

Committee Comments:

- The OMSPC supports in principle to create a new fee for this service but proposes to create a complex assessment code with appropriate descriptor and payment criteria, similar to codes such as A250 Retinopathy of prematurity assessment or A252 Initial vision rehabilitation assessment.

35.17 A/C/W231 - Neuro-ophthalmology consultation

The section is requesting a fee increase for A/C/W231 Neuro-ophthalmology consultation from $120.00 to $150.00 and a revision to its payment rules to allow referrals from optometrists.

The Section put forward the following in support of their request:

- The code is undervalued, and the service is underpaid. In Alberta, the service is reimbursed at $220.87 and in Quebec the service is reimbursed at $240.
- Please note that in addition to the increased fee, the payment rules include eligibility for payment when the referral for consultation is made by a physician or optometrist. At the time the code was created, it was an oversight that referrals from optometrists were excluded.
- In terms of time and intensity relative to a routine ophthalmology consultation, neuro-ophthalmologists are highly specialized physicians with fellowship training in neuro-ophthalmology and care for patients with complex neuro-ophthalmic disease associated with multisystem neurological problems.
- Consultations for patients with neuro-ophthalmic problems are longer than a general consultation due to broad patient data collection, increased need for patient education, and require ongoing communication with neurologists and other medical specialists, as well as follow up on ocular testing results and medical imaging. Patients often present with an acute, sight-threatening neuro-ophthalmic problem and require timely care with the need for multiple investigations for diagnosis.
- In addition to consulting with an ophthalmologist with neuro-specialized training, other medical specialists, such as neurologists, neurosurgeons, internists, respirologists, nephrologists, dermatologists and infectious disease specialists are consulted and are regularly in the circle of care of these patients.
- There are approximately 20 neuro-ophthalmologists in Ontario who would qualify to bill A231/C231/W231 codes with the proposed payment rules.

Committee Comments:

- The OMSPC supports in principle.

35.18 Exxx Cyclo-photocoagulation/ablation/destruction (laser to the ciliary body) - either trans-scleral or endoscopic

The section is requesting a new fee for cyclo-photocoagulation/ablation/destruction (laser to the ciliary body) - either trans-scleral or endoscopic at $400.

The Section put forward the following in support of their request:

- Currently there is no code for this procedure which is billed as E134 Laser angle surgery ($205.55) and is regularly done for the treatment of glaucoma; there is a billing code for this procedure in Quebec and BC
- It is outlined as a glaucoma treatment option in the Canadian Ophthalmological Society glaucoma guidelines.
- The closest existing code is E134 Laser angle surgery ($205.55) which include laser angle surgery, typically used for laser trabeculoplasty, which is much less involved than cyclophotocoagulation laser (as this requires local anaesthesia by injection rather than topically, and can be done in both office or operating room setting).
- Patients with glaucoma (traditionally those with refractory glaucoma and limited vision potential, but with newer technology available currently, this laser is used also earlier in the disease staging i.e., even for mild-moderate glaucoma).
- The physician requires specialty training to be capable of performing local anaesthesia injection (subconjunctival / sub-Tenon's / retro-bulbar), and operation and application of the laser machine and probe, and management of post-procedure inflammation or complications (e.g., hypotony).
- Risk, stress and technical levels are considered to be moderate.
- The above comparable code does not have recurring probe costs (which is approximately $323-$395 CAD per probe, depending on model), and are technically less involved than cyclophotocoagulation laser.
- Estimated frequency is 4 or less (similar to other glaucoma laser such as E134 laser trabeculoplasty)

Committee Comments:

- The OMSPC supports in principle.

35.19 U235 - initial e-assessment

35.20 U236 - Follow-up e-assessment

The section is requesting a payment rule revision for U235 Initial e-assessment ($45.85) and U236 Follow-up e-assessment ($28.95) be revised to allow referrals from optometrists.

The Section put forward the following in support of their request:

- Majority of referrals (and therefore follow up examinations) to ophthalmology originate from optometry.
- The inability to use this code when the encounter originates from an optometrist act as a dis-incentive for the adoption of tele-ophthalmology.

Committee Comments:

- The OMSPC supports in principle.

36 Orthopaedic Surgery

36.1 Orthopaedic fee relativity adjustments

The Section put forward the following in support of their request:

- The Section developed its own relativity model that took the following three factors into account.
    - It used a more accurate measure of time using anaesthetic time units rather than the subjective measure used in the survey.
    - It took into account the additional procedures that are often performed as it is very unusual to bill the procedures alone rather than with other codes.
    - It assumed that the other measures typically used to compare procedures or specialties, e.g., years of training, practice expenses, etc. were the same for all the procedures since they were all performed by Orthopaedic surgeons.
- This analysis enabled a calculation of a moment of care price for each procedure which was a truer representation of what the surgeon would be paid. The moment of care price of any single code was then compared to the benchmark code's moment (R440 Total hip arthroplasty) to determine whether it was undervalued and if so, then by how much.
- The Section then applied its allocation to close the gap either partially or fully.

36.2 Rxxx Flatfoot Correction
36.3 Rxxx Cavovarus Foot Reconstruction
36.4 Rxxx ORIF Femoral Nonunion
36.5 Rxxx Subtalar Arthroeresisis
36.6 Rxxx Open Reduction Recurrent Shoulder Dislocation with Bone Block
36.7 Rxxx Distal Biceps Tendon Repair – Acute
36.8 Rxxx Acute Hamstring Repair
36.9 Rxxx Chronic Hamstring Repair
36.10 Rxxx Distal Biceps Tendon Repair – Chronic
36.11 Rxxx Distal triceps Tendon Repair – Acute
36.12 Rxxx Multi ligament knee reconstruction– Acute
36.13 Rxxx Osteochondral transplantation (any joint)
36.14 Rxxx Distal Triceps Tendon Repair - late repair or chronic
36.15 Rxxx Pectoralis Major Repair - early (less than 4 weeks)
36.16 Rxxx Pectoralis Major Repair - late repair (> 4 weeks, or requiring a graft)

Orthopaedic Surgery has a number of procedures or services provided that are not currently included in the fee schedule. These procedures are therefore billed as either:

1. another fee code that is listed and thought to be most appropriate by the surgeon, or
2. an Independent Consideration (IC)

Therefore, the Section requested to modernize the fee schedule, with the proposed fee values in relativity with comparable codes and R440 Total hip arthroscopy, so physicians have a mechanism to bill appropriately for the following services:

FC	Descriptor	Proposed	Details
Rxx1	Flatfoot Correction	$1,000.00	Comparable to R493 Ankle total replacement ($1,177.50). Currently billed using various codes
Rxx2	Cavovarus Foot Reconstruction	$1,000.00	Comparable to R493 Ankle total replacement ($1,177.50). Currently billed using various codes
Rxx3	ORIF Femoral Nonunion	$1,300.85	Comparable to fixation of femur fracture Approximately 125-175 cases yearly
Rxx4	Subtalar Arthroeresisis	$500.00	Comparable to subtalar fusion
Rxx5	Open Reduction Recurrent Shoulder Dislocation with Bone Block	$758.30	Currently billed as R401 ($419.65) + R568 ($338.65) or on IC basis Comparable to Rotator cuff repair (average payment of $979)
Rxx6	Distal Biceps Tendon Repair – Acute	$720.00	Currently billed using various codes Performed 10-20/year on average for those with applicable credentials
Rxx7	Acute Hamstring Repair	$387.00	Comparable to R587 Quadriceps repair - reconstructive - $387
Rxx8	Chronic Hamstring Repair	$580.50	Comparable to 1.5 x R587 Quadriceps repair - reconstructive - $387
Rxx9	Distal Biceps Tendon Repair – Chronic	$880.00	Alberta currently pays $880.00 Currently billed using various codes
Rxx10	Distal triceps Tendon Repair – Acute	$705.00	Alberta currently pays $705.00 Currently billed using various codes
Rxx11	Multi ligament knee reconstruction– Acute	$1,500.00	Currently billed using various codes
Rxx12	Osteochondral transplantation (any joint)	$500.00	Comparable code is R542 extensive ligament reconstruction ($517.85)
Rxx13	Distal Triceps Tendon Repair - late repair or chronic	$880.00	Alberta currently pays $880.00 Currently billed using various codes
Rxx14	Pectoralis Major Repair - early (less than 4 weeks)	$705.00	Currently billed using various codes
Rxx15	Pectoralis Major Repair - late repair (> 4 weeks, or requiring a graft)	$880.00	Typically billed as R521 ($314.60) and R527 ($434.25).

Committee Comments:

- The OMSPC defers deliberations on these proposals due to timing of submission.

37 Otolaryngology

37.1 Axxx Audiologist-requested assessment

37.2 Axxx Special Audiologist-requested assessment

37.3 Axxx Dentist-requested assessment

37.4 Axxx Special dentist-requested assessment

The section requested creating new Audiologist and Dentist requested fee codes as follows:

FC	Descriptor	Proposed	Details
Axx1	Audiologist-requested assessment	$79.90	Same fee as A245 Consultation
Axx2	Special audiologist-requested assessment	$160.00	Same fee as A935 Special surgical consultation Minimum of 50 minutes of direct contact with the patient
Axx3	Dentist-requested assessment	$79.90	Same fee as A245 Consultation
Axx4	Special dentist-requested assessment	$160.00	Same fee as A935 Special surgical consultation Minimum of 50 minutes of direct contact with the patient

Payment rules for Axx1 and Axx3 are as follows:

1. This service is limited to one per patient, per physician, per 12 month period.
2. The Otolaryngologist must submit his/her findings, opinions and recommendations in writing to both the audiologist/dentist and the patient's primary care physician, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Payment rules for Axx2 and Axx4 are as follows:

1. The Special audiologist/dentist assessment is a service that provides all the elements of an Audiologist/Dentist Requested Assessment (above) and spends a minimum of 50 minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

The Section put forward the following in support of their Axx1 and Axx3 requests:

- This service would be performed because of the complex, obscure or serious nature of the patient's problem. Urgent or emergency requests may be initiated verbally but must also be documented in writing.
- Our section members share close collaboration with Dentists and Oral Maxillofacial Surgeons (OMFS). Commonly, either when a dental pathology has impact on sinonasal health (e.g. oroantral fistulas, dehiscent apical cysts, overall poor dentition with resulting odontogenic rhinosinusitis), or when a sinonasal pathology is discovered during dental examinations, or oral mucosal lesions are found by dentists, or dental abnormalities are found due to nasal obstruction.
- Again, much like with audiologists, the patient cannot be referred directly to our section members by dentists and specifically oral maxillofacial surgeons. The family doctors gets notified, who then ends up referring to us. Often, unnecessary delays occur.
- Also, some dentists and OMFS attempt to refer patients to our members, but the latter still has to wait until a formal referral from the family doctor arrives.

- We therefore advocate for allowing audiologists, dentists and OMFS to directly refer to Otolaryngologists, much like optometrists can refer directly to ophthalmologists
- This includes the common and specific elements of a specific assessment.
- This service is comparable to the A245 Consultation, valued at $79.90. There would be no difference between the proposed code and the regular Otolaryngology consultation, as it involves the same amount of work.

The Section put forward the following in support of their Axx2 and Axx4 requests:

- The service would consist of a Full Otolaryngology consultation and examination.
- The rationale is the same as for its companion submission for an audiologist/dentist-requested assessment.
- Our section members have a very close collaboration with audiologists.
    - We routinely ask for audiograms for assessment of hearing loss and other otologic problems. Frequently, the patient gets referred to an audiologist first for an audiogram, or even self-presents to an audiologist with hearing concerns.
    - However, often upon discovery of asymmetric hearing loss, or conductive or mixed hearing loss, or TM perforation or any other abnormality, the audiologist reports this back to the patient's family doctor, who then in terms refers the patient to one of our section members.
- Even though many of these pathologies may be chronic, sometimes a therapeutic opportunity is lost due to delay in the referral process through the family doctor, such as in cases of sudden sensorineural hearing loss, which requires urgent treatment. We therefore advocate for allowing the audiologists, dentists and OMFS to directly refer to Otolaryngologists, much like optometrists can refer directly to ophthalmologists.
- There is no clinical difference between the referrals between these allied health providers in terms of eye vs. ear care.
- A935 Special surgical consultation was identified as a comparator code.

Committee Comments:

- The OMSPC supports in principle.

37.5 G816 Electrocochleography (per ear): to include myringotomy if performed

The section requested to revise G816 payment rules to not include myringotomy and reduce the fee to $19.15 from $104.45. The descriptor would be revised accordingly:

> Electrocochleography (per ear)~~: to include myringotomy if performed~~
>
> (Deletions ~~strikethrough)~~

The Section put forward the following in support of their request:

- Current ECoG (G816, $104.45 per ear) billings amount to a total of $816,172 for the specialty (all numbers from most recently provided FY19-20 interactive table). This makes it the 19th highest code in terms of total amount of billings.
- A reduction to $19.15, an amount the section believes to represent a fair reimbursement, would on its own result in significant savings.

- In the rare instance where a myringotomy tube is required for the placement of a trans-tympanic recording needle, the physician who places the myringotomy, should be permitted to bill that separately (Z914, myringotomy and tube placement, $78.60).
- The section does not believe that there will be any cases of this given current methodology of doing ECoGs.

Committee Comments:

- The OMSPC supports in principle.

37.6 E880 Parathyroid(s) re-implantation

The Section is proposing for thyroidectomy procedures, E880 add-on fee be restricted to total and complete completion following previous subtotal or hemithyroidectomy (S788 and S793).

The Section put forward the following in support of their request:

- Parathyroid preservation is important in the setting of thyroid surgery. However, it becomes critical in the setting of completion or total thyroidectomy, where other parathyroid glands may be put at risk as well. We therefore recommend restricting this code to total and completion thyroidectomies. We propose to reallocate all savings from this to subtotal thyroidectomy fee.

The Committee noted the following.

- The Section clarified that E880 would remain billable with S795 (Exploration and/or removal, parathyroids or parathyroid tumour) and S796 (Exploration and/or removal, parathyroids or parathyroid tumour – if requiring splitting sternum).

Committee Comments:

- The OMSPC supports in principle.

37.7 G456 - needle electromyography and nerve conduction studies

37.8 Gxx1 Vestibular evoked myogenic potential (oVEMP and cVEMP)

37.9 Gxx2 Video head impulse test (vHIT)

The Section proposed the following new codes and revisions related to vestibular testing

1. a new fee code Gxx1 Vestibular evoked myogenic potential performed to record ocular (oVEMPs) or cervical muscles (cVEMPs) reflexes to test for contralateral utricular function and ipsilateral saccular function, respectively at $19.15.
2. a new fee code Gxx2 Video head impulse test (vHIT) is performed for objective assessment of the vestibulo-ocular reflex (VOR), valued at 19.15.
3. the following revision to G456 descriptor:

   Schedule A
   Complete procedure i.e. conduction studies on two or more nerves presumed to be involved in the disease process together with EMG studies of appropriate muscles, as necessary and/or detailed studies of neuromuscular transmission. It also includes as necessary study of normal nerve and/or opposite side for comparison.

Procedure payable at nil if done for cVEMP and oVEMP purposes.

(Revision underlined)

The Section put forward the following in support of their request:

- Prior to this process, our section has already been actively involved with the Ministry of Health to address this issue of vestibular test utilization in Ontario.
- Our national society, the Canadian Society of Otolaryngology – Head & Neck Surgery, developed recommendations in conjunction with Choosing Wisely Canada related to the judicious use of vestibular testing (https://choosingwiselycanada.org/otolaryngology).
- These recommendations were further developed by the Ontario Working group on Oto-Vestibular Testing and were propagated by the Ministry of Health and OMA via a e-bulletin sent out in 2018.
- We recognize that part of the issue with vestibular testing over-utilization in Ontario was related to the nature of our vestibular fee codes.
- Furthermore, two helpful vestibular tests – the video head impulse test (vHIT) and vestibular evoked myogenic potential (VEMP) do not have dedicated OHIP codes.
- As a result, most vestibular centers are using the EMG code (G456, $99.90), which can be billed as unilateral or bilateral for this test for the VEMP.
- To correct this, we suggest to disallow the ability to bill EMG codes for VEMP.
- This would save $673,625.70.
- Gxx1 includes both oVEMP and cVEMP per patient.
- vHIT is used for objective assessment of VOR. There is no present alternative to this test done objectively. It's an objective version of a head-thrust manoeuvre.
- The Section put forward the following comparator codes for Gxx1 and Gxx2:
    - Brain stem evoked audiometry
      G146 -technical componen4 - $37.25
      G144 -professional component - $19.15

The Committee noted the following.

- EMG fee code G456 is currently under review by the Appropriateness Working Group (AWG).

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered.

38 Paediatrics

38.1 E082 Admission assessment by the MRP

The Section requested that E082 Admission assessment by the MRP (add 30%) be revised to allow payment for sick newborns on first day of life. The proposed revision to the commentary (page GP42) is as follows:

E082 is not eligible for payment for a patient admitted for obstetrical delivery or for a well newborn.

(Revisions underlined)

The Section put forward the following in support of their request:

- Section members are frequently asked to care for newborns who have medical issues on their day of birth that do not require admission to a NICU but require paediatric input and follow up during their admission and the Paediatrician is the MRP.
- E082 is not eligible for payment for a patient admitted for an obstetrical delivery or a newborn

Committee Comments:

- The OMSPC supports in principle.

38.2 K704 Paediatric outpatient case conference

The Section is requesting to change payment rule to require only one other health professional participant to be eligible to bill K704.

The Section put forward the following in support of their request:

- This change is requested to capture the work of paediatricians providing unbillable work (e.g., responding to CAS worker requests for information, calling schools to speak to teachers/principals/school psychologists, speaking with speech therapists, OT, Behavioural Therapists, etc).
- This above and beyond care is provided more often by female paediatricians as well and this time is not compensated leading to inequities in pay for work.

The Committee discussed the following issues:

- The OMSPC discussed the prospect of removal of in-personal requirement for K003 (Interviews with Children's Aid Society (CAS) or legal guardian).
- Creating a generic outpatient case conference code (non-specialty specific) may be preferred.

Committee Comments:

- The OMSPC supports in principle to creating a generic outpatient case conference code. In the absence of introducing the generic outpatient case conference fee, the Committee supports in principle the Section's proposal amend K704.

38.3 A265 Consultation (minimum 30 minutes)

38.4 Axx1 Consultation (minimum 45 minutes)

38.5 Axx2 Consultation (minimum 60 minutes)

The Section requested revising their standard consultation fee A265 to have a minimum time requirement of 30 min ($175.40) and create two new time-based consultation fees

1. Axx1 Consultation requiring a minimum of 45 minutes at $225.00
2. Axx1 Consultation requiring a minimum of 60 minutes $275.00.

The Section put forward the following in support of their request:

- Many members are seeing mental health consults/developmental consults and complex medical consults that are often 60/65 min in duration and are only able to bill the same as a more specific consult that is often 30 min in duration.
- Members who have expertise and tend to focus on this patient population in paediatrics are disadvantaged and many of these are women.

Committee Comments:

- The OMSPC supports in principle.

38.6 A661 Paediatrics Complex Medical Specific reassessment

38.7 A263 Medical specific assessment

The Section requested an increase to the annual limit for A661 Complex medical specific re-assessment from 4 to 6 per 12 month period.

The Section put forward the following in support of their request:

- The complexity of their patients has increased over the years both medically and psychosocially.
- These patients require close follow up in order to support their medical needs as well as their families and caregivers appropriately.
- Intra-Sectional Relativity (ISR) survey results indicated that A661 is under valued.

Committee Comments:

- The OMSPC supports in principle.

38.8 A815 Midwife requested special assessment

The Section requested that the paediatric age premiums found on page GP64 be applicable to A815 Midwife requested special assessment.

The Section put forward the following in support of their request:

- Although this code is billed for consultation from midwives on paediatric newborn patients, it does not include an age premium as our other paediatric codes do and thus is undervalued.
- Paediatric consultation codes have a 30% age premium for infants less than 30 days of age which would encompass most consults provided to midwives by Paediatricians.

Committee Comments:

- The OMSPC supports in principle.

38.9 Exxx Paediatrics Office Stabilization Premium

The Section requested a new add-on premium payable to a consultation fee provided in physician's private offices only at 10%.

A private outpatient setting would be defined as any paediatric outpatient clinic setting where the clinic overhead is being paid for by the paediatrician providing the service. This would exclude hospital settings where space and/or support is being provided at no cost to the physician as well as physicians in

alternate payment plans where overhead is provided for in the base or income allocations and incentives.

The Section put forward the following in support of their request:

- There is some inequity in those situations where hospital-based clinics are being utilized by some paediatricians at no additional cost to the physician and this would help address some of this inequity.
- There is also a reluctance for new and particularly female paediatricians to set up office practice due to the overhead expense and the difficulties encountered during maternity leave in covering these expenses- this premium would also assist in addressing some of this issue.

