OMA Ontario Medical Association

Ontario

Physician Payment Committee Report

Comments on proposed Schedule of Benefits fee changes for April 1, 2026

Draft # 3 Comments

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Preface

This report from the Physician Payment Committee (PPC) outlines proposed Schedule of Benefits fee changes under consideration for implementation on April 1, 2026. The proposals and committee comments herein pertain to all active proposals from the combined Year 3 (2021-2023 PSA) & Year 1 (2024-2028 PSA) fee setting process. As part of the announcement of the award for Year 1 (2024-2028 PSA), the PPC received direction to implement permanent Schedule of Benefits changes for Year 3 and Year 1 in unison, with a target date of April 1, 2026.

The PPC chose to invite OMA constituencies to submit additional fee proposals to join those already under consideration as part of the current fee setting process. In 2025, the committee received 362 new submissions from 46 OMA Constituencies containing 1,181 schedule changes. This adds to the 651 proposed changes already under consideration of the PPC as part of the Year 3 (2021 PSA) proposal intake process. In total, there are now 1,832 changes currently under review by the committee (submissions may contain multiple fee changes).

The PPC continues to deliberate and the comments in this report are preliminary. This report is the third of four, as part of a cycle of feedback and engagement that culminates with the PPC's final recommendations. OMA constituency leaders are encouraged to provide feedback, corrections, and additional information that would aid with the PPC's continued deliberations into the fall.

Proposals supported by the committee in principle are all subject to the constraints of available allocation (fitting). These decisions will be made in continued consultation with constituency leaders.

The committee would like to thank OMA constituencies (sections, medical interest groups, and fora) for providing their submissions in a complete and timely manner. We would also thank the OMA and Ministry of Health staff who have provided essential support to the work of the committee.

OMA PPC members:

- Dan Reilly, MD, obstetrics & gynecology, OMA co-chair
- Marilyn Crabtree, MD, family practice
- Peter Lovrics, MD, general surgery
- Neshmi Zaman, MD, family practice
- Meherzad Kutky (observer), MD, nephrology

MOH PPC members:

- Michael Klar, MD, family practice, MOH co-chair
- Moira Browne, MD, family practice
- Lindsay Davidson, MD, orthopedic surgery
- Michael de la Roche, MD, emergency medicine

Introduction

The PPC is tasked with making fee-setting recommendations to the Physician Services Committee (PSC) on an annual basis, as directed in the 2021 Physician Services agreement (PSA). The committee will recommend how to implement compensation increases to the Schedule of Benefits for each section or physician grouping.

Both parties agreed to adjust the PPC's timelines to better accommodate the inclusion of both the 2021 PSA Year 3 (2023-2024), and 2024 PSA Year 1 (2024-25) permanent increases into the current ongoing process. The committee is obligated to make recommendations to the PSC regarding the April 1, 2026 permanent fee adjustments by October 2025.

The bilateral PPC began the 2021 PSA Year 3 fee allocation process in June 2023. The PPC invited OMA constituencies to make new fee submissions by November 1, 2023, and to review their deferred items from the Year 1 and 2 allocation process by indicating if they wished to pursue, drop or further defer the proposals (by October 1, 2023). With the updated timelines set in the Supplementary Year 3 and Year 1 Implementation agreement, permanent Schedule of Benefits changes for Year 1 (2024 PSA) and Year 3 (2021 PSA) will be implemented simultaneously with an effective date of April 1, 2026. These new timelines allowed constituencies to submit additional proposals to the PPC for consideration by February 3, 2025. This also provided for continued opportunities for feedback into 2025. Please note, the fee submission deadlines have now passed and the PFAF portal is closed.

To support this work, the PPC hosted four information sessions where section, MIG and forum executives could ask questions. Those who were unable to attend could access a recording. The sessions were held on:

1. Wednesday, June 21, 2023 (8 - 9PM)
2. Wednesday, July 12, 2023 (8 - 9PM)
3. Wednesday, September 27, 2023 (8 - 9PM)
4. Monday, December 16, 2024 (7- 8:30PM)

The OMA also held an education session, called "Tariff Lead Orientation and Training." This session provided an extensive overview of tariff related activities at the OMA, including a substantive section on PPC and the fee setting process. It was held on Saturday, November 9, 2024 (all day).

OMA Constituencies received an Orientation Package that included the following information:

1. Introduction to the fee allocation process
2. Guiding principles
3. Guidelines to submitting a proposal
4. Presentation guidelines
5. Tentative fee allocation process timelines
6. Guide to using the interactive costing table
7. Fee setting allocation process FAQ
8. FAQ on OMA constituency entitlements
9. Professional fee assessment form (PFAF)

All of this information is available on the PPC webpage (oma.org/ppc).

- PPC resource page

- Implementation agreement and arbitration process

PPC worked to keep constituency leaders and members updated through several channels:

- Regular updates on the PPC fee allocation process via OMA News.
- Monthly Physician Leader update calls (OMA only)
- OMA Live webinar (OMA only)
- Ad hoc meetings with physician leaders throughout 2024 and early 2025 (some OMA only, and some bilateral).
- Constituency presentations (bilateral):
    - Met with 43 constituencies in early 2024 (following intake #1)
    - Met again with 44 OMA constituencies in March/ April 2025 (following intake #2)

Summary of Submissions

From the two calls for proposals, the committee received a total of 1078 fee proposals (including requests to pursue deferred items) from 54 OMA constituencies (sections, MIGs, and fora); these 1078 proposals make for a total of 1,832 Schedule of Benefits changes that are under consideration by the PPC. After each proposal intake window, OMA constituency leaders received a complete list of all fee proposal submissions under consideration by the PPC. This list was also included in OMA News along with information on how to make a member group submission to the PPC.

If a member raised a proposal with their constituency, and the constituency did not submit the proposal to the PPC, the member could submit a proposal directly to the PPC. This opportunity was presented twice to members (in 2024 and 2025) Members had to follow the same submission guidelines as constituencies and had to demonstrate support from their colleagues (50 or more members or 20 per cent of members of a given constituency, whichever was less). In 2024, the PPC received a total of 11 member group submissions. Five proposals met the necessary submission criteria and are under consideration by the committee. In 2025, the PPC received nine member group submissions, with eight meeting the necessary criteria to be considered by the committee.

OMA Constituencies' submissions fall into five broad categories, as summarized in Figures 1 and 2.

Figure 1. Summary total submissions by category

Total OMA Constituencies	66
OMA Constituencies without Submissions	12
OMA Constituencies with Submissions	54
Delete fee code	72
New fee code	314
Revision	141
Value change	458
Value Change and Revision	93
TOTAL	**1078**

Figure 2. Summary total submissions by OMA constituency

OMA Constituency	Delete fee code	New fee code	Revision	Value change	Value Change and Revision	TOTAL
Academic Medicine Forum	0	0	0	0	0	0
Addiction Medicine	1	2	1	2	2	8
Allergy & Clinical Immunology	0	1	1	3	1	6
Anaesthesiology	0	2	2	2	0	6
Cannabinoid Medicine	0	4	0	20	0	24
Cardiac Surgery	1	11	6	4	1	23
Cardiology	0	10	0	10	1	21
Cardiology (Member Group)	0	1	0	0	0	1
CHC and AHAC	0	0	0	0	0	0
Chronic Pain	0	9	0	5	2	16
Clinic Endoscopists	0	0	0	0	0	0
Clinical Hypnosis	0	0	0	0	0	0
College and University Student Health	0	0	0	0	0	0
Complementary and Integrative Medicine	0	0	0	0	0	0
Critical Care Medicine	0	9	1	3	0	13
Dermatology	0	6	1	0	0	7
Diagnostic Imaging	0	11	1	35	1	48
Diagnostic Imaging (Member Group)	0	0	0	1	0	1
Emergency Medicine	0	15	6	48	0	69
Endocrinology & Metabolism	0	0	0	8	1	9
Endocrinology & Metabolism (Member Group)	0	0	1	0	0	1
Fee-for-Service Family Physician	0	6	0	19	0	25
Gastroenterology	1	6	2	8	6	23
Gastroenterology (Member Group)	0	2	2	0	1	5
General & Family Practice	0	6	3	50	2	61
General & Family Practice (Member Group)	0	3	0	1	0	75
General Surgery	2	16	3	7	12	40
General Surgery (Member Group)	0	1	0	0	1	2
General Thoracic Surgery	10	2	6	12	5	35
Genetics	4	1	0	3	0	8
Geriatric Medicine	0	0	1	3	1	5
Green is Health	0	0	0	0	0	0
Haematology & Medical Oncology	0	5	8	8	6	27
Haematology & Medical Oncology (Member Group)	0	0	0	0	0	0
Hospital Medicine	0	7	1	1	1	10
Hyperbaric Medicine	0	3	1	2	0	6
Infectious Diseases	0	3	0	9	0	12