The Committee discussed the following issues:

- Input is required on further clarifying the definition of a private outpatient setting

Committee Comments:

- The OMSPC supports in principle upon receiving a clear definition of a private outpatient setting.

39 Paediatrics (Member group)

39.1 E078 Chronic disease assessment premium

On behalf of 50 plus members of the Section (member group), a submission was made to,

1. Create a new diagnostic code for atopic dermatitis (and and that atopic dermatitis be excluded from the current diagnostic code 691); and
2. Revised E078 Chronic disease premium applicable diagnostic codes to include the proposed new diagnostic code.

The member group put forward the following in support of their request:

- Atopic dermatitis is a chronic disease with an often profound impact on patients and caregivers.
- Consequences of atopic dermatitis may include chronic pruritus, skin pain, sleep disturbance, behavioural concerns and functional impairment, with social, academic and occupational impacts.
- This condition often has comorbidities, which may include food allergy, allergic rhinoconjunctivitis, asthma and eosinophilic esophagitis. Individuals with atopic dermatitis also have higher rates of anxiety, depression and suicidality.
- Children with atopic dermatitis are at risk for life-threatening infection, such as eczema herpeticum and bacterial sepsis, typically requiring hospitalization.
- Children with generalized atopic dermatitis have greater impairment in health-related quality of life than children with other chronic diseases of childhood, including asthma, epilepsy and diabetes.
- While asthma, epilepsy and diabetes are appropriately recognized as conditions eligible for payment of a chronic disease assessment premium (E078), atopic dermatitis is not.
- Caring for patients with atopic dermatitis requires a detailed history, physical examination and extensive counselling, including discussion of appropriate skin care and use of topical medications.

- Significant “steroid phobia” exists, which usually requires extensive discussion to appropriately address.
- Many patients with moderate to severe atopic dermatitis may not optimally respond to topical medications and require treatment with systemic medications, such as methotrexate, cyclosporine, dupilumab and, more recently, oral upadacitinib. Use of these medications requires close clinical monitoring, with three of the four requiring routine lab monitoring.

Committee Comments:

- The submission will be reviewed by the committee at its next meeting.

40 Palliative Medicine

40.1 C882 Palliative Care Inpatient Care

The Section is requested that C882 fee value be set equal to C002 at $34.10 (an increase from $31.00).

The Section put forward the following in support of their request:

- Palliative care is comprehensive and complex. While C-codes for inpatients have recently been increased, their C882 counterpart codes remain outdated. To address this inequity, we propose C882 be made equivalent to C002.

Committee Comments:

- The OMSPC supports in principle.

40.2 Axxx Medical Assistance in Dying Assessment and Support

The Section requested a new fee code for consultation and ongoing support for Medical Assistance in Dying care at $159.20.

The Section put forward the following in support of their request:

- Providing MAID is an intensive service that involves significant coordination with the patients’ care team and family. However, it is distinct from the role of a palliative care provider.
- As such, these services need to be distinguished in the OHIP Schedule. Notably, Palliative Medicine is now a Royal College accredited speciality and OHIP focused practice area, whereas there is no special qualification or designation to become a MAID assessor/provider.
- During their presentation to OMSPC, the section noted that they require multiple assessments on the same day and that those services should be separated.

The Committee noted the following:

- The PSC has established a Medical Assistance in Dying (MAiD) Working Group to consider appropriate payment policies for the provision of MAiD; the work was to be completed in two phases.
- The fist phase was to establish and interim payment policy; this was completed and approve by the PSC in the fall of 2018.

- The second phase was to propose fee codes to be introduce in to the OHIP Schedule. The second phase was never completed due, in part, to priority of the COVID pandemic.

Committee Comments:

- The OMSPC supports in principle.

40.3 A/C945 Special Palliative Care Consultation

The Section requested a fee increase from $159.20 to $203.30.

The Section put forward the following in support of their request:

- A specialized palliative care consultation (A/C945) deals with complex patients and it is very comprehensive in nature by addressing not only patient's physical symptoms but can also include a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling and consideration of appropriate community services.
- A945 is undervalued compared to relevant comparators in Geriatrics.
- The additional training, expertise and comprehensive nature of these consultations are not being acknowledged.

Committee Comments:

- The OMSPC supports in principle.

40.4 Kxxx Bereavement Support Code

The Section is requesting a fee code for Bereavement support as a time-based service payable for emotional support and counselling to loved ones/family members after the death of a patient at $72.15 per unit.

The Section also proposes amendments, related to bereavement, in various sections of the Schedule of Benefits as follows

- Intermediate Assessment - Pronouncement of Death (page GP27, code A/C/W777)

  INTERMEDIATE ASSESSMENT – PRONOUNCEMENT OF DEATH
  Definition/Required elements of service: Intermediate assessment – pronouncement of death is the service of pronouncing a patient dead in a location other than in the patient's home. This service ~~may include any counselling of relatives that is rendered during the same visit, and~~ <u>includes</u> completion of the death certificate.

- Pronouncement of Death (page A3, code A902):

  House call assessment - Pronouncement of death in the home
  A house call assessment - Pronouncement of death in the home is the service rendered when a physician pronounces a patient dead in a home. This service includes completion of the death certificate ~~and counselling of any relatives which may be rendered during the same visit~~.

- Certification of death (page A5, code A/C/W771):
  Certification of death Certification of death is payable to the physician who personally completes the death certificate on a patient who has been pronounced dead by another physician, medical resident or other authorized health professional. Claims submitted for this service must include the diagnostic code for the underlying cause of death as recorded on the death certificate. ~~The service may include any counselling of relatives that is rendered at the same visit.~~ Certification of death rendered in conjunction with A902 or A777/C777 is an insured service payable at nil.

- Palliative care support (page A47, code K023)
  Palliative care support is a time-based service payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care. Palliative care support also includes bereavement support to loved ones and/or family members after the death of a patient, on the day of death for the patient.

  Payment rules:
  1. With the exception of A945/C945, A777/C777/W777, A902, any other services listed under the "Family Practice & Practice in General" in the "Consultations and Visits" section of the Schedule are not eligible for payment when rendered with this service.

  [Commentary:
  1. If the same physician provides palliative care support while a patient is alive and bereavement support after death on the same day, it is permissible to add the total amount of time spent that day to calculate the total number of units of K023 that can be billed.
  2. If two different physicians provide palliative care support while a patient is alive and bereavement support after death on the same day, a manual review will be required for both physicians to submit K023.]

  (Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- Bereavement support is equivalent in intensity to Palliative Care support and similarly requires excellent communication and interpersonal skills. It also shares the relatively high level of stress.
- The Section agrees with the committee's assessment that OHIP would likely require any bereavement support provided on the day after death onwards to be billed to the patient receiving bereavement support, as opposed to the deceased, and it is currently too difficult to change OHIP's computer system regarding this point. In that case, existing codes such as K005 or K013 could be utilized.
- The Section feels that the 2014 recommendation of using K001 (detention) would place too many barriers to providing needed bereavement care.
- With regards to proposed changes to K023, the Section noted,
  - K023 already functions as our catch-all time-based palliative care code, and the rules of documenting start and stop times are already in place.
  - This would mean that a minimum of 20 minutes of bereavement support must be provided to bill at least one K023. K023 already should be billable on the day of death for the patient, so no changes to the OHIP computer system would be required.

- The Section wishes to ensure that K023 billed the same day as A902/A777/C777 is payable.

The Committee noted the following:

- The Section on Emergency Medicine has no objections.

Committee Comments:

- The OMSPC supports in principle.

41 Physical Medicine & Rehab

41.1 K083 - virtual care code

The Section requested the continued, indefinite use of the K083 virtual care code for specialist consultation or visit by telephone or video at $5.00 (per increment).

The Section put forward the following in support of their request:

- As rehabilitation providers, most patients have varying ability levels, specifically with regards to mobility. Having the option to assess patients virtually or via telephone is a more patient-centred approach to care
- Physicians will use their discretion as to which patients can be assessed virtually and which need in person visits; continuing to use the right type of contact, for the right patient, at the right time, for the right problem, as outlined by the OMA.
- Provision of virtual care facilitates physiatry consultations for patients in remote areas of the provinces who may otherwise not have access to this service.

Committee Comments:

- The OMSPC notes that this is no longer required given the terms within the recently ratified Physician Services Agreement (PSA).

41.2 A318 Partial Assessment

The Section requested a fee increase to A318 from $38.05 to $65.00.

The Section put forward the following in support of their request:

- The proposed value is commensurate with other re-assessment fees (A313: $74 A310: $65 A311: $70.90)
- Members do not feel they are being adequately compensated for the time it takes to provide a partial assessment. To complete all of the requirements and provide optimal patient care, physicians should be compensated for the service provided to the patient.

Committee Comments:

- The OMSPC supports in principle.

41.3 E446 - peripheral joint injection using image guidance following a failed blind attempt

The Section requested the removal of "following a failed blind attempt" from the descriptor of E446.

The Section put forward the following in support of their request

- Over the last 10 years, standard of care for intra-articular injections has moved from landmark based injections to using ultrasound guidance.
- This improves location accuracy, clinical outcomes and cost effectiveness. Patients should not have to receive sub-standard care (via landmark based guidance) before being eligible to receive standard of care injection via ultrasound “following a failed blind attempt” from the payment rule definition.
- Given ultrasound injections are a relatively new advancement, some colleagues may not be familiar with the technology or have access and elect to perform injections blindly based on anatomical landmarks.
- The Section would also support deletion of E446 and image guidance being added to the base code.

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

41.4 G456 EMG - Needle electromyography and nerve conduction studies

The Section requested a fee increase to G456 from $99.90 to $120.00.

The Section put forward the following in support of their request:

- This request is based on specific feedback from members who feel that G456 is undervalued and because the code was reduced in recent years.

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

41.5 A511 Complex physiatry assessment

The Section requested a revision to the descriptor for A511 as follows (page A148):

> This service is an assessment in relation to the following diseases where the complexity of the condition requires the ongoing management by a physical medicine and rehabilitation specialist:
>
> a. traumatic brain injury;
> b. stroke (hemorrhagic and ischemic)
> c. spinal cord injury.
> d. <u>neuromuscular disorders</u>
> e. <u>prosthetic and orthotics</u>

f. post COVID
g. transplant
h. dialysis
i. chronic pain; or
j. oncology

(Revisions underlined)

The Section put forward the following in support of their request:

- Physiatrists manage a wide range of complex patients including those with multifaceted chronic disorders.
- The parameters of this code do not currently reflect the entire discipline and should be expanded to include other diagnoses that are of equal or greater complexity.
- This should include: oncology rehab patients, neuromuscular disorder patients, prosthetic and orthotics patients, post-COVID rehab patients, transplant rehab patients, chronic pain patients, and dialysis rehab patients.

Committee Comments:

- The OMSPC supports in principle.

41.6 E078 Chronic disease assessment premium

The Section requested that the E078 list of diagnostic codes found on page GP26 be revised to include the following:

Diagnostic Code	Description
349	other diseases of central nervous system
739	other diseases of musculoskeletal system and connective tissue
781	leg cramps, leg pain, muscle pain, joint pain, arthralgia, joint swelling, masses

The Section put forward the following in support of their request:

- Physiatrists often receive referrals for complex patients with, at times, vague referral questions. At times, seemingly straightforward consults lead to long and detailed consultations.
- Managing complex patients can be challenging and time consuming.
- Working up and managing these complex patients in the outpatient setting should render them eligible for the chronic disease assessment premium.
- It is in the patient's and the system's best interest to encourage a physician to make these patients eligible for the premium, as it incentivises the provider to spend the required time needed to treat the patient in full during a visit.
- This ultimately will save the system money and be more cost effective, efficient and patient centred.

The Committee noted the following:

- This would have an impact on other Specialties.
- The diagnostic codes ambiguous and lacks specificity.
- In response to the committee, to increase specificity, the Section proposed the same 10 conditions listed for A511 Complex physiatry assessment.

Committee Comments:

- The OMSPC does not support, as the proposed diagnostic codes are ambiguous and lack specificity and the subsequent list of conditions would be captured in A511.

41.7 Chronic Pain Care

The Section requested a time-based code for the provision of care to the patients with chronic pain (pain lasting greater than or equal to 6 months), valued at $95.00 per unit (Unit means 1⁄2 hour or major part thereof).

The Section put forward the following in support of their request:

- Assessing a chronic pain patient would comply with the details specified under the schedule of benefits for other medical specific assessments.
- These are services rendered by specialists, in a place other than a patient's home, and require a full history of the presenting complaint and detailed examination of the affected part(s),
- The service includes the common and specific elements of all insured services listed under "Physical Medicine and Rehabilitation (31)" in the "Consultations and Visits" section of the Schedule.
- The fee value was determined bearing in mind a biopsychosocial approach is being deployed that involves a mix of biological, social and psychiatric care thus justifying a fee which is higher than counselling or outpatient psychiatric care alone.
- Adopting a slightly higher fee value will in the long term save health related costs associated with repeated specialist consultations seeking second or third opinions.
- Given fibromyalgia is analogous to chronic pain, the fibromyalgia care code was referenced to make it a time based code.
- We are proposing a limit to three units over a twelve month period to prevent overuse and with the expectation that physicians can revert to H313 thereafter if required.
- We are proposing using the time based physiatry code for counselling (H313) and the time based fibromyalgia care code (K037) as the basis for a new fee code for chronic pain patients.
- These patients require increased clinic time as they have complex past medical histories and often extensive psychosocial stressors.
- This requires increased clinic time to provide education and counselling regarding the diagnosis and treatment plan(s). On average, the time spent and intensity of, chronic pain clinic visits is more than the average general physiatric assessment or re-assessment.
- The code would be billable by other specialities.

The Committee noted the following:

- The Section on Chronic Pain supports the proposal and would like the fee to be eligible to all physicians and not just physiatry. In addition, the Section proposed the following amendments for consideration
    - The limits of 3 per year need to be expanded.

- To facilitate multimodal care, this code should involve an element of physician oversight and delegation to physiotherapy, counselling etc. all working in a physician-led team in the community.
- This would facilitate the creation of community pain multidisciplinary hubs under physicians' oversight which are currently lacking in the community given lack of funding

- Committee supports in principle, but the proposed amendment would require support of the other relevant Sections in order to fund the service.

Committee Comments:

- The OMSPC supports in principle.

42 Plastic Surgery

42.1 Cosmetic Surgery

The Section requested the following two clarifications be added to the Schedule of Benefits to clarify how to appropriately charge for cosmetic surgery (e.g., bill to OHIP or the patient):

1. A clarification to Appendix D, 16b (Page AD7)

   Excision of excess fatty tissue and/or skin other than for panniculectomy is not an insured service. <u>This includes: a. Facelift (Rhytidectomy), b. Neck Lift, c. Upper Back/Bra-Line Lift, d. Buttock Lift/Augmentation, e. Lower Body Lift, f. Male Chest Lift, g. Breast Lift (Mastopexy), h. Arm Lift (Brachioplasty), i. Thigh Lift (Thighplasty), j. Tummy Tuck (Abdominoplasty), k. Labia Minora/Majora, Reduction (Labiaplasty), l. Mons Pubis Lift (Monsplasty), m. Liposuction, c. Surgical treatment of rectus abdominis muscle diastasis is not an insured service.</u>

2. A clarification to Note 2, (Page M2): Skin and Subcutaneous Tissue Section – Excision (with or without biopsy – Lesions – Single of multiple sites

   Note:
   1.Tattoo removal - (see Appendix D Surface Pathology Section 3).
   2.Removal of any lesions (e.g., keratosis, nevi) for cosmetic purposes and not for any clinical suspicion of disease or malignancy is not an insured service<u>. Soreness, ache, discomfort, and mild/intermittent pain are NOT medically necessary indications for lesion removal.</u>

   (Revisions <u>underlined</u>)

The Section put forward the following in support of their request:

- Specifically listing the procedures that are not insured by name would provide much greater clarity instead of simply stating that anything other than a panniculectomy is not covered.
- Many plastic surgeons in the province of Ontario have a mixed practice that includes some publicly funded OHIP surgery as well as some privately funded cosmetic surgery.
- While some members of our Section have purely OHIP practices or purely cosmetic practices, the majority have a somewhat blended practice.

- Recently, there has been an increasing concern about blurred lines between what defines a cosmetic procedure versus what defines a medically necessary procedure.
- This leads to significant confusion and frustration for patients, as well as significant concern and liability for plastic surgeons (NB. This impacts any physician in the province who performs procedures/treatments beyond the scope of OHIP including Dermatology, Oto-HNS, Ophthalmology etc.)

Committee Comments:

- Decision deferred. The OMSPC is of the opinion that a working group with Ministry of Health should be established to review and clarify the Schedule on how to appropriately charge for cosmetic surgery (e.g., bill to OHIP or the patient), in consultation with applicable Sections, as part of modernization of the OHIP Schedule.

42.2 Z142, Z135, Z182 - Operations of the Breast

The Section is requesting the addition of the following notes for Z142, Z135, Z182 (page M27) to clarify how to appropriately charge for cosmetic surgery (e.g., bill to OHIP or the patient):

Note:

1. Correction of inverted nipple(s) is not an insured service.
2. Removal of a breast prosthesis, capsulotomy and capsulectomy for a breast implant that was inserted for cosmetic purposes is considered an insured service for the following medically necessary indications: hematoma, seroma, infection, Baker grade IV capsular contracture, intracapsular neoplasm or calcification, BIA-ALCL, and silicone implant rupture (intra- or extra-capsular).
3. Removal of a breast prosthesis, capsulotomy and capsulectomy for cosmetic deformities (i.e., implant malposition, implant malrotation, asymmetry, size, implant rippling/palpability) resulting from a breast implant that was inserted for cosmetic purposes, is considered a cosmetic procedure and is not an insured service.
4. The removal of a saline or silicone breast implant (including capsulotomy or capsulectomy), that was inserted for cosmetic purposes, and that does not meet the aforementioned criteria is considered a cosmetic procedure and is not an insured service.
5. The removal of a saline or silicone breast implant (including capsulotomy or capsulectomy), for systemic illness is not an insured service.
6. Emotional, psychological or psychiatric grounds are not considered sufficient reason for the coverage of breast implant removal, capsulotomy and capsulectomy.

(Revisions underlined)

The Section put forward the following in support of their request:

- The two most common indications for breast implant insertion are for cosmetic breast augmentation and breast reconstruction.
- As a part of the Appropriateness Working Group (AWG), the Section sought to define the appropriate indications more clearly for Z142, Z135 and Z182 codes.

- The potential exists for inappropriate indications for concerns or conditions that are not medically necessary and are more commonly cosmetic in nature. These codes may also be inappropriately billed to have hospital/inpatient costs covered for cosmetic patients.
- The Section recognizes that women who have breast implants placed for breast reconstruction following mastectomy are a distinct subset of patients – they have indicated in the notes that these criteria apply to patients who undergo cosmetic breast augmentation.
- The above listed recommendations are in line with the current rules listed in the OHIP SOB outlined in Section M and Appendix D but are much more explicit outlining what is insured and what is uninsured to prevent any in appropriate or inconsistent interpretation of the OHIP SOB.

Committee Comments:

- Decision deferred. The OMSPC is of the opinion that a working group with Ministry of Health should be established to review and clarify the Schedule on how to appropriately charge for cosmetic surgery (e.g., bill to OHIP or the patient), in consultation with applicable Sections, as part of modernization of the OHIP Schedule.

42.3 R143 Post Mastectomy Breast Reconstruction

The Section requested to add an addition note to R143 (Contralateral balancing mastopexy or reduction, to include nipple transplantation or grafting, if rendered) to clarify how to appropriately charge for cosmetic surgery (e.g., bill to OHIP or the patient):

Note:

1. R143 and R144 are only eligible for payment when performed for post-mastectomy and post-lumpectomy breast reconstruction. Prior authorization of payment from the Ministry of Health is not required.
2. R110 and R112 are not eligible for payment with R143 or R144.
3. Contouring of the lateral chest and/or axilla is not an insured service.

(Revisions underlined)

The Section put forward the following in support of their request:

- The addition of the "post-lumpectomy" wording to Note 1. accounts for the advent of oncoplastic breast reconstructive techniques that are now commonly used in the immediate breast reconstruction setting.
- The current wording of the code would not allow for payment of a contralateral balancing procedure at the same time.
- The Section strongly feels that a contralateral balancing procedure should still be eligible for payment in this setting, given the size of some of these lumpectomy defects that are now being reconstructed using oncoplastic techniques.
- Otherwise, patients will be forced to undergo another procedure on the contralateral breast at a later date, which will end up costing the system more in the long run.
- Stating that contouring of the lateral chest and axilla is not an insured service will also help to clarify for surgeons that the removal of extra skin/fat from these non-breast areas is cosmetic in nature and therefore should not be billed to OHIP.