Internal Medicine	0	3	3	5	1	12
Internal Medicine (Member Group)	0	0	0	0	0	0
Laboratory Medicine	18	5	7	6	0	36
Long Term Care & Care of the Elderly	0	2	3	4	0	9
Medical Students	0	0	0	0	0	0
Nephrology	0	3	1	9	0	13
Neurodevelopmental Disorders	0	1	1	0	0	2
Neurology	1	18	4	3	2	28
Neuroradiology	0	11	2	0	2	15
Neurosurgery	0	3	4	2	0	9
Nuclear Medicine	0	9	11	9	4	33
Obstetrics & Gynaecology	1	11	3	12	4	31
Occupational & Environmental Medicine	0	4	0	0	0	4
Ontario Psychiatric Hospitals	0	0	0	0	0	0
Ophthalmology	5	23	15	34	10	87
Orthopaedic Surgery	7	12	6	2	3	30
Otolaryngology	0	7	3	7	0	17
Paediatrics	2	9	4	5	1	21
Palliative Medicine	0	3	0	5	3	11
Physical Medicine & Rehab	0	0	0	0	0	0
Plastic Surgery	8	0	9	14	0	31
Primary Care Mental Health	0	0	2	13	0	15
Primary Care Solo Doctors	0	4	0	0	0	4
Psychedelic Medicine	0	0	0	0	0	0
Psychiatry	0	6	3	1	0	10
Public Health Physicians	0	0	0	6	0	6
Radiation Oncology	0	4	0	4	0	8
Reproductive Biology	0	2	1	0	0	3
Residents	0	0	0	0	0	0
Respiratory Diseases	0	1	3	0	0	4
Rheumatology	0	3	0	11	5	19
Rural Medicine Forum	0	0	0	3	0	3
Sleep Medicine	0	0	0	7	0	7
Sport and Exercise Medicine	0	3	0	2	0	5
Surgical Assistants	4	13	5	11	1	33
Urology	1	10	1	10	8	30
Vascular Surgery	6	2	3	9	5	25
TOTAL	**72**	**314**	**141**	**458**	**93**	**1078**

PPC Initiatives and Assignments from PSC/OWG

In addition to the constituency-driven proposals that make up much of this report, the PPC has also developed proposals internally. Many of the PPC's proposals involve several sections of the Schedule of Benefits and support simplification and modernization of the Schedule of Benefits. Details on these proposals can be found in the penultimate section of the report.

The PPC also received direction from the Physician Services Committee (PSC) and the Operations Working Group (OWG) to implement several Schedule of Benefits changes. These proposals can be found in the final section of the report.

Physician Payment Committee funding allocation process

In February 2024, the OMA and the Ministry of Health reached an implementation agreement on the amount of the Year 3 (2023-24) payments under the 2021-24 PSA and agreed to accelerate arbitration to determine increases for 2024-25 (Year 1 of the 2024-28 PSA). Both parties agreed to target the same date (April 1, 2026) for permanent implementation of both the Year 3 (2023-2024), and Year 1 (2024-25) increases. Additional details on the implementation agreement can be found on the OMA's website.

The final PPC recommendations of the PPC that are due in October 2025 must fit within the allocation assigned to each physician group in the PSA and the Board of Arbitration Award. Proposals will be costed in the coming months so that OMA constituencies can make informed recommendations related to the priority of their proposals.

The PPC will continue to engage with OMA constituencies as it works into the fall to finalize its recommendations. Constituencies have had opportunities to provide feedback, and there will be additional opportunities to provide feedback following the release of this, the third draft of the PPC's report. The most up-to-date information and committee timelines can be found on the OMA's PPC Webpage (oma.org/PPC).

Summary of PPC recommendations

This document contains all fee proposals under consideration by the PPC as part of the current fee setting process, as well as comments from the committee. This report is a follow up to the report published in September 2024. **For those proposals received in early 2025 (during the second submission window) the associated committee comments are new**. **Constituency leaders are invited to provide feedback on this draft report. No decisions in this report are final. PPC is tasked with delivering final recommendations to PSC in the fall of 2025.**

Scope of the Physician Payment Committee

As per the 2021 PSA, the mandate of the PPC will be to make recommendations on an annual basis to the PSC regarding:

i) addition, revision and deletion of fee codes in the Schedule of Benefits based on the allocation to each section of the normative fee increases, having regard to such factors as time, intensity, complexity, risk, technical skills and communication skills required to provide each service, as well as flow-through and any other financial changes to non-fee for service contracts and to other programs; and

ii) *"modernizing" the existing Schedule of Benefits on a revenue neutral basis, which may include addition, revision and deletion of Schedule language and/or fee codes, having regard to such factors as time, intensity, complexity, risk, technical skills and communication skills required to provide each service, as well as flow-through and any other financial changes to non-fee for service contracts and to other programs.*

In carrying out its mandate, the PPC will take such steps as are necessary to achieve gender pay equity, and to address medical innovation/technological advances. To that end, among other things, the parties agree that the work of the PPC will be aligned with the parties' bilateral work on the FAIR relativity model

The bilateral PPC is empowered only to recommend changes that fall within their scope of work, as agreed by the parties. As such, PPC must decline any proposals that fall outside of this mandate. Several proposals, though often well intentioned and articulated, simply cannot be addressed by the PPC. For example, the PPC may not make recommendations on the following topics:

- Claims adjudication issues
- Technical fees
- Terms within the Physician Services Agreement(s)
- Uninsured services and payments outside of the physician services budget

The PPC has also made a conscious effort to avoid making recommendations that would interfere with the work of other committees and working groups with their own clearly defined roles such as the Appropriateness Working Group, and APP working groups. Where possible, OMA staff will make efforts to redirect these types of proposals to the group that is most appropriate.

Deliberations

Deliberations for the current round of fee-setting commenced in November 2023 and are ongoing. The PPC has prepared preliminary responses to proposals that were brought forward as part of the combined year 3 & Year 1 fee setting process. Comments herein are current as of July 2025. Feedback may have been received by the committee since the committee's completion of this report draft – this feedback will be reviewed and considered in advance of the next report draft.

The committee has worked to evaluate each submission based on its merits in accordance with its Terms of Reference and Guiding principles. More information is available on the PPC's webpage (oma.org/ppc). Committee responses generally fell into one of the following categories:

- The committee supports the proposal in principle, subject to fitting, relativity and creation of appropriate Schedule language, definitions and/or payment rules.

- A decision has not yet been reached:
  - The committee is awaiting information from the constituency to aid in its deliberations.
  - More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.
  - If proposals vastly exceed allocation the committee may require additional information on constituency priorities to aid in deliberations.

- The proposal is not recommended to proceed:
  - This proposal falls outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.
  - The constituency declined to pursue this proposal as part of the current process.
  - The proposal may be revisited during a future fee setting process.
  - The constituency elected to withdraw this proposal.
  - The committee does not support this proposal
  - The committee has made a counterproposal to help address the issue(s) identified.
  - The proposal may not proceed as proposed, but fee codes may be modified in a manner that maintains relativity with other fee codes in the Schedule of Benefits.

There are a wide range of reasons that the committee may have chosen not to support a proposal, such as:

1. OMA constituencies' prioritization of fee proposals and decisions on how to stage implementation of fee proposals
2. Potential cost implications exceed available funding
3. Implications on fee relativity
4. Due to complexity of the proposal, additional information and study may be required to determine appropriate cost implications
5. Alternative solutions were raised during bilateral committee deliberations, requiring further study with OMA constituencies (for example, revision of existing codes rather than creation of new codes)
6. The proposal represents a large system-wide issue that involves multiple physician sections and potentially a significant re-rewriting of the Schedule of Benefits.
7. The Committee lacks evidence of the additional physician time and intensity associated with the provision of the proposed service.
8. This service or topics related to this proposal are under review at other tables (e.g., the Appropriateness Working Group, Hospitalist APP Working Group)
9. Changes to virtual care are relatively recent, and the PPC is not considering further changes at this time. We expect to have better data to support more informed discussion on virtual care changes as time progresses.
10. Following the introduction of a new fee code or a major fee code revision / value change, additional time may be required to allow for new data on utilization, prior to further modifications being made. This helps to ensure accurate costing of proposals.

Despite OMA constituency submissions and advocacy, the bilateral PPC must consider the broader system needs in its deliberations. Some proposals may not be recommended to proceed or may be amended to reflect the principles guiding the PPC, such as relativity, gender pay equity and Schedule modernization.

Schedule fee code changes often affect multiple sections. This means that:

- Section proposals and PPC decisions must consider various stakeholders and available allocations.

- Some PPC approved Schedule changes may require a portion of a section's allocation when members within that section provide those services even if they were not a stated priority of that section. This is a common scenario for fee code adjustments from the family practice and practice in general section of the Schedule, which can be claimed across the profession. It is important to remember that in all cases where a fee code has a cost impact to a section, it also contributed to increasing the size of the allocation for that section.
- Relativity with other fee codes may need to be considered when adjusting fee values.