Committee Comments:

- Decision deferred. The OMSPC is of the opinion that a working group with Ministry of Health should be established to review and clarify the Schedule on how to appropriately charge for cosmetic surgery (e.g., bill to OHIP or the patient), in consultation with applicable Sections, as part of modernization of the OHIP Schedule.

42.4 N183 - Nerve Graft - minor - (sensory/cutaneous nerve)

42.5 N288 - Nerve Graft - major - (mixed sensory and motor nerve, or pure motor nerve)

42.6 E899 - Nerve Graft - for each additional cable, to N288 add

The Section is requesting a revision to the descriptor to include nerve transfers as follows.

> N183 - Nerve Graft or Transfer - minor - (sensory/cutaneous nerve)
> N288 - Nerve Graft or Transfer - major - (mixed sensory and motor nerve, or pure motor nerve)
> E899 - Nerve Graft or Transfer - for each additional cable, to N288
>
> Note: Nerve graft/transfer fees include harvesting of the nerve(s) required for grafting/transferring.
>
> (Revisions underlined)

The Section put forward the following in support of their request:

- Nerve transfer surgery is an emerging and evolving area in plastic surgery that has been used in the treatment of patients with nerve injuries, nerve tumours, spinal cord injuries or compression neuropathies.
- At the present time, nerve transfer surgeries are not represented in the Schedule of Benefits, which has created a major issue for the select small group of plastic surgeons who perform these complex procedures in Ontario.
- Up until now, peripheral nerve surgeons in Ontario have had to use the N288A and N183A codes to bill for nerve transfers, as these were the closest codes to represent the novel work that was being done.
- However, peripheral nerve surgeons would agree that the time, skill, and risk associated with a nerve transfer procedure is much greater and more involved than with a nerve grafting procedure.
- Although a nerve transfer procedure is more complex and technically demanding than a nerve graft, the Section is proposing a modification of the wording of the Schedule of Benefits that would allow nerve transfer to be paid on par with nerve grafts.

Committee Comments:

- The OMSPC supports in principle.

42.7 R118 Post Mastectomy Breast Reconstruction

The Section is requesting a revision to the descriptor and notes associated with R118 to (Page M26):

> R118 - Breast skin reconstruction by local flaps or grafts, includes Wise pattern skin flaps and

de-epithelialized skin flaps, acellular dermal matrix, and alloplastic or biosynthetic support/mesh.

Note:

4. R118 and E529 can be billed for direct-to-implant breast reconstruction when the criteria for R118 are met. Otherwise, R156 should be billed for direct-to-implant breast reconstruction.

(Revisions underlined)

The Section put forward the following in support of their request:

- Since the Schedule of Benefits was last significantly updated, one of the major changes in immediate breast reconstruction has been the advent of single-stage direct-to-implant breast reconstruction following mastectomy.
- However, at the present time the R119 code does not account for the additional skill/training and the potential risk associated with single-stage direct-to-implant breast reconstruction following mastectomy.
- This modification would account for the added complexity/nuance associated with direct-to-implant breast reconstruction.

Committee Comments:

- The OMSPC supports in principle and requests that the Sections on Plastic Surgery and General Surgery develop a combined proposal that captures all services relevant to oncoplastic breast surgery. See General Surgery's submission item #17.2 – 17.4.

42.8 Free Island Flaps

The Section requested that the following clarification/note be made to Schedule of Benefits section on Free Island Flaps (page M20):

Note:
When excision of the lesion and preparation of the recipient site are carried out by different surgeons, the preparation fees should be reduced by 15%. This fee reduction does not apply to free island flap breast reconstruction following post-mastectomy or post-lumpectomy.

(Revisions underlined)

The Section put forward the following in support of their request:

- The 15% fee reduction when excision of the lesion and preparation of the recipient site makes sense when the ablation/lesion excision facilitates preparation of the recipient site. However, this is not the case in post-mastectomy breast reconstruction.
- Following a mastectomy, the breast parenchyma has been largely removed. However, the primary microvascular recipient site in free island flap breast reconstruction is the internal mammary artery and vein.
- To access these vessels, the surgeon preparing the microvascular recipient site must divide the pectoralis major muscle and intercostal muscles, remove a segment of rib/costal cartilage,

remove the perichondrium, and only then can they dissect out the internal mammary artery and vein.

- The removal of the breast parenchyma does not facilitate this dissection in any meaningful way, and therefore the 15% fee reduction should not apply to free island flap breast reconstruction.

Committee Comments:

- The OMSPC supports in principle.

42.9 E514 Post Mastectomy Breast Reconstruction

The Section is requested a revision to the descriptor and notes associated with E514 (page M26) as follows:

> E514 - Immediate breast reconstruction following mastectomy, to R125, R064, R156, R008, R118 or R155.
>
> Note:
> 3. E514 is only eligible for payment if post-mastectomy breast reconstruction is performed immediately following mastectomy and/or lumpectomy during the same anaesthesia.
> 4. E514 is not eligible for payment with R107, R108, R111, R117, R148, or R149
>
> (Revisions underlined)

The Section put forward the following in support of their request:

- The E514 modifier should be meant to reimburse the reconstructive surgeon for their time investment waiting for the ablative procedure to be performed.
- Further, the Section proposes the addition of the R118 code to the list of procedure that E514 can act as a modifier for. This accounts for the advent of immediate oncoplastic breast reconstruction.
- At present, reconstructive surgeons performing these oncoplastic reconstructive procedures cannot receive the additional 'immediate reconstruction' remuneration, even though they are limited by the ablative surgeon.
- This would help to modernize the Schedule of Benefits to recognize the time and effort that goes into this novel technique of breast reconstruction.

Committee Comments:

- The OMSPC supports in principle.

42.10 R064 - Elevation of free island skin and subcutaneous flap and closure of defect

42.11 R065 - Preparation of microvascular recipient site for free island skin subcutaneous flap

The Section is requesting that R064 and R065 be added to services where second assistant services are payable (GP90); authorization should not be required.

The Section put forward the following in support of their request:

- These perforator flap procedures are more technically challenging than comparable codes which are already listed (i.e., R008 free TRAM flap).
- These long, complex perforator flap procedures very often require 2 assistants, which helps to reduce surgery time and improve patient safety in these already lengthy procedures.

Committee Comments:

- The OMSPC supports in principle.

42.12 Surgical Assistant base units

The Section is requesting the addition of surgical assistant base units to the following procedures:

- E198 Eyelid Laceration Full Thickness
- E199 Eyelid Laceration Including Lid Margin
- E300 External Ear - Resection of Pinna with Primary Closure
- E301 External Ear, Resection of Pinna with Local Flap
- E317 Incision and Drainage of Extensive Hematoma of Pinna General Anaesthetic
- F137 Reduction Fracture Nasal Bones Open
- M012 Septoplasty
- M016 Repair of Septal Perforation
- M032 Rhinoplasty for Reconstruction of Cleft Lip Nasal Deformity
- R257 Bone Deformity, Osteotomy phalanx, Terminal
- R407 Synovectomy of extensor or flexor tendons
- R409 Arthrotomy or Incision and Drainage, Finger Joint
- R517 Foreign Body Removal
- R536 Tendon Release (open), finger / palm
- R606 Amputation, Phalanx
- R608 Amputation, Metacarpal or metacarpal phalangeal joint
- R610 Amputation, Trans-metacarpal 2nd to 5th ray
- R654 Pericranial Flap to Orbit or Face Unilateral
- R655 Pericranial Flap to Orbit or Face Bilateral
- S010 Wedge Resection of Lip with Plastic Repair
- Z130 Finger or Toe-Nail, Radical, including destruction of nail bed, one
- Z131 Finger or Toe-Nail, Radical, including destruction of nail bed, multiple
- Z138 Replacement of Tissue Expander by Permanent Prosthesis
- Z228 Biopsy, Muscle / Soft Tissue
- Z740 Drainage of Intramammary Abscess or Hematoma under General Anaesthesia

The Section put forward the following in support of their request:

- Many of these surgical procedures are made much easier and more efficient with a skilled surgical assistant.
- Given the current nursing shortages, it is becoming harder to rely on the scrub nurse to also act as the surgical assistant for the case.
- Many of these procedures are difficult (if not impossible) to perform without an assistant.

- The addition of assistant fee codes to these procedural codes would at ensure that if/when a surgical assistant is required for these procedures, they will be appropriately compensated for their time, efforts and skill.

The Committee noted the following:

- The General Preamble on Surgical Assistants' Services states the following on page GP85:

  b. where no basic unit is listed opposite the service in the column headed with "Asst" and where "nil" is not listed opposite the service in the column headed with "Asst", the number of basic units is that listed opposite the service under the column headed with "Anae". This type of service is only eligible for payment upon authorization by a medical consultant following submission of a letter from the surgeon outlining the reason the assistant was required. Submit claims for this type of service using fee code M400B.

Committee Comments:

- The OMSPC supports in principle.

42.13 E832 Hand and Wrist Excision Soft Tissue

The Section is requested to revise to the E832 fee descriptor as follows:

E832 – excision of fascia for Dupuytrens, ~~one or more~~ <u>for each</u> additional ray, to R551

(Revisions <u>underlined</u>, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- Hand surgeons are required to lump all additional work into one code. Hand surgeons (who are largely plastic surgeons in Ontario) are only remunerated for one additional ray of surgery performed at the same time.
- The current Schedule of Benefits devalues the additional work and risk associated with this procedure including nerve injury, vascular compromise, and digital amputation.
- The Section would compare the billing for Dupuytren's surgery directly to other surgical subspecialties that perform multiple procedures on the same patient in one operating room visit.
- The Section is open to discussing the creation of a new code with an alternate remuneration value for each additional ray treated after the second ray should this be a more appealing approach in the resolution of this current inadequacy.

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

42.14 R495 Fasciotomy for compartment syndrome (not including secondary closure wound)

The Section is requested the addition of the following note to R495:

Note:
Decompression of fascial compartments includes fasciotomy and/or escharotomy in the setting of burn injuries

(Revisions underlined)

The Section put forward the following in support of their request:

- At the present time, there is no code in the Schedule of Benefits for escharotomy. Escharotomy is a well-documented life- and limb-saving emergency procedure in the burn literature.
- Since escharotomy is conceptually the same procedure as a fasciotomy, the Section proposes that the existing R495 fee code be re-listed in the Burn section of the Schedule of Benefits, with a specific note added to clarify that this code also applies to escharotomy.
- These procedures are only performed by a limited number of surgeons in the province of Ontario, almost exclusively in tertiary burn centres.
- This modification would have no impact on non-burn surgeons because Orthopaedic Surgeons who bill most of the fasciotomy codes would never be treating burn injuries.

The Committee discussed the following issues:

- The committee considered creating a new code Rxxx for escharotomy in the setting of burn injuries for same value as R495, and place within burn section to avoid ambiguity.

Committee Comments:

- OMSPC supports in principle to creating a new fee code for escharotomy within the burn section of the Schedule (pages M10 – M12).

42.15 M014 Nose Reconstruction - Septorhinoplasty

The Section is requesting the following revisions to Appendix D in relation to Septorhinoplasty (page AD7):

15. Septorhinoplasty:

This is an insured service when the rhinoplasty component is necessary to obtain an adequate airway or; for persons aged 16 years and under, at the time of trauma and for whom the rhinoplasty is completed, or is part of a pre-planned staged repair which is commenced, at any time following trauma and prior to the age of 19 years; or, for persons aged 17 years and older at the time of trauma and for whom the rhinoplasty is completed, or is part of a pre-planned staged repair which is commenced, within 2 years following trauma. (see Paragraph 6 of this Appendix).

In cases where a septoplasty is necessary to improve function and a rhinoplasty is done for cosmetic purposes, the Ministry of Health will pay the part of the operation that was medically necessary (e.g. if a septorhinoplasty is performed and a septoplasty was necessary to improve the airway, the Ministry of Health will pay M012 and the surgeon is entitled to claim the difference from the patient). ~~However, if a septorhinoplasty is approved by the Ministry, no~~

~~extra charge may be made to the patient~~. M014 requires written prior authorization by a Ministry of Health medical consultant.

Prior authorization from the Ministry of Health is required. A description of the external deformity should be provided.

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- The current note in the Schedule of Benefits already contains the requested language (page P2).
    - Note: M013, M014, R319, R320 - These procedures require written prior authorization by a Ministry of Health medical consultant. (see Surgical Preamble, paragraph 17).
- There are several areas of the external nose that can contribute to nasal airway obstruction (e.g., internal valve, external valve).
- Specific portions of rhinoplasty can be performed to improve these areas without altering the appearance of other areas of the nose.
- Commonly, patients present to address these functional issues but also desire other cosmetic changes which are not medically necessary (e.g., dorsal hump reduction, tip refinement, etc.) and are solely for cosmetic improvement.
- This poses a problem for patients who would like to have their medically necessary portion of the procedure covered while paying out of pocket for cosmetic surgery.
- The standard of care would be to attempt to correct the functional and cosmetic concerns during the same surgery.
- Addressing these issues separately and knowingly committing a patient to a secondary rhinoplasty due to billing logistics would be below the standard of care.
- By removing the restriction "*However, if a septorhinoplasty is approved by the Ministry, no extra charge may be made to the patient*." from Appendix D, Section 15 would allow patients to have the medically necessary portion of their procedure covered and to pay out of pocket for the uninsured cosmetic portion.
- M014 should still require written prior authorization by a Ministry of Health medical consultant.

Committee Comments:

- The OMSPC supports in principle.

43 Primary Care Fee-for-Service Medical Interest Group

43.1 K037 Fibromyalgia/chronic fatigue syndrome care

The MIG presented a position that K037 is undervalued and proposed raising the value of this fee code. The MIG subsequently requested that this be accomplished by,

1. The K037 fee code be amended with a premium of 17% when it is used by physicians in dedicated practices providing consultation services;
2. Revise the descriptor to "Fibromyalgia, Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), Environmental Sensitivity/Multiple Chemical Sensitivity (ES/MCS)"; and

3. Add the following payment rules:

3. The focused practice ME/CFS, FM and ES/MCS care premium is payable automatically to an eligible physician subject to the definitions and rules described below.

a. "Fiscal year" means April 1 - March 31st. "Qualifying year" means the fiscal year preceding the date of determination of eligibility. "Date of determination of eligibility" means the date upon which the General Manager determines that the conditions for payment in (i) or (ii) below, have been met. "All payments" means all payments made to the physician for insured services listed in this Schedule other than payments made for insured services listed in this Schedule for which a technical fee is payable.

b. For the 12 month period following the date of determination of eligibility for the premium, the amount payable to a physician shall be automatically increased by 17% for K037A services rendered by the physician including through OTN and other virtual care platforms, in the following circumstances:

i. When the sum of all payments made to the physician for the qualifying services rendered in the qualifying year exceeds 50% of the sum of all payments made to the physician in the qualifying year; or

ii. When the sum of all payments made to the physician for the qualifying services rendered in the qualifying year is at least 40% but not more than 49% of the sum of all payments made to the physician in the qualifying year and the requirements set out in (1.) were met by the physician in respect of the fiscal year preceding the qualifying year.

The MIG put forward the following in support of their request:

- Initial Consultation provided once. Follow up appointments are undertaken every 2-6 months, based on complexity of patient needs.
- The assessment requires providers to have had additional training in the areas of systems biology medicine, as well as expertise in diagnosis and management of ME/CFS, FM, and ES/MCS.
- There is a high level of trauma, both early adverse childhood events and medical system induced trauma, and clinician needs to have a high degree of communicative and interpersonal skills, using a trauma informed lens when taking the history and providing the assessment.
- Knowledge of current literature is essential and continuously evolving at a very rapid pace (often requires weekly survey of newly published medical literature). High level of knowledge and skill needed to screen for and address the potential differential diagnosis list as well as comorbid conditions.
- A significant portion (more than 50%) of services provided in a focused practice seeing patients with ME/CFS, FM and ES/MCS are not remunerated.
- The current billing codes which are used when providing ME/CFS and FM consultation care within family practice (K037 and A912) do not adequately reflect the intensity of work and changes in clinical practice due to advances in the field since they were introduced.
- Other time-based and non-time-based family practice codes (not including A912 or K037) are for services that require much less pre- and post- visit time.
- Most of the time spent on patient care (including charting) is covered within the unit time billing for these codes.

- ME/CFS, FM and MCS/ES are three of the most complex conditions seen by physicians when looking at the number of symptoms and comorbid diagnoses. A "one problem per visit" guideline, as what is typically presented in family medicine practice to patients, is not feasible.
- Regarding A912, there is effectively a 75 min cap and no complexity add-on fee. In a consultation setting, 75 minutes does not cover half of the face-to-face assessment time needed, therefore K037 is used instead.
- The length of the visit is reflected in the length of the consultation report generated by the visit; for example, whereas the average consultation note from specialists is ~1-3 pages, a typical consultation report for ME/CFS, FM, and/or ES/MCS exceeds 5 pages (on average 10 pages).
- The pre- and post-visit work in this field, given the volume of material, is not adequately compensated with the A912 code, while there is no compensation for this built into the K037 code.
- The individual psychotherapy premium of 17%, if applied to the K037 fee code, would improve the income relativity gap from the present 57% to 51%.
- The underfunding of clinical services is deeply rooted in gender inequality in healthcare and starkly reflected in the undervaluing of the K037 fee code and the services associated with it.
- This code is used to address the complex needs of ME/CFS, FM and ES/MCS, conditions that predominantly affect women. In addition, all of the physicians in Ontario providing consultation services, particularly for ME/CFS and ES/MCS, are women.
- There are no other physicians in the province with recognized knowledge and expertise in the field of care for patients with ME/CFS and ES/MCS.
- In 2018, there were 8 physicians in Ontario who were identified as billing for services related to ME/CFS, Fibromyalgia and ES/MCS (based on diagnostic code used) for more than 50% of their billings.
- The Myalgic Encephalomyelitis Association of Ontario (MEAO) supports the request
- Millions Missing Canada supports the request

Committee Comments:

- The amended submission will be reviewed by the committee at its next meeting.

43.2 Expression of Support for SGFP proposals

The MIG expressed support for the proposals brought forward by the Section on General and Family Practice, including:

- a time-based modifier to be added to A007
- Increases to A007, A005, A911, K005 (and its equivalent)
- Removing limits on K013
- Increases to all the PAP fee codes and proposed IUD fees
- Introduction of a tray fee for gynaecological exams with a speculum.
- Support for the Cannabinoid Medicine MIG's proposal for the creation of specific focused-practice codes for its members to avoid negating FHO and FHT family physicians.
- The MIG also noted that MSPC should be conscious to avoid raising out of basket codes

Committee Comments:

- The OMSPC supports in principle.

44 Primary Care Mental Health

44.1 K701 Mental Health Out-Patient Case Conference

The Section requested that K701 be revised to include designated GP Psychotherapist and thus be eligible to bill.

The Section put forward the following in support of their request:

- Currently, outpatient case conferences are eligible for payment only when the most responsible physician is in the specialty of Psychiatry (in cases of adult/paediatric outpatient and inpatient mental health case conferences) or Paediatrics (in cases of paediatric outpatient and inpatient mental health conferences).
- However, many patients of GP Psychotherapists present with complexities similar to psychiatric and paediatric patients who would benefit from the same level of shared care/collaboration, especially with the increasing demand for mental health care.
- In many ways, GP psychotherapists fulfil similar roles as psychiatrists in a case conference setting (e.g., clarifying patient diagnosis and treatment trials; providing education or improved understanding of the patient to other physicians or interdisciplinary staff; facilitating/generating discussion around additional treatment recommendations/direction).

Committee Comments:

- OMSPC supports in principle the development of a generic outpatient case conference code. However, if this is not possible, OMSPC supports the Section's request in principle.

44.2 K007 Psychotherapy - Individual care
44.3 K005 Primary mental health care - Individual care
44.4 K004 Psychotherapy - Family – 2 or more family members in attendance at the same time
44.5 K019 Psychotherapy - Group - 2 people
44.6 K020 Psychotherapy - Group - 3 people
44.7 K012 Psychotherapy - Group - 4 people
44.8 K024 Psychotherapy - Group - 5 people
44.9 K025 Psychotherapy - Group - 6-12 people
44.10 K006 Hypnotherapy
44.11 K623 Form 1 - Application of psychiatric assessment
44.12 K624 Form 3 - Certification of involuntary admission
44.13 K629 Form 3 - All other re-certification(s) of involuntary admission including completion of appropriate forms

The Section requested a 5.6% fee increase the first year and then a yearly increase of 1.4% thereafter to the following fee codes.

FC	Descriptor	Current	Proposed	$ Increase	% Increase
K007	Psychotherapy - Individual care	$67.75	$71.54	$3.79	5.6%

K004	Psychotherapy - Family – 2 or more family members in attendance at the same time	$73.55	$77.67	$4.12	5.6%
K025	Psychotherapy - Group – 6-12 people	$11.95	$12.62	$0.67	5.6%
K005	Primary mental health care - Individual care	$67.75	$71.54	$3.79	5.6%
K019	Psychotherapy - Group - 2 people	$33.90	$35.80	$1.90	5.6%
K020	Psychotherapy - Group - 3 people	$22.55	$23.81	$1.26	5.6%
K012	Psychotherapy - Group - 4 people	$17.05	$18.00	$0.95	5.6%
K024	Psychotherapy - Group - 5 people	$14.05	$14.84	$0.79	5.6%
K006	Hypnotherapy	$67.75	$71.54	$3.79	5.6%
K623	Form 1 - Application of psychiatric assessment	$113.35	$119.70	$6.35	5.6%
K624	Form 3 - Certification of involuntary admission	$139.60	$147.42	$7.82	5.6%
K629	Form 3 - All other re-certification(s) of involuntary admission including completion of appropriate forms	$41.35	$43.67	$2.32	5.6%

The Section put forward the following in support of their request:

- Patients are presenting with more complex mental health concerns.
- Patients are presenting with mental illnesses disguised subconsciously as somatic symptoms.
- There is an impending rise in mental illness due to the multiple stressors imposed on people by the Covid 19 pandemic and the associated limited number of MD psychotherapists in the province.
- There is increasing demand for and lack of mental healthcare resources and the benefits of having more Primary Care Physicians invest more time in psychotherapy.
- There is a need to catch-up in relativity payments: There is significant separation of relativity in the last 30 years due to psychotherapy being fixed to a time-based formula while other procedure fees grew exponentially in the same period because of technological advancement allowing the same procedure to be conducted in less time.
- The most common fee code billed by PCPs is A007. It is common for family physicians to carry out 5 A007 procedures and therefore bill 5 A007 codes in an hour.
- At the current rate, that is equal to $184.25 per hour. That would require an increase of 4.2% of psychotherapy codes i.e., K007. In addition, to keep pace with the same growth in billing for the most commonly billed Family practice code, i.e., A007, the K007 would need to increase 1.4% per year.
- Therefore, the total increase for K007 fee code would be 4.2% + 1.4% = 5.6% for the first year and then a yearly increase of 1.4% thereafter.

Committee Comments:

- OMSPC supports in principle. The Section on General and Family Practice Medicine will need to be consulted in determination of the appropriate fee values and the Sections on Psychiatry, and Emergency Medicine for K623, K624 and K629.
- Please review Section on General and Family Practice for common submission.

44.14 Focused Practice Psychotherapy Premium

The Section is proposing that the Focused Practice Psychotherapy premium be increased by 3 percentage points - from 17% to 20%

The Section put forward the following in support of their request:

- There are very long wait times to see a psychiatrist for therapy and scarcity of good access to mental healthcare resources.
- There is a dire need of attracting more family physicians to psychotherapy.
- PCPs are in the ideal position of often being the first to see a patient with a mental illness whether it is overt – common anxiety or major depression symptoms or covert – presenting with physical symptoms.
- There is extra training required to deal with the complexity of working as trauma-informed therapists.
- More complex patients often require unpaid advocacy to help them navigate the confusing and often discriminatory situations with HR at their place of work, with landlords at their residences and in dealing with insurance companies.
- In addition, some complex patients require intra session support via emails to manage dysregulated states and keep them out of hospital.
- Increasing the GP Psychotherapy Premium to reduce inter-sectional relativity, especially with other Primary Care Physicians, will make this focused practice more feasible for those interested, thus supporting a valuable resource for mental health care in Ontario and decreasing the burden on overworked family physicians and other specialists.

Committee Comments:

- OMSPC supports in principle. The Section on General and Family Practice Medicine will need to be consulted in determination of the appropriate fee value.

44.15 Kxxx Psychotherapy Services

The Section is requested the Committee to allow psychotherapy services, delivered in any format – in-person, virtual (video or by phone) and in any platform (OTN or other PHIPA protected platforms), to be able to bill K007, K004, K025, K019, K012, K024, K025, K005, K020, K006, K623, K624 and K629. (K082 will no longer be necessary for psychotherapy.)

The Section put forward the following in support of their request:

- Paying less for virtual care would discriminate against those with difficulty accessing care including those with mobility issues, the elderly, those without access to transportation. Such a barrier of access would be inconsistent with the province's responsibilities under the "Accessibility" criteria of the Canada Health Act.
- Some Studies have shown that online therapy is just as effective as face-to-face therapy for major depression and anxiety disorders.
- For some people, especially for those with social anxiety, it can be easier to share private information to a therapist online.
- The population treated by telephone usually have no reliable access to the internet, often are older, and/or are socioeconomically challenged.

- Several doctors in the survey have said it was necessary to use non-OTN platforms to properly deliver group therapy for virtual care but were not compensated the same as OTN.
- A key reason has been that the current OTN platform is technologically limiting compared to other platforms.
- Members would like to use the same K-codes and get the same compensation in all platforms – OTN video platform, non-OTN video platforms, in-person and telephone) as long as they are PHIPA protected.

Committee Comments:

- The OMSPC notes that this is no longer required given the terms within the recently ratified Physician Services Agreement (PSA).
- The Ministry of Health has agreed to work with the OMA to consider and, where appropriate, address situations where pre-existing, pre-pandemic virtual care practice patterns that were enabled by the Ontario Telemedicine Network (OTN) and supported access to and continuity of patient care, may have been unintentionally restricted under the 2021 PSA.
- It is unclear whether this review will be completed in time to be considered as part of the PPC's final recommendations to the PSC.

45 Primary Care Solo Doctors

45.1 Axxx After Visit Care Fee

In response to the committee, the MIG revised its request for a new add on fee of $30.00 to at a time based fee of $16.00 per 5 minutes to remunerate for additional work associated with a particular patient and visit (in-person or virtual) for that patient that is currently unpaid and requested that time billed under this code would not count towards weekly billing for the Non-patient Facing Care Code. In addition, as requested, the following payment rules and examples were provided:

Payment Rules:

1. Time stamp (beginning and end) the work involved directly in the patient chart (EMR). Example: Searching on CPSO for specialist or Hospital clinic. Completing the referral form/ attachments etc.
2. Billed on 5 minute increments (maximum of 20 minutes for work associated with one patent visit). This time could be accrued over more than 1 day if necessary, as long as documented.
3. Code would be an add on code to the A007 for example. A007 and T007 for that one patient.

Examples:

- Reflects patient care involved before and after the visit that is not captured with the patient encounter
- Downloading OLIS results before the visit so that we don't order duplicate tests
- Finding the right referral for patients living out of district
- Finding the correct imaging or referral form for a particular hospital or clinic (since many places don't accept a generic referral)

- Logging into other Platforms—HSC/ EPIC, Hospital Epic Care, Ontario Bariatric Network, Connecting Ontario.
- completing forms not covered by OHIP. Wheel Trans, Hearing Aide Forms
- Continuity of Care policies—Following up on tests ordered. Reminders to for tests to book in the future- 6 month follow up mammograms etc.

The MIG put forward the following in support of their request for a new after visit care add-on fee:

- Ensuring complete patient care requires time. A detailed referral letter ensures that the patient receives proper care. Ensuring that their test or procedure is booked in a timely manner guarantees patient safety.
- These are the tasks that family physicians must complete before, during and after each visit to provide standard of care.
- Due to constraints on time, unpaid non-face time medical work leads to rushed and sometimes substandard care. Proper time spent and payment for this time spent on these after visit tasks ensures patient-centred, best care.
- Examples of such tasks includes writing specialists' referrals, review of the chart, review of lab results, time spent to ensure that diagnostic tests are booked in a timely fashion, RX renewals, and completion of unpaid forms (e.g., Wheel Trans/Hearing Aid Forms) etc.

The Committee discussed the following:

- Upon reconsideration of this proposal, this would require a re-write of the constituent and common elements of insured services and specific elements of assessments. It may also require re-evaluation of other service fee values.
- The committee noted that some of the examples provided would be captured in service elements of other fees or represent uninsured services.
- Further, it is unlikely that the Ministry would consider such a re-write.

Committee Comments:

- OMSPC does not support the MIG's request.

45.2 Axxx Non-Patient-Facing Care Code

In response to the committee, the MIG revised its request for a new code to encompass the daily care provided to patients that is not associated with the patient encounter at $48 per unit (initial proposal was for a fee of $30.00 per unit), where 1 unit of time = 15 minutes and a maximum of 25 units per week. The following information was provided for development of payment rules, along with some examples:

Payment Rules:

1. Create a Dummy patient chart for logging of time spent on in-box EMR and similar work. OHIP would need to create a mechanism for billing to a dummy patient: may be able to use some mechanism they used for H-codes during the pandemic.
2. Billed in 15 minute increments
3. Generally, this code would not be claimed with the After Visit Care code for a particular patient. However, if information unrelated to the visit purpose came in during the same

week as the After Visit Care code was claimed, the work related to that information could be counted towards this NPFC code for that week.

4. Physicians on EMR would have their EMR log the time we spend working after hours. Most of this work is really going through our inbox. EMR providers would have to cooperate with this technology, including a way to sum it to bill to the dummy patient.
5. For physicians not on EMR, or whose EMRs do not yet support this logging function, would need to document this work in a "dummy patient "chart, total work done in a day at a high level, e.g., HRM/lab inbox for 20 patients for 30 minutes, etc.
6. It should be noted that for this code we need to have a way of billing not attached to any particular patient. However, this would also apply to other situations where it would be useful to have this function; e.g., medication reviews for series of patients in long-time care, where few individual patients may take the time required to bill a separate code but there is significant time spent on the collective of patients. As above, may be able to use same mechanism as for H codes.

Examples:

- Answering Emails and inquiries/questions from patients that is not billable with a patient encounter
- Lab/HRM inbox –takes hours depending on roster size
- Preventive care not associated with the patient encounter. Arranging the 5 year follow colonoscopy because the Gastroenterologist doesn't automatically book them in 5 years
- RX renewals when patient is not being brought back (e.g., FHO practices, and also FHG/CCM who do not bring patient back or have virtual visit for this)
- Updating CPP with – new meds patient is taking, Preventive care results
- Coordinating with Allied Health Professionals that see our pts (NPs, Dietitians, Physiotherapists, Dentists).
- Would include physician time instructing staff re: doing the parts they can add on to what the physician has done, but not the time the staff actually spend doing those tasks

The MIG put forward the following in support of their request for a new non-patient facing fee:

- There is necessary unpaid work associated with each patient. Non-patient-facing care examples are:
  a) Reviewing lab results
  b) Replying to patient emails and inquiries.
  c) Preventive care and ensuing referrals not associated with the visit. Example, pt is due for colonoscopy after 5 years. Referral needed. No patient encounter.
  d) Reviewing consult reports coming in daily and updating the CPP/ Patient chart to ensure continuity of care.
  e) Rx renewals without a patient visit
  f) Communicating with allied health professionals (naturopath requesting blood work, chiropractors requesting X-rays etc.)
  g) Pharmacy MedsCheck reviews and replying to inquiries/clarification from pharmacists
- Female physicians see more female patients who present more often to their doctors. This results in more inquiries, referrals, and review of tests etc. This non-patient-facing care code would help to address the gender pay gap and physician burnout.
- The service Encompasses more of the general patient care between visits and not associated with one particular patient visit; represents a summing of such work over many patients in a day

- Similar to the Preventive Care Bonus codes billed, a new time based code would be created. One unit of time = 15 minutes. Maximum of 25 units per week. Fee per unit - $ 48.
- To maintain party with other time-based codes such as K124 (10 minute increments) or K005, we propose revising the rate in the PFAF to $48.00 per 15 minutes

The Committee discussed the following:

- The committee requests the MIG to provide strict payment rules excluding uninsured services and non-patient facing work associated with a patient encounter. Proposed payment rules should ensure:
  - Work was not initiated by the billing physician for a particular encounter.
  - Uninsured services would not be eligible for payment under this proposed code.
  - Any non-patient facing work associated with a patient encounter would not be eligible for payment (see item 1 above).
  - That the fee would not be eligible for payment by a PEM physician on a rostered patient
- Circumstances eligible for payment could be further articulated (e.g., Investigations ordered by others for which this physician needs to review and/or act on).

Committee Comments:

- OMSPC supports in principle with the following qualifiers,
  - requires strict payment rules developed by the MIG to exclude uninsured services and non-patient facing work associated with a patient encounter,
  - the MIG is to provide further details on the descriptor and payment rules for the requested new fee, as noted above.

46 Psychiatry

46.1 Virtual Care and Telepsychiatry

The Section requested that virtual psychiatric care should be remunerated at 100% of in-person care (i.e., on par with in-person care), acknowledging that not all psychiatric care can be virtual.

Committee Comments:

- The OMSPC notes that this is no longer required given the terms within the recently ratified Physician Services Agreement (PSA).
- The Ministry of Health has agreed to work with the OMA to consider and, where appropriate address, situations where pre-existing, pre-pandemic virtual care practice patterns that were enabled by the Ontario Telemedicine Network (OTN) and supported access to and continuity of patient care, may have been unintentionally restricted under the 2021 PSA.
- It is unclear whether this review will be completed in time to be considered as part of the PPC's final recommendations to the PSC.

46.2 Age Premiums

The Section requested there should be similar Age-Based Premiums applicable to psychiatric services for child/adolescent psychiatric services (up till age 22, consistent with the age requirement of consultative

services A197/A198) and for geriatric psychiatric services (age 65 and above, or with a diagnosis of dementia, consistent with the requirements of consultative services A191/A192).

The Committee noted the following:

- The OMSPC awaits the receipt of additional information to evaluate the merits of this proposal.

Committee Comments:

- The OMSPC defers comments pending the receipt of additional information to evaluate the merits of the proposal.

46.3 K189 Urgent community psychiatric follow-up

The Section requested that the descriptor for K189 be revised such that it can be billed with both A198 (consultative interview with patient less than age 22) and A192 (consultative interview with patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia).

The Section put forward the following in support of their request:

- The current K189 code incentivizing urgent community psychiatric follow-up.
- The rules for K189 should be modified to allow K189 to be billed with both A198 and A192.

The Committee noted the following:

- The OMSPC awaits the receipt of additional information to evaluate the merits of this proposal.

Committee Comments:

- The OMSPC defers comments pending the receipt of additional information to evaluate the merits of the proposal.

46.4 Exxx Level I modifiers

46.5 Exxx Level II modifiers

The Section requested two new psychiatric services premium modifiers,

a) Exxx Level I modifiers – 15% premium to psychiatric services rendered, and
b) Exxx Level II modifiers –30% premium to psychiatric services rendered.

The Section put forward the following in support of their request regarding Level I and II modifiers:

- Modifiers would be provided for psychiatric services identified through the following principles:
    - Care that is more difficult or intense.
    - Care that carries higher risk (for either the patient or physician).
    - Care involving higher degrees of judgement and skill.
    - Care that involves significantly higher degrees of 'indirect' or 'non-face-to-face' services (the rationale being that direct patient contact time-based billing does not allow for appropriate billing of necessary services).

- Proposed Level I Clinical Care Modifiers:
- Severe depression: HAM-D score above 17, or MADRAS score above 30.
    - Treatment resistant depression plus moderate depression, HAM-D 14-17.

- Severe mania: Young Mania Rating Scale (YMRS) score above 25.
- Severe anxiety: Hamilton Rating Scale for Anxiety, Structured Interview version (SIGH-A) score above 24.
- Severe psychosis: Positive and Negative Syndrome Scale (PANSS) score above 61.
- Childhood/ Adolescent Depression: management of depression in under 16 years old; Child Depression Inventory (CDI) score of (probably 20, must confirm) or above, or Children's Depression Rating Scale – Revised (CDRS-R) score of 45 or above.
- Management of Patient with Substitute Decision Maker.
- Trauma scale for PTSD – still investigating most appropriate scale and cut-off points.
- Dual diagnoses, concurrent diagnoses: presence of specific multiple diagnoses.

- Proposed Level II Clinical Care Modifiers:
  - Similar to the current ability to combine the individual 15% premiums of K187 and K188, if both situations are present, for a 30% premium, Level II modifiers would essentially reflect a combination of multiple clinical modifiers concurrently present and increasing complexity/intensity/risk. For example
  - Severe depression plus treatment resistance, HAM-D > 17 or MADRAS > 30.

The Committee noted the following:

- The OMSPC awaits the receipt of additional information to evaluate the merits of this proposal.

Committee Comments:

- The OMSPC defers comments pending the receipt of additional information to evaluate the merits of the proposal.

46.6 Psychiatry fee relativity adjustments

The Section on Psychiatry requested fee increases to time-based Psychiatry fees to maintain fee relativity with GP/FP time based psychotherapy fees (See Primary Care Mental Health submission item 44.2 – 44.14). See Appendix IV for complete list of proposed fee increases.

47 Reproductive Biology

47.1 1 J476 Transvaginal sonohysterography - including Echovist contrast media for demonstration of tubal patency

The Section is requesting to revise the J476 descriptor to allow for the use of any contrast media specifically made for use in the assessment of tubal patency (i.e., removal of the word "Echovist") as follows:

> J476 - Transvaginal sonohysterography - including ~~Echovist~~ contrast media for demonstration of tubal patency.
>
> (Deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- While Echovist was a very good product, it has since been replaced by new and improved contrast media.
- Currently, the most heralded replacement for this product is likely a foam solution. A recent (2021) review and meta-analysis confirmed the test as highly accurate and has become a preferred method of analysis due to its lack of radiation, ease of use, improved tolerance, non-reliance on anaesthetics and safety.
- As the medical community has moved to newer contrast media for the interrogation of the fallopian tubes, there should be an update in the descriptor for this service.
- Specifically, the term, "Echovist contrast media", should just be "contrast media".
- The descriptor should be in line with the actual current use.
- The removal of the specific trade name, Echovist, rather than replacing it with another trade named product, allows for subsequent innovations, without requiring future changes to the descriptor of the J476 fee.

Committee Comments:

- Please see Diagnostic Imaging submission item #10.20

48 Respiratory Diseases

48.1 Multiple Fee Adjustments

The Section requested fee increases associated with consultation and visits, subsequent visits by the MRP and pulmonary function studies codes. Details of these proposed revisions can be found in the table below:

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
Consultation and Visits					
A471	Complex Medical Specific Re-assessment	$73.75	$85.08	$11.33	15.40%
A473	Medical Specific Assessment	$84.65	$95.82	$11.17	13.20%
A474	Medical Specific Re-assessment	$63.70	$73.50	$9.80	15.40%
A475	Consultation	$169.65	$188.40	$18.75	11.10%
A476	Repeat Consultation	$105.25	$126.30	$21.05	20.00%
A478	Partial assessment	$38.25	$45.66	$7.41	19.40%
A575	Limited Consultation	$105.25	$126.30	$21.05	20.00%
Subsequent Visits by the MRP					
C122	Subsequent visits by the Most Responsible Physician (MRP) – day following the hospital admission assessment	$61.15	$76.44	$15.29	25.00%
C123	Subsequent visits by the Most Responsible Physician (MRP) – second day following the hospital admission assessment	$61.15	$76.44	$15.29	25.00%

C124	Subsequent visits by the Most Responsible Physician (MRP) – day of discharge, page A171	$61.15	$88.20	$27.05	44.20%
Pulmonary Function Studies					
J304	Volume versus Flow Study - from which an expiratory limb, and inspiratory limb if indicated, are generated. A flow volume loop may include derivation of FEV1, VC, V50, V25	$11.30	$32.25	$20.95	185.40%
J306	Pulmonary Function Studies – Functional residual capacity – Airways resistance by plethysmography or estimated using oesophageal catheter, page H4	$16.85	$17.69	$0.84	5.00%
J307	Pulmonary Function Studies – Functional residual capacity – by body plethysmography. Page H5	$18.75	$19.69	$0.94	5.00%
J310	Pulmonary Function Studies – Functional residual capacity – Carbon monoxide diffusing capacity by single breath method	$18.90	$19.85	$0.95	5.00%
J311	Pulmonary Function Studies – Functional residual capacity – by gas dilution method. Page H5	$18.45	$19.37	$0.92	5.00%
J327	Volume versus Time Study - must include Vital capacity, FEV1, FEV1 /FVC, and may include calculation of MMEFR(FEF25-75) repeat after bronchodilator	$6.75	$7.09	$0.34	5.00%
J333	Pulmonary Function Studies – Oxygen saturation – Non-specific bronchial provocative test (histamine, methacholine, thermal challenge), page H5	$34.70	$36.44	$1.74	5.00%

The Section put forward the following in support of their request:

Consultation and Visits:

- They require significant service time, communication and interpersonal skills, knowledge, judgement, risk and stress. They require thorough clinical review, history and physical examination, review of updated imaging, pulmonary function tests, and bloodwork.
- Adjustments to the patient's long-term management are required. Extensive discussion and counselling are required for optimal acute and chronic disease management. Consultation and visit services differ from other medicine subspecialty consultations in that there is significantly increased risk of contagious airborne diseases like Covid-19.