The committee recognizes the significant time and effort OMA constituencies put into canvassing constituency groups, developing and refining proposals from the PPC. The PPC will also be reviewing their processes to look at opportunities for improvement for future allocations. The committee hopes to consider Schedule changes on a more regular and iterative basis going forward.

Major Initiatives

As part of the second proposal intake process (2025), the PPC introduced a brainstorming (a.k.a., "big ideas") form which allowed constituency leaders to put forward major initiatives with broad schedule implications; proposals may include hard-to-cost or transformational changes that may not be feasible in the short-term. The PPC received 13 of these proposals (identified as "MI-25-0##" in the report). Deliberations on these proposals are ongoing. Work on long term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

Committee meetings and constituency leader engagement

Committee members balanced busy clinical schedules and made personal sacrifices to meet the demands of the Year 3 & Year 1 fee-setting process.

OMA constituencies were invited to present to the PPC on their submissions in both 2024 and 2025. The PPC has also invited questions and feedback throughout the process and has worked to make itself available to constituency leaders. The process of refining recommendations will be iterative, and constituencies will have further opportunity to provide feedback before the PPC's final recommendations.

The PPC relied on the subject matter expertise of section, medical interest group and forum leaders to inform its work throughout the fee-setting process. The committee also engaged with OMA constituency leaders at multiple junctures to better understand proposals, constituency group priorities, and to address any concerns raised.

At several stages throughout the process, constituency leaders were invited to provide written feedback to the committee and in many cases were asked specific questions to help the committee in its deliberations. PPC and OMA staff received a significant volume of queries, helpful commentary and responses to the targeted questions mentioned above.

1 Addiction Medicine

1.1 Opioid Agonist Maintenance Program (OAMP) monthly management fee – intensive and maintenance (K682 and K683) (PFAF 23-045)

Constituency Proposal

- The constituency requested:
    i. Delete K682 OAMP– intensive, and
    ii. Revise K683 OAMP - maintenance and re-invest funding from K682 deletion into fee increase from $38.00 to $TBD.

Committee Comments

- The committee believes the workload involved in caring for an addiction patient in the intensive phase of treatment is greater and therefore should be compensated differently than the maintenance phase of care.
- The committee does not support this proposal.

1.2 Kxxx – Non-Opiate Agonist Addiction Maintenance Program monthly management fee - per month (PFAF 23-045)

Constituency Proposal

- The constituency requested a new fee code Kxxx Monthly management of a patient in an Addiction Maintenance Program (AMP) with a proposed free of $38.00 per month for non-Opiate Agonist Addiction Maintenance Programs.
- Definition/Required elements of service:

    Monthly management of a patient in an Addiction Maintenance Program (AMP) is the one-month management and supervision of a patient receiving addiction treatment (excluding opioid agonist treatment) by the physician most responsible for the management and supervision of that patient when rendered in accordance with the definitions and payment rules described below. The monthly management of a patient in an AMP is only eligible for payment to a physician who is qualified for the treatment of addictions in accordance with the standards and requirements of the College of Physicians and Surgeons of Ontario (CPSO).

- This service includes the following specific elements:
    a) All medication reviews, adjusting the dose of the addiction therapy, and where appropriate, prescribing additional therapy, and discussions with pharmacists;
    b) With the exception of all physician-to-physician telephone consultation services, discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), in person, by telephone, fax or e-mail on matters related to the service, regardless of identity of person initiating discussion; and
    c) All discussions in respect of the patient's addictive substance dependency, except where the discussion is payable as a separate service.
- Definitions:
    a. Required services are:
        I. a consultation, assessment or visit from the Consultation and Visits section of this Schedule; or

II. a K-prefix time-based service excluding group services and case conferences.

b. AMP - intensive, is the service for management of an AMP patient receiving an addiction treatment where the physician renders at least two (2) required services in the month.
c. AMP - maintenance, is the service for management of an AMP patient receiving an addiction treatment where the physician renders one required service in the month.
d. For the purposes of Kxxx the required services may be rendered by direct patient encounter or telemedicine.

(Commentary: Telemedicine services are considered eligible as required services. See CPSO Standards and Guidelines for Methadone Maintenance Treatment related to telemedicine.)

e. A service primarily for the purpose of providing a prescription does not constitute a required service and does not count towards the minimum requirements of Kxxx.

- Payment rules:
    1. Kxxx is only eligible for payment to the physician most responsible for the patient's AMP for the applicable month.
    2. A maximum of one of K682, K683, or Kxxx is eligible for payment per patient per month any physician.
    3. In circumstances where the administration of an addiction treatment is delegated to another qualified health professional, Kxxx is only eligible for payment if the physician can demonstrate that he/she is in accordance with the standards and requirements of the CPSO for providing addiction treatment.
- Claims submission instructions: Claims for Kxxx is payable only after the minimum requirements have been rendered for the month.