Subsequent visits by the MRP:

- Inpatient ward work is grossly undervalued and under-remunerated. Assessing a respirology inpatient on the second and third day after admission is a particular high-risk time for a patient.

- Careful assessment and interpretation of lab and imaging results are required to determine a patient's trajectory and need for changes to the acute care plan.
- Day 2 and day 3 assessments after admission require substantial service time, a high level of knowledge and judgement, good communication skills, and is associated with both significant risk to the patient and to the physician as well as significant stress to the physician.

Pulmonary Function Studies:

- PFTs can result in high aerosol generation and have an increased risk of Covid-19 transmission. Infectious droplets can be spread even from asymptomatic Covid-19 patients.
- Cross-contamination of equipment, testing rooms, corridors, offices and waiting rooms is possible.
- Pre-screening of patients is required to establish their risk of having Covid-19 and adds to the time and complexity of PFT testing.
- PFT test performance is highly dependent on the patient's ability to perform the test adequately.
- Significant instruction, coaching, and repeat test performance is required in order to obtain good test results
- Communicating how to perform the test is more difficult due to the need for PFT testing staff to wear N95 PPE masks and its interference with demonstrating how to perform the procedure. In addition, wearing an N95 mask all day is far more uncomfortable than a regular surgical facemask.
- Post-testing Covid-19 sanitization protocols are required, adding to the time needed to complete the test. Post-testing Covid-19 room ventilation is also required and significantly increases the time needed to complete the test.
- This is independent of staff PPE or vaccination status as subsequent patients are at risk when they have to remove their mask to perform testing. In addition, their vaccination status is not always certain; a subsequent patient could be unvaccinated, have partial vaccination, or have failed vaccination.
- All of these features contribute to the stress of practicing respirology, the complexity of practicing respirology, the knowledge and skill required, the time commitments, and the risk physician morbidity, mortality, and burnout.
- Targeted increases to these fees will help to address the intra-sectional relativity gap between General Respirologists, Sleep and ICU Respirologists.

The Committee noted the following:

- The Section acknowledged that the proposed Increases to the consultation and visit fees would only apply to the A prefix codes, not C codes.
- Hospitalist Medicine's has submitted a proposal to establish a day of discharge add-on fee for medically complex patient. The Section has indicated support, but not of the required time component.
- Fee adjustments to the MRP codes C122, C123 and C124 may have implications for multiple Sections and would invite feedback from other Sections.

Committee Comments:

- The OMSPC support in principle but will need to consult with affected Sections who bill the MRP subsequent visit fees (C122, C123 and C124).
- Please review Section on Hospital Medicine for common MRP fee submissions.

48.2 A570 Complex Respiratory assessment

The Section requested,

1. an increase for A570 from $89.85 to $107.82 (by 20%),
2. a revision of the payment rules (page A170), as follows:

Payment rules:

2.A570 is limited to ~~6~~ 10 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.

(Revisions underlined, deletions ~~strikethrough~~)

3. The addition of the following conditions:
    - Long Covid-19 symptoms
    - Sarcoidosis
    - Pulmonary hypertension

The Section put forward the following in support of their request:

- Patients have complex respiratory needs including multiple assessments and potentially the need for additional oxygenation or ventilatory support.
- There is also the need for additional pharmacologic therapy and subsequent monitoring.
- These patients may also have evidence of respiratory disability thus requiring support for these assessments for the purposes of employment and/or disability claims.

Committee Comments:

- The committee supports in principle.

48.3 G412/G408/G409 – Nephrological component of renal transplantation

The Section requested a revision of the fee descriptors and payment rules without changing the respective fee values (page J70):

G412 - Nephrological or pulmonary component of organ transplantation - 1st day following transplantation
G408 - Nephrological or pulmonary component of organ transplantation - 2nd to 10th day, inclusive ~~per diem~~
G409 - Nephrological or pulmonary component of organ transplantation - 11th to 21st day, inclusive ~~per diem~~

Payment rules:
G412, G408, G409 are not eligible for payment following transplantation of an organ other than the kidney or lung. Note: G412, G408, G409 includes complete patient care.

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- All solid organ transplant recipients require high-intensity specialized care following transplantation, not just kidney transplant.
- Specialized knowledge and experience in the care of early post-transplant patients required. High risk, high stress service with frequent complications.
- Must manage and educate around multiple new health issues e.g., immunosuppressive meds, infection prophylaxis, new onset diabetes and hypertension etc. Regular, detailed communication with highly stressed patients and families required.
- These services are billed for all new transplant patients (200/yr) – average LOS for each Lung transplant patient is 2-3 weeks.

Committee Comments:

- The OMA supports in principles but proposes pursuing a new set of organ specific codes (for each system) rather than the requested modification to the Nephrological management of donor procurement per diem fees.

48.4 Kxxx Multidisciplinary Respiratory Case Conference

The Section requested a new code Kxxx Multidisciplinary Respiratory Case Conference, valued at $31.35 per unit per patient per actively participating respirologist.

Eligible respiratory diseases for this service include 1) interstitial lung diseases and 2) lung transplantation.

Other eligible participants include the following:

1. For a lung transplantation MRCC, this must include at least 2 other physician participants, one of which must be a physician from one other discipline. Other eligible participants can include other physicians with a Royal College specialty designation and/or a regulated social worker and/or another regulated allied health professional with expertise in lung transplantation.
2. For an interstitial lung disease MRCC, other eligible participants must include at least two other physicians one of which is from a different discipline with a Royal College specialty designation.

The Section put forward the following in support of their request:

- Respirologists conduct multidisciplinary meetings to review patients with respiratory diseases given the complexities of their diseases and their subsequent management.
- Where applicable, each patient discussed is evaluated for their diagnostic considerations, transplant candidacy, appropriateness for therapy and ongoing management.
- Specialized knowledge and experience in the area being discussed in the MRCC is required.
- This services is currently billed as K121 Hospital in-patient case conference paid at $31.35.
- Conference are held weekly though each physician would not necessarily be present every week.
- Number of physicians and number of cases presented would vary by discipline and program size.

The Committee noted the following:

- The Section's request shares significant similarities with K121 and it is unclear why a new code is needed.
- The Section clarified this fee code is to be applied to outpatient discussions for these complex patient populations.

Committee Comments:

- The committee supports in principle.

49 Rheumatology

49.1 Proposed Intrasectional Fee Adjustments:

The Section of Rheumatology is requesting fee value changes to the following fee codes:

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
Consultation and Visits: Fee Relativity					
A485	Rheumatology Consultation	$170.10	$183.00	$12.90	7.60%
A483	Medical specific assessment	$81.70	$85.00	$3.30	4.00%
A481	Complex medical specific re-assessment	$72.65	$75.65	$3.00	4.10%
A486	Repeat Consultation	$109.35	$114.00	$4.65	4.30%
A484	Medical Specific Re-Assessment	$62.60	$64.60	$2.00	3.20%
A488	Partial Assessment	$39.10	$45.00	$5.90	15.10%
A590	Comprehensive rheumatology consultation	$300.70	$312.50	$11.80	3.90%
Injections or Infusions					
G328	Aspiration of bursa or complex joint, with or without injection	$39.80	$42.00	$2.20	5.50%
G329	Aspiration of bursa or complex joint, with or without injection - each additional bursa or complex joint, to a maximum of 2	$20.25	$42.00	$21.75	107.40%
G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	$20.25	$21.00	$0.75	3.70%
G371	Injection of each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5	$19.90	$21.00	$1.10	5.50%
Other					
G382	Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, monthly	$13.80	$15.00	$1.20	8.70%

K481	Rheumatology-Rheumatoid arthritis management by a specialist	$75.00	$80.00	$5.00	6.70%

The Section put forward the following in support of their request:

- Rheumatology Consultation code A485, much like ALL the other rheumatology consultation and assessment codes (i.e., A480, A488, A484, A486, A481, A483) were not increased for years and are undervalued.
- Although the Consultation Code, A485 itself an undervalued code, A485 was used as the benchmark code in the Intra-Sectional Relativity Undervalued Code Evaluation Survey sent out by the OMA to all members of the section of Rheumatology August 23, 2019, because it is a code familiar to and used by the majority of members.
- From the OMA Analysis of the Rheumatology Intra-Sectional Relativity Undervalued Codes Survey (September 2019) it was overwhelmingly evident that ALL RHEUMATOLGY BILLING CODES were considered undervalued! Percent changes to existing fee codes ranged from 24.5%-410.3%.
- Rheumatologists care for patients with arthritis, the majority of whom are over age of 65 years.
- The inflammatory arthropathies are lifelong, chronic diseases that require the long-term care of a rheumatologist
- With each passing year, rheumatologists acquire more and more sick patients with chronic diseases (additive burden of care on rheumatologists).
- Patients in general are living longer with rheumatic diseases, so they are older with additional comorbidities.
- Visits with a rheumatologist often take longer or require additional visits to manage other problems or co-morbidities, in turn, rheumatologists spend more time (with the patient and after ours) undertaking the work necessary to care for their patients.
- In addition to rheumatologic patients living longer and having a greater number of comorbidities, patients are also exposed to a greater number of available novel & potent immunologic therapies (ie., biologic therapies) that grow each year that requires extensive patient education and careful monitoring.
- Consequently, rheumatologists have assumed additional responsibility and more time is required to conscientiously look after patients in their practice.
- Many seniors are slower, may go to their rheumatologist with a caregiver and therefore take longer to evaluate.
- There is no question that the care rheumatologists provide has changed, become more intense and more complex, take longer yet there is no special code or premium for patients 65 or older, unlike rheumatologists treating patients 16 years of age and younger.
- As another comparison, Physical medicine and Rehabilitation (physiatry) which bills similar neuromuscular diagnostic codes as rheumatology, consultation fee is $189.20 which represents 11.22% more for a consultation than rheumatology.
- As rational for the proposed increase to G282, the Section noted:
    - G382, much like all the rheumatology code has not been increased in years and is markedly undervalued. From the OMA analysis of the Rheumatology Intra-Sectional Relativity Undervalued Code Survey (September 2019) rheumatology members sampled designated G382 = 334.2 Relative Value Units compared to the benchmark code A485, Consultation = 960 Relative Value Units.

- Analysis of rheumatology member survey indicates G382's new fee (RVUs /Value per Unit) should be $54.64 which represents a 310.8% increase in the G382 compared to its current fee.
- Biologic drugs have been linked to heightened risk of TB and other infections, malignancies especially lymphomas, platelet and thrombotic disorders, autoimmune diseases, cancer, dermatitis, MS and cardiac adverse events.
- Consequently, rheumatologists have assumed additional responsibility and more time is required to conscientiously review all bloodwork and properly look after patients in their practice

The Committee noted the following:

- The injection and infusion codes G328, G329. G370 and G371 will not be considered at this time, as the codes are under review by the Appropriateness Working Group (AWG)

Committee Comments:

- The OMSPC supports in principle, with the following exception:
  - The requested fee increases to injection and infusion codes G328, G329. G370 and G371 will not be considered at this time, as submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

49.2 G328 Aspiration of bursa or complex joint, with or without injection

49.3 G329 Aspiration of bursa or complex joint, with or without injection - each additional bursa or complex joint, to a maximum of 2

The Section requested the descriptors for G328 and G329 be revised to exclude "complex" joint and deletion of note 1 and payment rule 4.

~~Note 1: For the purpose of G328 and G329, a joint is defined as complex only if it is: a.a joint other than the knee; or b.a knee joint in which the anatomy is distorted by disseminated lupus erythaematosus, dermatomyositis, rheumatoid arthritis, Still's disease, ankylosing spondylitis or other seronegative spondyloarthropathies.~~

~~Payment rule 4: G328/G329 are not eligible for payment solely for injection of complex joint.~~

(Deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- The anatomy of a knee joint can be distorted by trauma/injury, crystal disease, infection, osteoarthritis (especially with advancing severity producing joint space narrowing, osteophytes, loose bodies and meniscal abnormalities)!
- Lupus, dermatomyositis on the other hand, typically do not cause joint destruction or a distorted joint anatomy.
- Further, the joint most commonly requiring aspiration is a knee!

- This means by the definition above, there is in fact no fee code for aspirating knee OA or other mechanical causes of knee effusion such as hemarthrosis, suspected infections or gout/pseudogout.
- With no fee code existing for aspiration of a non-complex joint (i.e. Knee), there is a disincentive to aspirate a non-complex joint (i.e., a knee), when in fact sending synovial fluid for analysis often yield a diagnosis in the case of crystals, infection, and hemarthrosis and is helpful to patients.
- Aspirating synovial fluid may be therapeutic to patient's relieving joint pain and swelling, improving mobility especially in the case of large joint effusions or hemarthrosis (which is extremely painful and improves immediately after draining blood from the joint).
- Joint aspiration may be particularly important in the elderly who may already have compromised ambulation and are at increased risk of falling.
- A knee joint, like other joints, can be difficult to aspirate.
- Aspirating a non-complex knee joint can be a lengthy procedure such as when effusions are large or loculated, in the case of elderly and other frail patients, in patients with a great deal of joint pain/swelling/ stiffness, HIV, cancer, infection or fear of needles.
- Knee aspiration has a high diagnostic yield and therapeutic effect particularly in the aged who may not be able to walk from the knee effusion and are increased risk of falling).
- Knee aspirations may prevent elderly patients from falling, from fractures, orthopaedic procedures, hospitalizations, other complications related to immobility/fall and permanent disability.
- Not remunerating physicians for aspirations of a non-complex joint is economically unsound.
- This strategy is counterintuitive and will end up costing healthcare more long-term.
- The definition of G328 should therefore be revised and remuneration for joint aspiration should comprise of ALL joints including knees.
- There should be NO distinction between a complex and non-complex joint.
- ALL joints aspirated or injected take time and expertise, and the physician should be remunerated for the time and expertise taken to complete the procedure.

The Committee noted the following:

- The injection and infusion codes G328, G329. G370 and G371 will not be considered at this time, as the codes are under review by the Appropriateness Working Group (AWG)

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

49.4 A480 Complex Rheumatology Assessment

The Section requested an increase for A480 from $92.20 to $95.00 (by 3.0%), removal of the annual billing limits and a revision of the fee descriptor and payment rules, as follows:

Complex rheumatology assessment

A complex rheumatology assessment is an assessment for the ongoing management of the following diseases of the musculoskeletal system where the complexity of the condition requires the continuing management by a rheumatologist:

a. Systemic vasculitides;
b. Inflammatory myopathies;
c. Polymyalgia rheumatica;
d. paediatric vasculitides, and chronic autoimmune diseases; or
e. Other rare multisystem autoimmune diseases (e.g., Cogan's syndrome, Sweet's syndrome, IgG4 disease, Familial Mediterranean Fever, Relapsing polychondritis, antiphospholipid antibody syndrome).

Payment rules:

1. A complex rheumatology assessment must include the elements of a medical specific reassessment, or the amount payable will be adjusted to lesser assessment fee.
2. This service is not eligible for payment to a physician for the initial evaluation of the patient by that physician.
3. ~~Complex rheumatology assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.~~
4. E078 is not eligible for payment with A480.

(Revisions underlined, deletions ~~strikethrough~~)

The Section put forward the following in support of their request:

- Other rare multisystem autoimmune diseases should also be included in this category: Cogan's syndrome, Sweet's syndrome, IgG4 disease, Familial Mediterranean Fever, Relapsing polychondritis, antiphospholipid antibody syndrome. Further, all adult and paediatric vasculitides, and chronic autoimmune diseases described, should be eligible for the E078 chronic disease assessment premium. These diseases represent some of the most complex, multisystem diseases rheumatologists treat!
- All of these conditions are complex multisystem diseases that require great care, frequent visits because patients are usually very sick and treated with steroids and immunosuppressive medications that can lead to patient complications (i.e., steroid induced diabetes, infections).
- Further, all adult and paediatric vasculitides, and chronic autoimmune diseases described, should be eligible for the E078 chronic disease assessment premium. These diseases represent some of the most complex, multisystem diseases, time consuming patients' rheumatologists treat!
- Further, complex rheumatology assessments are limited to 6 per patient, per physician, per 12-month period should be deleted from payment rules.
- The sicker a patient is, the more frequently that patient will have to be assessed.
- Patients with active vasculitis for example may have to be assessed monthly.
- The physician looking after the sickest patients should not be penalized with a fee code of lesser value because they are assessing that patient more than 6x/year.
- From the OMA Analysis of the Rheumatology Intra-Sectional Relativity Undervalued Codes Survey (September 2019) Rheumatology Members sampled designated A 480 = 800 Relative Value Units compared to the benchmark code A485, consultation (= 960 value units). Analysis of Rheumatology members surveyed shows A480's new Fee (RVU Value per Unit) should be

$130.80 which represents a 42% increase in the A480 fee compared to its current fee, (coefficient of variation 0.47 which is a low value). This low coefficient of variation suggests that responses are consistent amongst rheumatology members surveyed and therefore, more reliable, and credible.

Committee Comments:

- The committee supports in principle.

49.5 Kxxx Initiating or switching of biologic or small molecule advanced therapeutic

The Section requested a new code Kxxx Initiating or switching of biologic or small molecule advanced therapeutic, valued at $125.00. This fee code would be in addition to another visit fee but would be billed when a Rheumatologist initiates or switches biologics (i.e., TNFis, IL-6is, Rituximab, abatacept).

The Section put forward the following in support of their request:

- Initiating or switching biologics/small molecule advanced therapies requires extensive physician expertise on the agent being prescribed.
- Physician assessments involving initiation or switching of a biologic/small molecule due to lack of efficacy or intolerance generate work that goes on for weeks after the decision is made to change therapy, all currently performed without compensation.
- 4-element intensity evaluation (each scored from 1-7): Communication and interpersonal skills 6, knowledge and judgment 7, risk and stress 5, technical skills 3.6
- For the majority of patients, initiating/switching a biologic or advanced therapy is not expected to be performed annually. Initiation or switching of a biologic/JAKi would for the majority of patients likely occur more seldom than annually and its precise frequency is uncertain.
- Occasionally, additional letters are needed to explain or clarify the indication for starting or switching a biologic or small molecule.
- Rheumatologists have numerous non-remunerating time-consuming after hour tasks especially when initiating or switching advanced therapies (i.e., biologics and JAKi):
- Reviewing patient charts, reviewing patient charts, reviewing patient charts, Reviewing patient charts

The Committee noted the following:

- The Section on Dermatology supports the proposal and requested to also be eligible to bill if within the Section's funding allocation.

Committee Comments:

- The committee supports in principle both the Sections on Rheumatology and Dermatology's request.

49.6 Kxxx Psoriatic Arthritis management by a specialist - annual

The Section requested a new code Kxxx Psoriatic Arthritis management by a specialist – annual, valued at $80.00. The following fee descriptor was proposed:

Service rendered by a specialist in Rheumatology who is most responsible for providing ongoing management of a patient with psoriatic arthritis. This service includes all services related to the coordination, provision, and documentation of ongoing management, including documentation of all medical record requirements, using a planned care approach.

The Section put forward the following in support of their request:

- 4-element intensity evaluation (each scored from 1-7): Communications, knowledge and judgment, risk and stress, technical skills - 4.5
- Comparator service is K48 Rheumatoid arthritis management by a specialist (an annual fee). Like, Psoriatic Arthritis, Rheumatoid arthritis management by a specialist is based on the Treat to Target ("T2T") strategy.
- The service involves
    1. Measurement of tender joint count;
    2. Measurement of swollen joint count;
    3. Physician and patient global assessment of disease activity;
    4. Patient pain score;
    5. Patient assessment of function (e.g., HAQ [Health Assessment Questionnaire] or SF36 [Short Form 36]);
    6. Measurement of acute phase reactant (ESR or CRP); and
    7. Calculation and recording of a pooled measure of RA disease activity (DAS-28 [Disease Activity Score 28], SDAI [Simplified Disease Activity Index], or CDAI [Clinical Disease Activity Index].
- T2T is a favoured approach that has been validated for Psoriatic Arthritis. T2T helps to standardize care in both RA and Psoriatic Arthritis, drive therapeutic management to achieve remission or low disease activity and improve patient outcomes.

Committee Comments:

- The committee supports in principle.