Committee Comments

- It is unclear to the committee what work this code would be remunerating which is not part of existing consultations and assessments both in person and virtual.
- The committee does not support this proposal.

1.3 A680 - Initial assessment – substance abuse (PFAF 25-117)

Constituency Proposal

- The constituency proposed a revision to the payment rules associated with A680 Initial assessment for substance abuse.
- Specifically, the constituency requested the deletion of the following payment rules on A57:

~~1.If A680 is not pre-booked at least one day before the service is rendered, the service is not eligible for payment.~~
~~2.A680 is limited to one per patient per physician except in circumstances where a 12 month period has elapsed since the most recent insured service rendered to the patient by the same physician.~~
~~3.A680 is limited to a maximum of two per patient per 12 month period.~~

~~(strikethrough~~ deletion)

Committee Comments

- The committee supports deletion of payment rule 1, above.
- The committee does not support deletion of payment rule 2, as evidence that this needs to be provided more frequently by the same physician has not been provided.
- The committee does not support deletion of payment rule 3, as the committee believes the payment rule supports best practice.
- The committee notes that payment rule 5 is no longer relevant and should be deleted.

1.4 K682 - Opioid Agonist Maintenance Program monthly management fee-intensive, per month (PFAF 25-119, 25-120)

Constituency Proposal

- The constituency has proposed revisions to the payment rules on J68
- Specifically, Payment rule 3 on page A60 is requested to be deleted:
  3.~~K682 is limited to a maximum of six services per patient per 12 month period.~~
  (~~strikethrough~~ deletion)
- The constituency proposed a fee value change to K682. See PFAF 25-123 for further details.

Committee Comments

- The committee was not provided with evidence that the intensive phase of management exceeds six months.
- The committee does not support this proposal.

1.5 Gxxx - Monthly maintenance code for Substance Use Pharmacotherapy (PFAF 25-121)

Constituency Proposal

- The constituency proposed the creation of a new Monthly maintenance code for Substance Use Pharmacotherapy valued at $38.00.
- The proposed payment rules are similar to K683 for OAMP but would be applicable to Pharmacotherapy for other Substance Use Disorders.

Committee Comments

- The committee notes that no evidence has been provided supporting that the work associated with the proposed code is equivalent to opioid agonist therapy.
- The committee does not support this proposal.

1.6 K682, K683, K684 – Fee value changes to Opioid Agonist Maintenance Program codes (PFAF 25-122, 25-123)

Constituency Proposal

- The constituency proposed directing current UDS allocation funds toward the following fee codes to double their value:
  - K682 Opioid Agonist Maintenance Program monthly management fee - intensive, per month
  - K683, Opioid Agonist Maintenance Program monthly management fee - maintenance, per month
  - K684 Opioid Agonist Maintenance Program - team premium, per month

- The constituency proposal requested these fees increase so that physicians receive $100 per OAT patient per month, constituency stated physicians currently receive $45-$50 per OAT patient per month.
- The constituency noted that the proposal will support PPC goals of gender pay equity.

Committee Comments

- The committee supports a value change, subject to fitting and prioritization.

2 Allergy and Clinical Immunology

2.1 A625 - Consultation (PFAF 23-177)

Constituency Proposal

- The constituency requested a fee increase to A625 from $159.00 to $181.00, by 13.8 per cent.

Committee Comments

- The committee supports the proposed change, subject to fitting and relativity.

2.2 A623 - Medical specific assessment (PFAF 23-179)

Constituency Proposal

- The constituency requested a fee increase to A623 from $80.90 to $89.00, by 10 per cent.

Committee Comments

The committee supports the proposed change, subject to fitting and relativity.

2.3 G197 - Skin testing - professional component (PFAF 23-184)

Constituency Proposal

- The constituency requested a fee increase to G197 from $0.37 to $0.57, by 54.1 per cent.

Committee Comments

- The committee supports a change to the value of G197, consistent with the increase in value of other codes billed by the section.
- That amount will be determined according to fitting and relativity.

2.4 G208 - Provocation testing (PFAF 23-185)

Constituency Proposal

- The constituency requested a fee increase to G208 from $21.25 to $30.00, by 41.2 per cent.
- The constituency also proposed removing the limitation of 5 testing sessions per 12-month period.
- The constituency notes that if changes proposed to G190 proceed, that this proposed rule change would not be unnecessary.