49.7 Exxx Geriatric premium

The Section requested a 25% Geriatric premium applicable to their consultation and assessment fees for a person 65 years of age or older. The applicable fee codes include: A486, A590, A595, A486, A483, A484, A481, A488 and A480.

The Section put forward the following in support of their request:

- A paediatric age premium exists in the Schedule of Benefits as follows:
  1 Less than 30 days of age 30%
  2 At least 30 days but less than one year of age 25%
  3 At least one year but less than two years of age 20%
  4 At least two years but less than five years of age 15%
  5 At least five years but less than 16 years of age 10%

The Committee noted the following:

- An alternative approach could be to establish a time based assessment fee in place of the geriatric premium

- The Section on Internal Medicine supports the proposal.

Committee Comments:

- The OMSPC supports in principle and may explore such a premium applying to all specialties' consultation and assessment fees.

50 Rural Medicine Forum

50.1 Commentary

In their written submission, the Rural Medicine Forum (RMF) highlighted a number of issues and priorities for rural and remote physicians, specifically:

1. Recruitment and Retention
2. Remunerating Complexity
3. Administrative Burden

The Forum put forward the following in support of their request:

- RMF expressed support for existing proposals related to providing remuneration for unremunerated administrative work and time-based consultations to help remunerate for long difficult cases.
- Several ideas for payment modifiers and premiums were discussed as possible solutions to address unique challenges of rural practice.

Committee Comments:

- The OMSPC values the feedback from the Rural Medicine Forum and will keep this in mind throughout deliberations.

51 Sports & Exercise Medicine

51.1 A005 Family Practice & Practice in General - Consultation

The Section is requesting a fee increase to A005 from $84.45 to $105.00.

The Section put forward the following in support of their request:

- The A005 current fee significantly undervalues the service that focused practice physicians provide.
- As most focused practice physicians are fee-for-service physicians, this code is a major contributor to their incomes.
- When reviewing consultation fees for Royal College medical specialties (e.g., physiatry, internal medicine, paediatrics), consultation fees range from around $157 for 4-year programs, to approximately $170 for 5-year programs.

- Accounting for their added years of training, for a 3-year training program, a consultation fee should come out to between $102 and $117.

The Committee discussed the following issues:

- As an alternative to a fee increase to A005, the committee suggested the option of creating a new focus practice Sports Medicine consultation fee.

Committee Comments:

- Decision is deferred pending the Section's feedback on the prospect of creating a new Sports Medicine Consultation fee.
- Please review Section on General and Family Practice for common submission.

51.2 A917 Sport medicine Focused Practice Assessment

The Section is requesting that this code be de-linked from the A007, removed from the 'in-basket' codes if possible, and increased from $36.85 to $46.88.

The Section put forward the following in support of their request:

- Sport and Exercise medicine specialists provide comprehensive musculoskeletal (MSK) consultations for Ontarians. The A917 is the most commonly used code, as it is used for patient assessments – both initial (when there is no attached referral) and follow-ups.
- This fee is grossly undervalued for the service provided on initial assessment with no referral
- This fee is also undervalued for the assessments provided in follow-up as MSK specialists.
- This code is linked to the A007 in money value. However, Section members have identified that a typical A917 visit takes 25 min to complete due to the comprehensiveness of the assessment and management that we provide.
- Based on the OMA 2019 ISR – Sport & Exercise Medicine document, this code has an average RVU of 446.5 compared to the A005. Based on our request for the A005 to increase to $105.00, the A917 would increase to $46.88.
- As we are mainly a fee for service Section, MSK specialists, and this is our most commonly used assessment code, de-linking it from A007 would allow us to increase its value to better reflect the expert service we offer as well as help to address the intra-sectional relativity gap we face.
- Lastly, as per the Interactive Cost Analysis excel sheet, increasing the A917 from $33.70 to $46.88 would impact the budget by only $1.6 million, while increasing the A007 by $1 would impact the budget by $20.6 million.

The Committee discussed the following issues:

- The Section is requested to comment on maintaining A917 fee relativity with A007 Intermediate assessment in the event that A007 is increased by more than what your Section proposed.
- The Section on General and Family Practice (SGFP) is requesting a new time based complex add on fee to A007, which would pay $33.85 for service exceeding 20 minutes in duration (see item #16.1). The Section is requested to comment on whether they would be interested in creating a similar complex time based add-on fee for assessments.

Committee Comments:

- Decision is deferred pending section response to OMSPC questions.

51.3 E446 - peripheral joint injection using image guidance following a failed blind attempt, to G370 or G371

51.4 G328 Aspiration of bursa or complex joint, with or without injection

51.5 G329 - each additional bursa or complex joint, to a maximum of 2

51.6 G370 Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath

51.7 G371 - each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5

The Section is requesting,

1. E446 fee be increased from $30.00 to $65.02 and a revision to its descriptor to allow blind injection when standard of care would demonstrate that it is not advisable.
2. G328 either have a fee increase from $39.80 to $58.00 or a descriptor revision to remove the restriction that G328 is not eligible for payment solely for injection of complex joint
3. G329 either have a fee increase from $20.25 to $29.50 or a descriptor revision to remove the restriction that G329 is not eligible for payment solely for injection of complex joint
4. G370 fee be increased from $20.25 to $29.51
5. G371 fee be increased from $19.90 to $29.00

The Section put forward the following in support of their request for E446:

- Physicians providing injections under image guidance have added training through the form of a residency or enhanced skills training program, fellowship, or continuing medical education.
- The performance of these injections requires regular use for maintenance of skill and requires costly equipment to perform (i.e., Ultrasound, fluoroscopy).
- E446 is only eligible for payment when injection of the joint must be repeated using any method of image guidance following a failed blind attempt(s) by the same or different physician or when standard of care would demonstrate that a blind injection is not advisable.

The Section put forward the following in support of their request for G328 and G329:

- Option 1: The previous submissions by the sections and MIGs that are part of the GP assembly were to increase the value of the other injection fee codes G370 & G371 by 45.73%. We are proposing to increase the G328 and G329 injection fees by the same amount.
- Option 2: The added expertise and time required to aspirate a 'complex joint' is the same as would be needed to also inject this joint. There are many circumstances where you would be injecting a complex joint without first doing an aspiration. There is currently no fee code that reflects the extra time and training required to inject a complex joint and by removing this restriction on the descriptor, consultants with the extra training and expertise to perform this procedure would be compensated.

The Section put forward the following in support of their request G370 and G371:

- Sport and Exercise medicine specialists are often consulted to provide injections for common musculoskeletal complaints. The G370 & G371 are the most commonly used injection codes. As this procedure does require some added expertise and continued use to maintain skills, many primary care practitioners do not offer this service in their practice.
- Based on discussions with the Sections and MIGs of the GP assembly, including the SGFP, and averaging their respective calculations of their section/MIGs RVUs, it was decided to put forth a

recommendation to increase both the G370 to $29.51 & the G371 to $29.00 (an increase of both by 45.73%)

- It does not take any less time or expertise to perform a second injection at the same visit thus our rationale for making both codes have roughly the same value.

Committee Comments:

- Submissions related to matters under consideration by the Appropriateness Working Group (AWG) will not be considered. The OMA-MSPC will re-engage affected Sections at a later date once AWG recommendations have been finalized.

51.8 K013 Counselling - Individual care

51.9 K040 Counselling - Group counselling -2 or more persons

51.10 K033 - additional units per patient per provider per 12-month period per unit

The Section is requesting,

1. a fee increase to K013 from $67.75 to $70.95.
2. a fee increase to K040 from $67.75 to $70.95
3. a fee increase to K033 to $47.00

The Section put forward the following in support of their request:

- Consultants provide a lot of education and counselling during a visit to educate and empower patients and caregivers with knowledge on the patient's condition, how to manage it if chronic, and how to prevent it if episodic.
- Sport and Exercise Medicine (SEM) specialists can often be asked to see the same patient for more than 1 problem per year.
- The increase in concussion awareness and call to action by regulatory bodies has increased the number of concussion patients that SEM physicians care for. Concussion care can range from simple cases to significantly complex cases requiring a lot of education and mental health counselling.
- The benefits of physical activity and exercise in the management and prevention of chronic diseases such as diabetes, obesity, heart disease and mental health have become quite well known, but the prescription of exercise is still quite novel to many physicians, leading to increased referrals to SEM physicians for counselling on exercise and exercise prescription.
- With the current descriptors, SEM specialists quickly exceed the K013 limits, and find themselves billing the K033 code, while continuing to provide the same amount of education and counselling.
- Although our Section would ultimately like to propose a Sport and Exercise Medicine specific counselling code for all the different counselling and education that we do, we understand that this is not feasible during this round of fee allocation.
- Upon discussion with the Sections and MIGs of the GP Assembly (including the SGFP), we have come to a consensus that the K013 should increase by about 5% (to $70.95), and the K033 by about 23% (to $47.00).

The Committee noted the following:

- K033 fee value is currently set at $47.70 and as such will not consider the Section's K033 request.

Committee Comments:

- Please refer to the Section on General and Family Practice submission item #16.6

52 Surgical Assistants

52.1 Assistant Unit Fee

The Section requested,

1. a 15% increase to their assistant unit fee from $12.25 to $14.09
2. triple time units start after 90 minutes (i.e., from 2.5 hours to 1.5 hours).

The Section put forward the following in support of their request:

- An increase in the unit fee is the number one concern to surgical assistants and affects all assistants.
- Over the years, the increase of the unit fee has been very restrictive.
    - In 2011 it was increased to $12.04. It was not increased again until 2019 from $12.04 to $12.25, a 1.7% increase.
    - On average, this is equivalent to 0.17% per year since 2011, not compounded. In Canada, the inflation rate has been an average of 2% on the dollar since 2011.
    - Thus, our unit increase has been sadly inadequate as it does not support the increase in cost of living in Canada.
- We propose an increase in the unit value of 15% to compensate for the lack of increases over the years. A 15% increase over 10 years is about 1.4% increase per year since 2011.
- The total cost of this according to calculations by the OMA is estimated to be $16 233 711 of which the portion to family medicine and general practice is $6 956 448.
- Anaesthesia has a similar unit value method of billing, but unlike us they are able to add many more add on codes, including for extra procedures, that we are not able to do.
- Their time units triple at 90 minutes. Ours triple at 150 minutes. We are asking for ours to triple at 90 minutes.

The Committee noted the following:

- The argument presented by the MIG was not based on intensity, work effort and relativity to comparable services.
- The committee suggests establishing a working group be struct to explore all issues related to surgical assist remuneration.

Committee Comments:

- Decision deferred pending framework for evaluating surgical assistant services relative to other physician services.

52.2 E676B Morbidly obese patient, surgical assistant, to major procedure add

The Section requested,

1. all procedures completed on patients with a high BMI be eligible for the BMI codes.

2. The E676B BMI premium be revised to the following:
   a. ExxxB BMI 35 to 39.9 = 5 units
   b. ExxxB BMI 40 to 49.9 = 6 units
   c. ExxxB BMI > 50 = 8 units
3. Alternatively, the following codes be added to the eligible list of codes for E676:
   - R743: coronary artery repair-two
   - R441: Hemiarthroplasty - Total replacement/both compartments
   - R244: Hemiarthroplasty - Revision total arthroplasty knee
   - R483: Hemiarthroplasty -double component (e.g. Marmar)
   - R442: Hemiarthroplasty - replacement liner
   - S716: vagina repair - Anterior or posterior repair
   - S717: vagina: Anterior and posterior - repair
   - S718: vagina: Anterior and posterior – repair- enterocoele and/or vault prolapse
   - S719: vagina: Posterior repair and repair of: enterocoele and/or vault prolapse
   - S816: Hysterectomy -with or without adnexa (unless otherwise specified) – vaginal
   - N512: Posterior spinal decompression: lumbar - one level - bilateral
   - N511: Posterior spinal decompression: lumbar - one level unilateral
   - N582: Posterior spinal arthrodesis as sole procedure: Lumbar with instrumentation: one disc level
   - R698: Necrotizing fasciitis: Debridement, excision and flap and/or graft closure -in Operating Room Debridement, excision and flap and/or graft closure for necrotizing fasciitis
   - R111: Operations of the breast: Excision: partial mastectomy or wedge resection for treatment of breast disease, with or without biopsy, e.g. carcinoma or extensive fibrocystic disease.
   - R108: Operations of the breast: Mastectomy -female (with or without biopsy) - simple
   - R118: Operations of the breast: Repair: Post-mastectomy breast reconstruction: Breast skin reconstruction by local f laps or grafts, includes Wise pattern skin flaps and de-epithelialized skin flaps
   - R109: Operations of the breast: Mastectomy, radical or modified radical (with or without biopsy)
   - R110: Operations of the breast: Reduction mammoplasty and augmentation mammoplasty (other than post-mastectomy breast reconstruction) - Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral
   - Z427: Lymph Channels: Biopsy: Sentinel node biopsy, per draining basin
   - M133: Lungs and Pleura: Incision: Thoracotomy for removal of foreign body
   - M134: Lungs and Pleura: Incision: Thoracotomy for post op haemorrhage or empyema
   - M132: Lungs and Pleura: Incision: Thoracotomy with repair of ruptured diaphragm
   - M135: Lungs and Pleura: Incision: Major decortication of lung for empyema or tumour
   - M144: Lungs and Pleura: Incision: Segmental resection, including segmental bronchus and artery M149: Lungs and Pleura: Excision: Pleurectomy, and/or apical bullectomy for pneumothorax
   - M105: Lungs and Pleura: Excision: chest wall tumour, resection of 2 or 3 ribs or cartilages
   - M106: Lungs and Pleura: Excision: Mediastinal tumour
   - M151: Lungs and Pleural: Excision: bullectomy for major bullous disease

- M137: Heart and Pericardium: Thoracotomy – with or without biopsy
- M101: Trachea and bronchi: Repair - tracheal -bronchial rupture, transthoracic
- M103: Trachea and bronchi: Excision - segmental resection of trachea with either sternotomy or thoracotomy
- M108: Chest wall and Mediastinum: Chest wall reconstruction - ligation of thoracic duct– as sole procedure
- M130: Lungs and Pleura: Incision - Closure of broncho-pleural fistula (transthoracic or trans-sternal)
- M138: Lungs and Pleura: Excision - Hilar lymph node or lung biopsy with full thoracotomy
- Z338: Lungs and Pleura: Excision - biopsy of pleura or lung- with limited thoracotomy
- E300: Ocular and Aural Surgical Procedures: External Ear: Excision -resection of pinna - with primary closure
- R301: Ocular and Aural Surgical Procedures: External Ear: Excision -resection of pinna - with local flap
- S251: Rectum: Excision - Fistula in ano
- S075: Oesophagus: abdominal approach
- S073: Oesophagus: cervical approach
- S074: Oesophagus: thoracic approach
- R400: Elbow and forearm: Reduction: Dislocations: Elbow Joint – repair chronic, recurrent
- R421: Elbow and forearm: Joint Contents - synovectomy/capsulectomy/debridement, etc

The Section put forward the following in support of their request:

- We propose that all procedures completed on patients with a high BMI be eligible for the BMI codes, as obesity does not just affect the abdomen and the hips but rather all areas of the body. Patients need to be positioned (sometimes repetitively during the case), supported and transferred.
- This expansion of BMI codes should include all vaginal, obstetrical, orthopaedic and neck procedure billing codes.
- Although we are advocating for all codes to be eligible for E676B, based on the patient's BMI, a list of codes that have specifically been requested by surgical assistants in our survey, as listed above.

The Committee noted the following:

- The committee invites feedback from relevant surgical sections.

Committee Comments:

- The OMSPC supports in principle to adding the requested surgical fee codes to the list of eligible codes to E676 provided there is support from the relevant surgical Sections.
- The committee does not support creating a tiered BMI premium system, as sufficient supporting documentation was not provided to justify the request.

52.3 Surgical assistant basic units relativity adjustments

The Section is requesting the following increases to their base units:

- 6 base units increase to 8
- 7 base units increase to 8
- 8 base units increase to 9

The Section put forward the following in support of their request:

- Each surgical case starts with a certain number of base units, and these units are then added to the time units.
- Base units have the same value and are designed to be based on the intensity and difficulty of the surgical assistant's role. The lowest value is 6 and the highest is 24. Most are 6 units.
- These units have previously not been distributed evenly and fairly based on the above criteria. Some orthopaedic elective cases have higher base units than most gynaecological and other abdominal/pelvic cases, despite the increase in intensity, the need for skills, such as camera skills and the physical demands that are also present in these cases.
- There is also a gender difference in the physicians that assist for these cases. The ratio of female to male surgical assistants is 35.9% to 64.1%.
- Although there are more male assistants than female, the proportion of female to male assistants is less for the higher paid procedures. There is an inherent discrepancy in historically underpaid codes that are attached to gender differences.
- The difficulty of a gynaecological case with one assist can sometimes be more challenging than an arthroplasty case with two assists. Thus, we would like to propose an increase of the gynaecological units from 6 to 8 for more equality and fairness.

The Committee noted the following:

- Assigned base units to a particular procedure is one way to account for differences in complexity between procedures. As such, changing a base unit should be based on complexity and relativity with other comparable services.

Committee Comments:

- Decision deferred pending framework for evaluating surgical assistant services relative to other physician services.

52.4 Preamble - Second assistant

The Section requested that the following surgical fee codes be added to the list of surgical assist services not requiring authorization by a medical consultant (i.e., added to table list on page GP90):

S166, S167, S168, S188, S176, S175, S177, S171, S180, S185, S213, S214, S727, S738, S745, S763, S727, S757

The Section put forward the following in support of their request:

- Many of the above cases require a second assistant to improve access to the surgical field. Many are laparoscopic and the surgical assistant cannot hold instruments steady and control the boom on the camera at the same time.
- Lack of a good view increases the timing of the surgery and increases the risk of complications. Many of them, the instruments need to be too far apart to be held by the same person.

The Committee noted the following:

- The proposed list of surgical procedures requires support from the relevant surgical Sections.

Committee Comments:

- The OMSPC supports in principle to adding the requested surgical fee codes to the list of surgical assist services not requiring authorization by a medical consultant pending support from the relevant surgical Sections.

52.5 E101B Surgical assistant Standby

The Section requested that the E101B payment rule be changed such that it can be billed as soon as the start of the delay rather than following a minimum of 30 minutes.

The Section put forward the following in support of their request:

- E101B is a time-based service limited to one surgical case per physician per day payable for standby as a surgical assistant for unforeseen delay beyond the scheduled start time for surgery.
- The physician must be physically present in the operating room suite for the period between the scheduled and actual surgical start time.
- Procedures are frequently delayed for unforeseen purposes when the surgical assistant is in the surgical suit ready to start. This code pays for the surgical assistant's time while waiting.
- They cannot do other paid work at the same time.

The Committee noted the following:

- The committee clarified that E101B is paid based on surgical assistant time units (i.e., 1 time unit for every 15 minutes or major part thereof) and not 1 unit per 30 minutes.
- Delays and cancelled cases occur in many specialties. The committee agrees that it is reasonable to be compensated for being required to wait beyond some reasonable threshold.

Committee Comments:

- The OMSPC support in principle and suggests the MIG provide payment rules to deliver an appropriate amount of delay beyond which the fee would be eligible for payment.

52.6 Exxx Stand by for Caesarean Section

The Section requested a new surgical assistant time-based fee for standby for Caesarean section.

The Section put forward the following in support of their request:

- Often an assistant is called in for a potential emergency caesarean section. The mother is able to deliver vaginally and the assistant is cancelled.
- The assistant needs to be there for the safety of the mother and baby, as the time to come into hospital is too long. The code needs to cover waiting time, even if the caesarean section occurs.

The Committee noted the following:

- Anaesthesiology has E100C for attendance at delivery.

Committee Comments:

- Please refer to committee comments on Exxx Cancelled case (item #52.7) below.

52.7 Exxx Cancelled case

The Section requested a new fee code for a cancelled surgery at $50.

The Section put forward the following in support of their request:

- Surgical assistants are often called to assist in a case, that is subsequently cancelled, due to more urgent cases, patient factors, or other cases taking longer and running out of time.
- Physicians do not get paid for coming in.
- Currently a visit code can be used, but it may have been billed by another physician already, and they are not eligible for premium codes or visit/travel codes.

The Committee noted the following:

- Currently cancelled surgeries prior to induction of anaesthesia is billable as a subsequent visit.
- In situations where another same specialty physician has submitted a subsequent visit fee and the claim is subsequently rejected, the claim can be manually submitted for payment (e.g., submit a Remittance Advice Inquiry (RAI) form requesting payment).

Committee Comments:

- The OMSPC supports in principle and requests the MIG to provide payment rules to define start and stops times for the requested fee code.
- A single code should apply to all cases where the assistant is required to stand-by for a length of time and is not required for surgery.