Committee Comments

- The committee supports a change to the value of G208, consistent with the increase in value of other codes billed by the section.
- That amount will be determined according to fitting and relativity.
- The committee does not support the proposed rule change as no evidence was provided to justify the change.

2.5 Exxx - Allergy procedure stabilization premium (PFAF 23-187)

Constituency Proposal

- The constituency requested a new premium for allergy procedure stabilization at 10%.
- The premium would only be applicable to allergy procedures provided in the community, outside of hospitals to cover the cost of higher overhead in the community.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

2.6 G190 - Serial oral or parenteral provocation testing to a food, drug or other substance when the service is rendered in a hospital (PFAF 21-D03)

Constituency Proposal

- The constituency requested a revision to G190 to allow out of hospital claims for the following allergens: peanuts, tree nuts, milk, and eggs.

Committee Comments

- The committee notes that G190 requires direct and ongoing physician attendance to the patient undergoing the testing to the exclusion of other patient care. After consultation with the section, the committee believes this requirement would not be met in an office setting.
- The committee does not support this proposal.

2.7 Major Initiative – Complexity Modifier (MI 25-011)

Constituency Proposal

- The section requested the creation of a complexity modifier for patients on advanced therapies, like biologics, targeted immunomodulators, and gene therapies.
- The section noted that this proposal works to ensure fair compensation that reflects the extra time, resources, and expertise involved in these cases.
- Section noted support in their proposal from: Pediatrics, Psychiatry, Rheumatology, Respirology and Genetics.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

3 Anesthesiology

3.1 A/Cxxx - Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service) (PFAF 21-D04)

Constituency Proposal

- The constituency proposed modernization of acute pain services by
  I. Creating a new fee code Axxx/Cxxx Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service), valued at $47.50
  II. Deletion of A/C215 - Limited consultation for acute pain management in association with special visit to hospital in-patient.

Committee Comments

- As part of the last fee allocation process, G222 was deleted and the savings generated were reinvested towards increasing A/C215 limited consultation for acute pain management, A/C015 consultation and A/C013 specific assessment.
- It is unclear to the PPC how this service differs from the current consult and assessment which can be billed when managing acute pain.
- The committee does not support this proposal.

3.2 Exxx - Anesthesia units greater than 99 add-on (PFAF 23-099)

Constituency Proposal

- OHIP anaesthesia claim submissions are limited to 2 digits. The new Exxx add-on code would be billed where 100 or more anaesthesia units are claimed, same patient, same physician, same day, same service.
- This would eliminate the administrative burden of having to manual submit these claims, reduce delays in payment and rejection of claims.

Committee Comments

- Issues related to claims submission and adjudication fall outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.
- The proposal is not recommended to proceed.

3.3 E084 - MRP premium - Saturday, Sunday or Holiday (PFAF 23-100)

Constituency Proposal

- The constituency requested that E084 be revised to allow anaesthesiologist to bill.

Committee Comments

- Analysis has demonstrated that this change would provide limited benefit to members.
- The committee does not support this proposal.

3.4 Anaesthesiologist Unit fee (PFAF 23-101)

Constituency Proposal

- The constituency requested an increase to the anaesthesiologist unit fee depending on available funding.

Committee Comments

- The committee supports an increase in the Anaesthesia unit fee, subject to fitting.

3.5 Z438A - Insertion of Swan-Ganz catheter (PFAF 23-102)

Constituency Proposal

- The constituency requested a revision to Z438A payment rules, such that it is included in the anaesthetic basic units and not eligible for payment.

Committee Comments

- The committee notes that this service is only provided 50% of the time by Anaesthesia.
- The committee does not support this proposal.

3.6 Anaesthesia basic unit relativity adjustment (PFAF 23-103)

Constituency Proposal

- The constituency requested to add one extra basic unit to those cases with 6 or more basic units whose average hourly rates are among the lowest.
- The constituency proposes working with the PPC to choose a reasonable hourly rate threshold for these increases which will be subject to available funding, including new funds and funds that may be shifted as a result of the Z438A revision.

Committee Comments

- The committee continues to deliberate and awaits further feedback from the constituency regarding the best approach to addressing the problem identified.

4 Cannabinoid Medicine MIG

4.1 General & Family Practice time-based “K” prefix fee codes relativity adjustment (various, excluding K023) (PFAF 23-030)

Constituency Proposal

- The constituency requested a 7% across the board fee increases to various GP/FP time-based K-codes, except K023 Palliative care support.
- The Fee-for-Service Family Physician (MIG) made the same request. See Fee-for-Service Family Physician (MIG) for more information.