52.8 Exxx Rural indicator code premium

The Section is requesting a 20% premium to surgical assistant fees based on the facilities rurality index score.

The Section put forward the following in support of their request:

- The idea of this code is to encourage surgical assistants to work in smaller communities, where often only one or two cases need an assist and clinic sacrifices are made for much less income, as an incentive.
- This premium would allow for a 2nd assistant in smaller communities when a resident, who is a 3rd MD, is less often available, when a 2nd assistant is not allowed according to the schedule of benefits.
- Rural surgical assistants often travel long ways for only one or two cases but need to cancel a whole day or half day of other earnings. This would be an incentive. The 2nd assistant would add safety to the case.
- We also propose a rural indicator code to apply to the surgical assistant according to the already established rurality index. (Rurality index. https://apps.oma.org/RIO/index.html).

The Committee noted the following:

- OMSPC principles in evaluative fee proposals requires that the proposed fee be based on time, intensity and relativity to comparable services.

- The MIG could consider an alternate means to compensate rural surgical assistants for excess time spent in travelling to approved rural locations.

Committee Comments:

- The OMSPC does not support the Section's request, as it is not clear how surgical assisting in rural areas differs in comparison to urban areas in terms of time, intensity and relativity to comparable services.

52.9 C988B Special visit premium to assist at non-elective surgery with sacrifice of office hours -first patient seen

The Section requested the payment rule relating to C998B be deleted. The payment rule for deletion is as follows:

> C988B is not eligible for payment in respect of any special visits to assist at surgery in a calendar month if the amount payable for all surgical assistant's fees (including special visit premiums associated with performing surgical assistant services) rendered by the physician in that month is greater than 20% of the total amount payable for all insured services rendered by the physician in that month

The Section put forward the following in support of their request:

- Currently, premiums associated with performing surgical assistant services rendered by the physician in that month is greater than 20% of the total amount payable for all insured services rendered by the physician in that month.
- We are requesting to remove 20% limit as this affects rural physicians most, as they do not get a full day and are often small cases.
- Often a full clinic is sacrificed for one or two procedures, which is not compensated for by the C988. The physician may decide not to be on call for this due to the loss of income. This may affect patient care.

Committee Comments:

- The committee supports in principle.

52.10 E401B After hours premium - Nights

52.11 Preamble - After hours premiums (E400B and E401B)

The Section requested,

1. E401B after hours premium be increased from 75% to 100%
2. E400B and E401B after hours premiums be applicable during the specified time periods and not be based on the start time.

The Section put forward the following in support of their request:

- The E401B code is currently 75%. If the assistant is called into the operating room after midnight, the effect on the next day physically, emotionally, and financially is not worth the amount that is paid. We propose it is increased to 100%.
- Procedures often start just before 17:00 or 00:00 and go for hours but are paid at the lower rate.

- This would provide for fairer compensation of when the assistant actually works. The same would apply to daytime, if the case goes after 07:00.

The Committee noted the following:

- The OHIP computer might not be able to able to process the proposed claims submissions, and as such, may require manual submission and calculation of appropriate payments.
- The requested revisions would impact all specialties. For example, to maintain relativity, after hours fee codes E409, E410, E412 and E413 would also need to be modified accordingly. This would require consultation with all affected OMA Constituencies.
- The Section on Anaesthesiology objected to the proposal pointing out that E401B is directly linked to E401C, E410A and E410C, which share its value for the same time period and to maintain relativity the cost could be prohibitive. The Section is also not convinced that the premium is out of relativity.

Committee Comments:

- The OMSPC support in principle to increase E401B from 75% to 100%.
- The committee acknowledges there would be cost implications for other Specialties, whose input needs to be sought as part of the Physician Payment Committee's (PPC) allocation process (e.g., Section on Anaesthesiology who shares E401 with surgical assistants).
- The OMSPC does not support changing after hours premiums to specific time periods, given previous exploration revealed implementation challenges.

53 Urology

53.1 Urology fee relativity adjustments

The Section proposed intra-sectional relativity adjustments evenly to their consultation and visit codes, as well as a set of undervalued procedural codes. Under their proposal, appropriate values for procedural codes would be valued according to anaesthesia time.

The Section put forward the following in support of their request:

- We propose that 50% of any increase will be applied to consultation and visit codes (A355, A354, A353 etc.), with the general principle that our fees will be comparable to other Surgical Specialty fees. This is in alignment with the MSPC comments on page 4 of the OMA-MSPC Fee Setting Process Orientation Manual Economics, Policy & Research, August 2021, "that services that take similar time and are of similar work intensity are paid similar fees across specialties". This is a fair and equitable distribution of fee increases, as all urologists bill consultations and visit codes.
- The remaining 50% will be applied to our Surgical Fees using the principles of Relativity outlined by the OMA. It would involve a comparison of the payment for a service as a function of time (derived from anaesthesia time-based billing data). This would require the most up to date data from economics. We would encourage other sections to engage in the same exercise as failure to address procedural discrepancies contributes to pay bias across the profession.
- Just as we had proposed in our past recommendations to MSPC, there is still a significant issue with undervalued, low volume services, which we suggest need further efforts to receive

adequate increases. We propose targeted increases to these existing services. The importance of these services, and the need for appropriate payment, pertains to the provision of necessary care to the population. The provision of that care needs to be given the greatest weight.

- The Methodology proposed to the MSPC in the past is summarized as follow (excerpt from 2020 MSPC Report:
    - The Section developed its own relativity model based primarily on time using anaesthesia units as a proxy to generate a rank order list based on the average fee per hour.
    - The ranking was adjusted in recognition that some codes were frequently claimed with other procedures and therefore the rank did not always represent the entire remuneration.
    - Procedures were categorized as better paid, paid an average amount or poorly paid. Some subjective input was also applied based on members' experiences.
    - Modest increases were applied to average paid codes and larger increases to those that were poorly paid. Better paid procedures were not increased.
- A general time-based surgical code should be implemented. This would provide a minimum, appropriate hourly remuneration for being in the operating room in instances where an appropriate fee code does not exist for a particular operation. This addresses general inequities in the SOB and would also address a potential element of the gender pay gap. Furthermore, complex or unique surgery is not well captured in the SOB, which contributes to another element of payment inequity. Time based payments in surgery by Anaesthesiology and Surgical Assistants are well established.
- Expansion of time based "visit" codes would similarly contribute to a fairer mechanism of remuneration, balancing patient volumes with quality of interaction. Time based fees already exist in the SOB (e.g., counselling K codes, special surgical consult A935 etc.). The most common explanation of pay gap is the time spent per patient. This would require a cross sectional/specialty initiative.
- The nature of this exercise remains very much contingent on whatever agreement or arbitration is to come. The size of any increase, directives on its use, special projects and major changes to practice such as virtual care could significantly alter our allocation plan.

The Committee noted the following:

- The OMSPC awaits a response from the Section on fee codes to be included in the intra-sectional relativity exercise.

Committee Comments:

- Decision is deferred pending a response from the Section on fee codes to be included in the intra-sectional relativity exercise including proposed fee values.

53.2 Exxx - Botox bladder injection for neurogenic bladder - first treatment of injection of botulinum toxin into detrusor muscle of bladder wall, add

53.3 Exxx - Botox bladder injection for neurogenic bladder - subsequent injection of botulinum toxin into detrusor muscle of bladder wall, add

The Section requested that the MSPC's 2014 recommendations on Botox bladder injection for neurogenic bladder be implemented. The MSPC's recommendations are as follows:

Exxx – first treatment of injection of botulinum toxin into detrusor muscle of bladder wall, add $154.00
Eyyy – subsequent injection of botulinum toxin into detrusor muscle of bladder wall, add $154.00

Payment rules:
Initial and subsequent treatments with four conditions, viz
(a) Not responsive to behavioural modification or anticholinergics;
(b) Payable only when symptomatic and not more frequently than every 12 weeks;
(c) Number of injections and total dosage to conform with current standards, and;
(d) Subsequent treatments not eligible for payment if not responsive to the initial treatment.

Committee Comments:

- The OMSPC supports in principle.

54 Vascular Surgery

54.1 Exxx Multilevel revascularization modifier

The Section requested a new add-on fee for Multilevel revascularization valued at $300 per level for revascularization spanning the aortoiliac and femoral and infrainguinal fields.

The Section put forward the following in support of their request:

- Increasingly there has been recognition in vascular surgery that multilevel revascularization for critical limb ischemia is of paramount important for life and limb preservation.
- Unilevel revascularization has been found to be insufficient to save legs and often repeat visits to the OR increases morbidity and mortality.
- This however need be balanced with the effects of time under anaesthesia and as such many (though not all) of these multilevel cases are performed using open and endovascular techniques, often referred to as hybrid procedures.
- Careful patient selection is a heavy responsibility for the vascular surgeon. This complexity requires extensive knowledge of the procedures and their risks, judgement, and are stressful. These procedures have been so successful that there has been relatively quick adoption as the standard of care.
- These cases typically require:
    - Two levels are typically completed; there are 3 basic levels (aortic-iliac, infraninguinal, and infrangeniculate)
    - additional imaging studies (CT, US and angio)
    - additional time to plan the case reviewing such imaging
    - additional time studying the patient and their co-morbidities to ensure they can medically tolerate the longer procedure
    - additional time performing the procedure
    - additional time in hospital for post op care, physio, medical complications
    - additional time discussing the procedure and its risks with the patient and their loved ones-as it is not that easy to explain.

    - additional time discussing the post operative course wit the patient's loved ones.
- We feel that this code would start to properly renumerate the vascular surgery group without affecting intersectional relativity or the gender pay gap as these are procedures are performed by most vascular surgeons in both academic and community settings.
- The procedure is currently billed under R797 (In-situ saphenous vein arterial bypass – popliteal - $1,414.15), R815 (Arterioplasty with or without patch graft including microvascular anastomosis, arterial or venous - $581.85) and R804 (In-situ saphenous vein arterial bypass – popliteal - $1,643.00)
- This is a cost neutral request.

The Committee noted the following:

- The primary motivation for this request is to avoid the administrative burden of having to manually submit claims, as multiple "R" codes are currently billed for rendering this procedure.
- If Ministry requirement for manual review was lifted, this request could be withdrawn.

Committee Comments:

- The OMSPC support in principle.

54.2 A175 Consultation

54.3 Axxx Special neurosurgery consultation

The section requested,

1. A/C175 be increased from $90.30 to $160.00 (77.2%).
2. A/C9xx be set at $300.00 and that the minimum time requirement be increased to 75 minutes.

The Section put forward the following in support of their request:

- The recent Intra-Sectional Relativity (ISR) survey results suggest demonstrated that a vascular surgical consultation takes a minimum of 47.1 minutes and special surgical consultation takes 74.7 minutes.
- Vascular surgery is a unique amongst surgical specialties in that we must bridge both the medical and surgical worlds to a much high degree than the average surgical specialty in order to effectively deliver care.
- Our patients require intensive risk factor modification, discussion, and education, which takes significant time and knowledge of current guidelines. There is no dedicated specialty that is able to assist us in this role. Therefore, we are responsible for all of the preventive and medical management necessary to keep these patients out of the operating room, in addition to the technological knowledge and surgical skills necessary to deliver them safely through high-risk procedures if they need to go there. Vascular surgical patients are high-risk for morbidity and mortality.
- One requires significant interpersonal and communication skills in order to educate patients and on their condition and the therapies, interventions, and procedures necessary to improve their health. Adversity is frequent, and because of this, an extraordinary high level of judgement is necessary to properly select patients and communicate the pros and cons of different approaches. When adversity occurs, we must also be available and able to effectively carry on the physician-patient relationship. The medico-legal risk is high, and the stress a heavy burden

to carry. None of this is possible without our membership being highly skilled. We need to be fairly remunerated so that we can take the time necessary to perform our roles properly.

- When surgery is required on our patients, the time necessary to properly counsel becomes astronomical. As the nature of this type of surgery is high-risk, patients naturally need extra time in discussion with their surgeon. Often, separate calls need to be placed to family members to go over the information and adequately prepare them for what is required. As our specialty is evolving and becoming increasingly dependent on technology, we also have to ensure that the cases are properly planned and liaise with industry to ensure the appropriate devices and materials are available. Much of this work is being provided after hours and over the span of multiple days.
- The ISR survey data indicates that our members are spending average amounts of time in regular consultation on par with a special surgical consultation. We are also performing a significant amount of medical care in addition to surgical care and are faced with a patient population that has significant comorbidity and past history. Properly sorting through this information to arrive at the correct patient-focused solution requires time, and our membership should be fairly compensated.
- We believe that our members are investing time in the delivery of service that is on par with medical specialties, and that we should be compensated accordingly.
- Most medical specialties would be paid $160 or more for consultation, with no time qualifier. When our members are needing to perform comprehensive special vascular surgical consultations, the amount of time investment to ensure the patient is appropriately investigated, prepared, consented and planned for surgery, discussed in multidisciplinary fashion, and that materials are available to provide the care becomes overwhelming.
- This type of consultation should be paid in line with specialties that have comprehensive consultation codes, associated with approximately 75 minutes of care, and paid $300, or more.

The Committee noted the following:

- The Section modified its request for a fee increase to A/C935, to a request for a new special consultation fee at $300.00 with a minimum time requirement of 75 minutes in line with other medical specialties special consultation.

Committee Comments:

- The OMSPC supports in principle.

54.4 Second surgeon Endovascular Aortic Surgery

The Section requested a new fee code for Endovascular aortic surgery with a fee value of $921.95 with the following descriptor “Two Surgeons, Endovascular aortic surgery, second surgeon”

The Section put forward the following in support of their request:

- There is a well-known association between improved outcome and multidisciplinary care. For endovascular aneurysm repair (EVAR), our patients benefit when the procedures are performed with a vascular surgeon and radiologist.
- When this model is employed, only one is eligible for remuneration. Our membership is currently being forced to develop income-splitting models developed on an individual program level in order for multidisciplinary teams to function.

- A common method is the 2/3:1/3 splitting model, which essentially means that our members do every third case for free in order to encourage multidisciplinary care.
- This is obviously quite difficult, and actively discourages multidisciplinary teams.
- Programs that choose to function this way are delivering care at a heavy discount to the MOHLTC.
- To our knowledge, a comparable multidisciplinary care service code does not exist in the schedule.
- As all time elements are the same, and the first surgeon is still responsible for the bundled post op care, we propose that the current EVAR code, R875 paid at $1396.90 to the vascular surgeon, remain unchanged.
- The second member of the multidisciplinary team, who is not involved in post operative care yet is still required to be present for all planning, technical skills, and intraoperative decision making, should be paid at a fee of approximately 66%, or $921.95.
- We propose that a second surgeon code be added for EVAR to encourage multidisciplinary care.

The Committee noted the following:

- The OMSPC awaits the receipt of additional information to evaluate the merits of this proposal.

Committee Comments:

- The OMSPC defers comment pending receipt of requested information to evaluate the merits of this proposal.

54.5 Multidisciplinary Vascular Surgery Case Conference

The Section proposes a new multidisciplinary vascular surgery outpatient case conference, valued at $31.35 per unit of time.

The Section put forward the following in support of their request:

- As the complexity of vascular surgery and need for multidisciplinary care has increased, we propose a multidisciplinary case conference code that is paid on a per patient basis to remunerate our members who are regularly engaging in these conferences, yet providing the service without remuneration
- Our members engage in weekly rounds that take between 1-1.5 hours, discussing 6-12 patients on average.
- We propose that a code similar to multidisciplinary cancer case conferences (K708, k709, k710) be on offer to our membership on a per patient basis.

Committee Comments:

- The OMSPC supports in principle, pending clarification that this represents a multidisciplinary conference and not a case conference.

54.6 Surgical unbundling

The Section is requesting a revision to the Surgical Preamble to allow pre- and post-operative care and visits to be billed.

The Section put forward the following in support of their request.

- The OR codes assume 2 weeks of post operative care but there is a reasonable subset of vascular patients that stay well beyond 48hrs for which their case, which is quite involved, is uncompensated and/or undervalued.
- Their time with us is not just 'supervision for physiotherapy'. They suffer major medical issues. For the vascular surgery patient experiencing an MI, acute kidney injury, heart failure or a wound dehiscence, their length of stay is long (average about 5-14days) and typically presents on post op Day 2 or later.
- Vascular surgeons tend to be the primary manager of these complications-the quarterback of the complex care-even if our medical colleagues are involved.
- Furthermore, the communication with the family rests with the surgeon as well-often providing daily updates and/or multidisciplinary family meetings.

The Committee noted the following:

- The Section on General Surgery made the same request. See General Surgery item #17.5

Committee Comments:

- See General Surgery item #17.5

Appendix I: OMA-MSPC Fee Proposal Evaluation Process for 2021/2022

The OMA-MSPC Fee Setting Process Orientation Manual provides an overview of the process the OMA will use to bring recommendations on changes to the Schedule of Benefits forward bilaterally with the Ministry of Health (MOH) at the MSPC in any fee allocation process in 2022. This Evaluation Process was developed prior to the ratification of the 2021 Physician Services agreement. The 2021 PSA has adjusted the initial timelines and will transition the work of the OMA-MSPC to the OMA-Physician Payment Committee. More information is described below. Additional revisions to this process may be made in future years as may be required.

The OMA-MSPC shall use Guiding Principles in carrying out their responsibilities for fee setting : https://www.oma.org/uploadedfiles/oma/media/member/membermappedpdfs/negotiations/oma-mspc-guiding-principles.pdf/

This document will provide greater detail on OMA-MSPC's review and evaluation process, which includes:

1. Review of submissions by OMA Sections and constituencies "Constituencies";
2. Presentation from Constituencies to the OMA MSPC;
3. Revised Constituency Proposals;
4. Posting of Constituency proposals for OMA members and opportunity for members to submit on potential gaps, and;
5. Evaluation and decisions on proposals to recommend at the bilateral MSPC.

1. Review of submissions from Constituencies (December 2021 – January 2022)

The deadline for Constituencies submissions is December 5, 2021. After that time, the OMA MSPC will begin its review of the submissions. The OMA-MPSC may contact Constituencies to seek clarification of their submission. This may occur in-person, or in writing.

2. Presentation from Constituencies to the OMA MSPC (January 2022 – March 2022)

Constituency presentations to the OMA-MSPC will commence in January 2022. The guidelines for the presentations can be found at – https://www.oma.org/uploadedfiles/oma/media/member/membermappedpdfs/negotiations/oma-mspc-presentation-guidelines.pdf/

It is expected that these presentations will highlight the major points of the written submission and, as set out in the Guiding Principles, will address:

- The modernization of the Schedule to reflect current medical practice;
- The gender pay gap within their Section; and
- Changes related to medical innovation/technological advances

Constituencies also have the option of sending a pre-recorded video to the OMA-MSPC in advance of their presentation. OMA-MSPC members will ask questions to the Constituency about their proposals, which may include technical details about a proposal(s), how the proposal(s) meet the guiding principles, how their constituents were consulted, potential impact of proposal on other Constituencies,

and why a submission does not include a proposal on an area that has been identified by either the OMA, OMA PSC, or OMA-MSPC that should be considered in the fee-setting process.

3. Revised Constituency Proposals (March 2022)

The OMA-MSPC may request more information. Such requests could include additional technical details about a proposal(s), how the proposal(s) meet the guiding principles, how their constituents were consulted, potential impact of proposal on other Constituencies, and why a Constituency's proposal does not address all or some of the major points set out in the Guiding Principles, if applicable.

4. Posting Draft OMA-MCPC Decisions for Constituency and OMA Members & Opportunity for Member Submissions (May 2022)

Once Constituencies have had an opportunity to provide additional information to the OMA-MSPC, draft decisions will be communicated to the Constituencies and will be posted on the OMA website for all OMA members to review. The OMA-MSPC will also identify Constituencies who did not submit any proposals, and any Constituency proposals that have not addressed all or some of the major points set out in the Guiding Principles.

If members are of the view that their Constituency did not bring forward a proposal that they believe should have been brought forward, they may submit a proposal to the OMA-MSPC as follows:

A members proposal requires the support of the lesser of 50 or more members OR 20% of members of a given Constituency whose names, OMA numbers and contact information must be included in the submission:

1. The group submitting will identify two physicians as the leads for the proposal;
2. The proposal must follow the Guidelines to Submitting a Proposal - https://www.oma.org/uploadedfiles/oma/media/member/membermappedpdfs/negotiations/oma-mspc-guidelines-submitting-proposal.pdf/
3. The submission shall address whether the proposal had been brought to Constituency for consideration, and, if so, information about why the proposal was not included

The OMA-MSPC will review any new proposal and may request additional information from the submitting group in a manner similar to Step 3 above. Such new proposals must be submitted by May 30, 2022. (Note: in is anticipated for the OMA-MSPC to convert to the OMA-Physician Payment Committee (PPC) in June and assume the responsibilities of the OMA-MSPC).

4. Evaluation and Decisions on Proposals to Recommend to Bilateral PPC (May 2022- June 2022)

The OMA-MSPC's evaluation of a proposal will include a review of all documents submitted, and all information presented and discussed in person. The OMA-MSPC will be guided by the OMA-MSPC Fee Setting Process Orientation Manual in carrying out its evaluation, including the Guiding Principles.
By the end of May, the OMA-MSPC will post draft recommendations for review. Any Constituency and/or other group who submitted a proposal will have an opportunity to review and comment on the recommendations to determine if the Constituency or other group accepts the draft recommendation,

or if they would like the recommendation to be revised, and written reasons for the revision. The deadline for the submission of comments on the draft recommendations is June 15, 2021.

The OMA-MSPC will consider feedback received from Constituencies and groups. Consideration may include requests for additional information and meetings in order to obtain additional information. After completion of this follow-up consultation, the OMA-MSPC will prepare its recommendations to be shared with the Bilateral Physician Payment Committee (PPC). The PPC will develop it own process to evaluate the recommended proposals that will be brought forward. Details of the process will be provided to the OMA membership once completed and approved by both the OMA and MOH.

Appendix II: GP/FP Time based codes

Fee Code	Descriptor	2021 Fee Value
K002	GP/FP - Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act per unit	$67.75
K003	GP/FP - Interviews with Children's Aid Society (CAS) or legal guardian on be half of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent per unit	$67.75
K004	GP/FP - Psychotherapy - Family -2 or more family members in attendance at the same time per unit	$73.55
K005	GP/FP - Primary mental health care - Individual care per unit	$67.75
K006	GP/FP - Hypnotherapy - Individual care per unit	$67.75
K007	GP/FP - Psychotherapy - Individual care per unit	$67.75
K008	GP/FP - Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities per unit	$67.75
K010	GP/FP - Psychotherapy - Group- Per member - First 12 units per day - Additional units per member (maximum 6 units per patient per day) per unit	$10.80
K012	GP/FP - Psychotherapy - Group - Per member - First 12 units per day - 4 people per unit	$17.05
K013	GP/FP - Counselling - Individual care - First three units of K013 and K040 combined per patient per provider per 12 month period per unit	$67.75
K014	GP/FP - Group Counselling - Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons per unit	$67.75
K015	GP/FP - Group Counselling - Counselling of relatives - On behalf of catastrophically or terminally ill patient - 1 or more persons per unit	$67.75
K019	GP/FP - Psychotherapy - Group - Per member - First 12 units per day -2 people per unit	$33.90
K020	GP/FP - Psychotherapy - Group - Per member - First 12 units per day - 3 people per unit	$22.55
K022	GP/FP - HIV primary care per unit	$67.75
K023	GP/FP - Palliative care support per unit	$72.15
K024	GP/FP - Psychotherapy - Group - Per member - First 12 units per day -5 people per unit	$14.05
K025	GP/FP - Psychotherapy - Group - Per member - First 12 units per day -6 to 12 people per unit	$11.95
K028	GP/FP - Sexually transmitted disease (STD) or potential blood- Borne pathogen management - STD management per unit	$67.75
K029	GP/FP - Insulin Therapy Support (ITS) per unit	$67.75
K033	GP/FP - Counselling - Individual care - Additional units per patient per provider per 12 month period per unit	$47.70
K037	GP/FP - Fibromyalgia/chronic fatigue syndrome care per unit	$67.75
K040	GP/FP - Group Counselling - 2 or more persons - Where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12 month period per unit	$67.75

Fee Code	Descriptor	2021 Fee Value
K041	GP/FP - Group Counselling - 2 or more persons- Additional units where any group member has received 3 or more units of any counselling paid under codes K013 and K040 combined per provider per 12 month period per unit	$48.50
K121	GP/FP - Hospital in-patient case conference per unit	$31.35
K124	GP/FP - LTC/CCAC case conference per unit	$31.35
K140	GP/FP - Chronic disease shared appointment - Per patient - maximum 8 units per patient per day - 2 patients per unit	$33.90
K141	GP/FP - Chronic disease shared appointment - Per patient - maximum 8 units per patient per day - 3 patients per unit	$22.55
K142	GP/FP - Chronic disease shared appointment - Per patient - maximum 8 units per patient per day - 4 patients per unit	$17.05
K143	GP/FP - Chronic disease shared appointment - Per patient - maximum 8 units per patient per day - 5 patients per unit	$14.05
K144	GP/FP - Chronic disease shared appointment - Per patient - maximum 8 units per patient per day - 6 to 12 patients per unit	$11.95
K680	GP/FP - Substance abuse - Extended assessment per unit	$67.75
K700	GP/FP - Palliative care out- Patient case conference per unit	$31.35
K701	GP/FP - Mental health out- Patient case conference per unit	$31.35
K702	GP/FP - Bariatric out- Patient case conference per unit	$31.35
K703	GP/FP - Geriatric out- Patient case conference per unit	$31.35
K704	GP/FP - Paediatric out- Patient case conference per unit	$31.35
K705	GP/FP - LTC -high risk patient conference per unit	$31.35
K706	GP/FP - Convalescent care program case conference	$31.35
K707	GP/FP - Chronic pain out- Patient case conference per unit	$31.35
K708	GP/FP - MCC Participant, per patient	$31.35
K709	GP/FP - MCC Chairperson, per patient	$40.45
K710	GP/FP - MCC Radiologist Participant, per patient	$31.35
K887	GP/FP - CTO initiation including completion of the CTO form and all preceding CTO services directly related to CTO initiation (per unit)	$91.60
K888	GP/FP - CTO supervision including all associated CTO services except those related to initiation or renewal (per unit)	$91.60
K889	GP/FP - CTO renewal including completion of the CTO form and all preceding CTO services directly related to CTO renewal (per unit)	$91.60
K016	GP/FP/Genetics - Genetic assessment per unit/ patient or family per unit	$74.05

Appendix III: OB/GYN Intrasectional Fee Relativity

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
Consultation and Visits: Fee Relativity					
A/C/W205	Consultation	$111.70	$150.00	$38.30	34.30%
A935	Special surgical consultation	$160.00	$175.00	$15.00	9.40%
A206	Repeat consultation	$59.45	$90.00	$30.55	51.40%
A203	Specific assessment	$52.15	$88.00	$35.85	68.70%
P003	General assessment (major prenatal visit)	$77.20	$100.00	$22.80	29.50%
P005	Antenatal preventive health assessment.	$45.15	$46.50	$1.35	3.00%
P004	Minor Prenatal Assessment	$36.85	$40.45	$3.60	9.80%
Diagnostic and Therapeutic Procedures: Fee Relativity					
G378	Insertion of intrauterine contraceptive device	$31.10	$70.00	$38.90	125.10%
G365	Pap smear	$8.65	$10.65	$2.00	23.10%
G394	Follow up Pap smear	$8.65	$10.65	$2.00	23.10%
Z463	Removal of Norplant	$65.30	$140.00	$74.70	114.40%
G398	Initial pessary fitting or re-fitting as required	$61.30	$100.00	$38.70	63.10%
G342	Hormone pellet implant - for contraception	$31.05	$120.00	$88.95	286.50%
Obstetrics: Fee Relativity					
P006	Vaginal delivery	$498.70	$600.00	$101.30	20.30%
E502	- vaginal birth after caesarean section (VBAC) whether successful or unsuccessful, add	$51.00	$200.00	$149.00	292.20%
P018	Caesarian section	$579.80	$650.00	$70.20	12.10%
P042	Caesarean section including hysterectomy	$837.25	$1,000.00	$162.75	19.40%
P045	Repair of third degree tear or episiotomy extension, must include repair of perianal sphincter and perineum	$82.15	$240.00	$157.85	192.10%
P046	Repair of fourth degree tear or episiotomy extension, must include repair of rectal mucosa, perianal sphincter and perineum	$200.00	$300.00	$100.00	50.00%
Z774	Postpartum haemorrhage - exploration of vagina and cervix, uterine curettage	$93.80	$220.00	$126.20	134.50%
Z734	Double set up examination to rule out placenta previa, or trial of forceps - failed leading to caesarean section (same physician)	$58.00	$200.00	$142.00	244.80%
P025	Non stress test	$9.65	$15.40	$5.75	59.60%
P034	Uterine inversion, manual replacements	$125.75	$160.00	$34.25	27.20%

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
Vulva and Introitus: Fee Relativity					
Z714	Abscess of vulva, Bartholin or Skene's gland - incision and drainage - local anaesthetic	$17.30	$46.00	$28.70	165.90%
Z715	Abscess of vulva, Bartholin or Skene's gland - general anaesthetic	$50.90	$100.00	$49.10	96.50%
Z716	Abscess of vulva, Bartholin or Skene's gland - Marsupialization of Bartholin's cyst or abscess	$71.90	$125.00	$53.10	73.90%
Z477	Biopsy(ies) - when sole procedure - local anaesthetic	$26.85	$60.00	$33.15	123.50%
Z475	Biopsy(ies) - when sole procedure - general anaesthetic	$50.90	$75.00	$24.10	47.30%
S707	Biopsy(ies) - when sole procedure - Hymenectomy (with or without perineotomy) or hymenotomy	$92.30	$100.00	$7.70	8.30%
S706	Biopsy(ies) - when sole procedure - Cyst of Bartholin's gland	$112.00	$200.00	$88.00	78.60%
Z769	Genital warts - GA excise/cautery	$115.10	$130.00	$14.90	12.90%
Vagina: Fee Relativity					
Z478	Vaginoscopy (premenarchal) with or without medication	$50.90	$80.00	$29.10	57.20%
Z728	Incision and drainage of cyst, abscess or haematoma	$92.30	$110.00	$17.70	19.20%
Z722	Vagina Excisional Biopsy(ies) -when sole procedure -local anaesthetic	$26.85	$45.00	$18.15	67.60%
Z723	Vagina Excisional biopsy - General Anaesthesia	$92.30	$120.00	$27.70	30.00%
S715	Vagina - Excision of cyst(s), or benign tumour(s)	$123.70	$150.00	$26.30	21.30%
S742	Vagina - Excision - Colpectomy -e.g. for carcinoma	$349.00	$375.00	$26.00	7.40%
S702	Excision of congenital vaginal septum	$123.70	$180.00	$56.30	45.50%
S716	Anterior or posterior repair	$164.00	$320.00	$156.00	95.10%
S717	Anterior and posterior - repair	$303.40	$500.00	$196.60	64.80%
S718	Anterior and posterior - repair of enterocoele and/or vault prolapse	$349.00	$600.00	$251.00	71.90%
S719	Posterior repair and repair of - enterocoele and/or vault prolapse	$307.80	$500.00	$192.20	62.40%
S723	Posterior repair and repair of - anal sphincter	$272.40	$450.00	$177.60	65.20%
S720	Anterior repair - with or without posterior repair and repair of uterine prolapse (Fothergill or Watkin's interposition)	$349.00	$480.00	$131.00	37.50%

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
S721	Anterior & Posterior repair and excision of cervix stump	$349.00	$480.00	$131.00	37.50%
S722	Post hysterectomy vault prolapse - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	$349.00	$500.00	$151.00	43.30%
S812	Post hysterectomy vault prolapse - repeat - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	$453.70	$650.00	$196.30	43.30%
S760	Abdominal approach to vaginal vault prolapse - vaginal sacropexy	$349.00	$500.00	$151.00	43.30%
S813	Abdominal approach to vaginal vault prolapse - repeat - vaginal sacropexy	$453.70	$650.00	$196.30	43.30%
S724	Abdominal approach to vaginal vault prolapse - Perineorrhaphy (not eligible for payment with delivery or other vaginal surgery procedures)	$122.75	$200.00	$77.25	62.90%
S725	Abdominal approach to vaginal vault prolapse - Colpocleisis (LeFort or modification)	$257.05	$500.00	$242.95	94.50%
S549	Retropubicurethropexy for stress incontinence - primary procedure	$376.70	$500.00	$123.30	32.70%
S546	Retropubicurethropexy for stress incontinence - repeat procedure for failed retropubic or vaginal surgery for stress incontinence	$489.70	$650.00	$160.30	32.70%
S815	Tension free vaginal tape mid-urethral sling by any method/ approach	$381.60	$420.00	$38.40	10.10%
Z735	Examination and/or dilatation (may include insertion and/or removal of IUD) - general anaesthetic - as sole procedure	$50.90	$130.00	$79.10	155.40%
Cervix Uteri Procedures: Fee Relativity					
Z731	Initial investigation of abnormal cytology of vulva and/or vagina or cervix under colposcopic technique with or without biopsy(ies) and/or endocervical curetting	$50.90	$60.00	$9.10	17.90%
Z787	Follow-up colposcopy with biopsy(ies) with or without endocervical curetting	$50.90	$60.00	$9.10	17.90%
Z730	Follow up colposcopy without biopsy with or without endocervical curetting	$25.50	$40.00	$14.50	56.90%
Z766	Loop Electrosurgical Excision Procedure (LEEP)	$78.00	$125.00	$47.00	60.30%
S744	Cervix - cone biopsy - any technique, with or without D&C	$173.15	$220.00	$46.85	27.10%
Z720	Biopsy - with or without fulguration	$20.00	$30.00	$10.00	50.00%

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
S765	Amputation of cervix	$173.55	$250.00	$76.45	44.10%
S766	Cervical stump - abdominal	$321.90	$400.00	$78.10	24.30%
S767	Cervical stump - vaginal	$321.90	$400.00	$78.10	24.30%
Z582	Hysteroscopy - diagnostic	$105.40	$150.00	$44.60	42.30%
Z583	Hysteroscopy - -with uterine biopsy and/or D&C	$131.40	$170.00	$38.60	29.40%
Z585	Hysteroscopy - with cannulization of tube(s), lysis of intrauterine adhesions or embryo transfer	$131.40	$200.00	$68.60	52.20%
Z587	Hysteroscopy - with resection of one or more endometrial polyps, with or without D&C	$200.00	$235.00	$35.00	17.50%
Z586	Hysteroscopy - with lysis of intrauterine adhesions/synechiae requiring a minimum of 60 minutes of surgical time	$349.00	$400.00	$51.00	14.60%
Z770	Endometrial sampling	$34.05	$45.00	$10.95	32.20%
S772	Endometrial ablation by any method	$218.65	$450.00	$231.35	105.80%
S768	Abortion - spontaneous, incomplete - including D&C	$93.00	$150.00	$57.00	61.30%
S756	Abortion - missed abortion, or evacuation of molar pregnancy, by any surgical technique	$112.40	$150.00	$37.60	33.50%
S754	Abortion - Diagnostic curettage (with or without cauterization, biopsy of cervix removal of polyps, or hysterosalpingography)	$92.30	$150.00	$57.70	62.50%
S764	Abortion - Myomectomy	$383.90	$500.00	$116.10	30.20%
S757	Hysterectomy - with or without adnexa (unless otherwise specified) - abdominal - total or subtotal	$463.00	$850.00	$387.00	83.60%
S816	Hysterectomy - with or without adnexa (unless otherwise specified) - vaginal	$463.00	$850.00	$387.00	83.60%
S758	Hysterectomy - with or without adnexa (unless otherwise specified) - with anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	$616.60	$1,100.00	$483.40	78.40%
S759	Hysterectomy with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	$523.55	$950.00	$426.45	81.50%
Fallopian Tube: Fee Relativity					
S784	Ectopic pregnancy - management by any surgical technique	$306.85	$550.00	$243.15	79.20%

		Fee Value			
Fee Code	**Descriptor**	**Current**	**Proposed**	**$ Increase**	**% Increase**
E852	Ectopic pregnancy - with tuboplasty, add	$47.90	$100.00	$52.10	108.80%
S738	Ectopic pregnancy - Salpingectomy or salpingo-oophorectomy (uni- or bilateral)	$306.85	$350.00	$43.15	14.10%
S735	Tubal plastic operation (unilateral or bilateral) -fimbriolysis.	$306.85	$350.00	$43.15	14.10%
S736	Tubal plastic operation - salpingostomy	$359.55	$350.00	-$9.55	-2.70%
S739	Tubal plastic operation - fimbriolysis and salpingostomy	$407.45	$500.00	$92.55	22.70%
S743	Repair of extensive unilateral or bilateral tubal and peritubal disease - For infertility, pelvic inflammatory disease or endometriosis with or without laser treatment and ureterolysis - laparotomy	$616.60	$700.00	$83.40	13.50%
Z552	Peritoneoscopy, culdoscopyor laparoscopy - without biopsy	$131.45	$210.00	$78.55	59.80%
Z553	Laparoscopy - with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants	$173.25	$270.00	$96.75	55.80%
Other					
Z725	Dilatation and cauterization under general anaesthesia	$50.90	$100.00	$49.10	96.50%
S745	Oophorectomy -and/or oophorocystectomy	$306.85	$380.00	$73.15	23.80%

Appendix IV: Psychiatry Fee Relativity Adjustment

		Fee Value			
FC	Descriptor	Current	Proposed	$ Increase	% Increase
K190	Psychiatry - Psychotherapy - Individual in-patient psychotherapy per unit	$91.00	$96.10	$5.10	5.6%
K191	Psychiatry - Family psychiatric care - In-patient per unit	$113.70	$120.07	$6.37	5.6%
K192	Psychiatry - Hypnotherapy - Individual per unit	$86.85	$91.71	$4.86	5.6%
K193	Psychiatry - Psychotherapy - Family psychotherapy - In-patients (two or more members) per unit	$103.25	$109.03	$5.78	5.6%
K194	Psychiatry - Hypnotherapy - Group - for induction and training for hypnosis - Per member (maximum eight people) per unit	$15.80	$16.68	$0.88	5.6%
K195	Psychiatry - Psychotherapy - Family psychotherapy - Out-Patients (two or more members) per unit	$98.55	$104.07	$5.52	5.6%
K196	Psychiatry - Family psychiatric care - Out-Patient per unit	$98.55	$104.07	$5.52	5.6%
K197	Psychiatry - Psychotherapy - Individual out-Patient psychotherapy per unit	$86.85	$91.71	$4.86	5.6%
K198	Psychiatry - Psychiatric care - Out-Patient per unit	$86.85	$91.71	$4.86	5.6%
K199	Psychiatry - Psychiatric care - In-patient per unit	$100.15	$105.76	$5.61	5.6%
K200	Psychiatry - Group psychotherapy, in-patients - Per member - First 12 units per day - 4 people per unit	$22.70	$23.97	$1.27	5.6%
K201	Psychiatry - Group psychotherapy, in-patients - Per member - First 12 units per day - 5 people per unit	$18.15	$19.17	$1.02	5.6%
K202	Psychiatry - Group psychotherapy, in-patients - Per member - First 12 units per day - 6 to 12 people per unit	$16.40	$17.32	$0.92	5.6%
K203	Psychiatry - Group psychotherapy, out- Patients - Per member - First 12 units per day - 4 people per unit	$21.75	$22.97	$1.22	5.6%
K204	Psychiatry - Group psychotherapy, out- Patients - Per member - First 12 units per day - 5 people per unit	$17.35	$18.32	$0.97	5.6%
K205	Psychiatry - Group psychotherapy, out- Patients - Per member - First 12 units per day - 6 to 12 people per unit	$15.65	$16.53	$0.88	5.6%

		Fee Value			
FC	Descriptor	Current	Proposed	$ Increase	% Increase
K206	Psychiatry - Group psychotherapy, out- Patients - Per member - First 12 units per day - Additional units - Per member (maximum 6 per patient per day) per unit	$13.90	$14.68	$0.78	5.6%
K207	Psychiatry - Group psychotherapy, in-patients - Per member - First 12 units per day - Additional units - Per member (maximum 6 per patient per day) per unit	$13.90	$14.68	$0.78	5.6%
K208	Psychiatry - Group psychotherapy, out- Patients - Per member - First 12 units per day - 2 people per unit	$43.45	$45.88	$2.43	5.6%
K209	Psychiatry - Group psychotherapy, out- Patients - Per member - First 12 units per day -3 people per unit	$28.95	$30.57	$1.62	5.6%
K210	Psychiatry - Group psychotherapy, in-patients - Per member - First 12 units per day - 2 people per unit	$45.55	$48.10	$2.55	5.6%
K211	Psychiatry - Group psychotherapy, in-patients - Per member - First 12 units per day - 3 people per unit	$30.35	$32.05	$1.70	5.6%
K620	Psychiatry - Consultation for involuntary psychiatric treatment per unit	$91.95	$97.10	$5.15	5.6%
K630	Psychiatry - Psychiatric consultation extension per unit	$113.70	$120.07	$6.37	5.6%