Committee Comments

- The Fee-for-Service Family Physician (MIG) made the same request. Please see PFAF 23-049 in the Fee-for-Service Family Physician (MIG) section for more information.

4.2 Kxxx - Monthly Management Fee for Focused Practice Family Doctors (exception of Addiction Medicine) (PFAF 23-032)

Constituency Proposal

- The constituency requested a new monthly management fee for focused practice family doctors for monthly management of complex patients. The new fee would be modelled after the Opioid Agonist Maintenance Program (OAMP) monthly management fees – intensive and maintenance (K682 and K683):
  i. Same rules as K682 and K683
  ii. Same fee value as K682 ($45) and K683 ($38)

Committee Comments

- The Fee-for-Service Family Physician (MIG) made the same request. Please see PFAF 23-050 in the Fee-for-Service Family Physician (MIG) section for more information.

4.3 Community-based infrastructure premium-for office-based practices (out of hospital) and in-basket (PFAF 23-033)

MIG Proposal

- The constituency requested a new Community-based infrastructure premium for office-based practices (out of hospital) and in-basket paid at 20% for family doctors who work in a community (non-hospital-based practice); this is to reflect higher overhead costs in the community.

Committee Comments

- The Fee-for-Service Family Physician (MIG) made the same request. Please see PFAF 23-047 in the Fee-for-Service Family Physician (MIG) section for more information.

4.4 Exxx - Unattached patient premium (PFAF 23-034)

Constituency Proposal

- The constituency requested a new 15 per cent premium for family doctors who care for an unattached patient who does not have a primary care physician.

Committee Comments

- This proposal was also submitted by the Fee-for-service Family Physician MIG. Please see Fee-for-Service Family Physician (MIG) for more information.

4.5 Increases to Commonly Billed Fee Codes, including Assessment and Consultation Codes (PFAF 25-267)

Constituency Proposal

- The constituency requested an increase to commonly billed fee codes, in general terms. This includes a request to increase the A007 – intermediate assessment.

Committee Comments

- Please see PFAF 23-023 in Section on General and Family Practice for more details.

5 Cardiac Surgery

5.1 E682 - Pump bypass - graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device, to E650 add (PFAF 23-128)

Constituency Proposal

- The constituency proposed a revision to E682 as follows:

  - graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device, to E650, R701, R702, R703, R704, R743...add

  (Revisions underlined)

Committee Comments

- The committee supports the proposal, subject to fitting and relativity, and notes would apply to Z743, R701, R702, R703, and R704.
- The committee notes that the constituency clarified R743 was a typo in their proposal and meant Z743.

5.2 E651 - Excision - when done in conjunction with coronary artery repair, add (PFAF 23-129)

Constituency Proposal

- The constituency proposed a revision to E651 where there is no limit for the code and the medical consultant is removed from the note for this code.

Committee Comments

- The PFAF references to no limit for the code, is not a schedule matter and is therefore out of scope for the PPC.
- The committee notes that the note under E651 is not what determines whether or not a case is reviewed by a medical advisor, it was inserted here in order to remind providers of their option to request a review of a complex case. Given the section feels this advice is not necessary, then the committee supports removal of the note.

5.3 E646 - Coronary artery repair – vein patch angioplasty of coronary artery, add (PFAF 23-130)

Constituency Proposal

- The constituency proposed a revision to E646 where there is no limit per case.

Committee Comments

- The PFAF does not address a Schedule change and, as such, this proposal falls outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.

5.4 E654 - Coronary artery repair – each additional, add (PFAF 23-132)

Constituency Proposal

- The constituency proposed that note #3 be deleted for E654:

  ~~"3. Where a single segment of vein is used for more than 2 anastomoses, the second and subsequent anastomoses are to be claimed at 50% of the E654 fee."~~

  (deletions ~~strikethrough~~)

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

5.5 Zxxx - Removal of temporary epicardial wires (PFAF 23-300)

Constituency Proposal

- The constituency proposed a new fee for removal of temporary epicardial wires, valued at $25.00.
- The constituency requested that this be one fee code regardless of the number of wires removed.

Committee Comments

- In general, the removal of drains, wires, and other devices placed at time of surgery are considered a component of the initial surgical procedure. The chest tube removal code was designed to compensate physicians for removing chest tubes they had not placed.
- The committee does not support this proposal.

5.6 R741 - Coronary artery endarterectomy and/or gas endarterectomy (PFAF 23-301)

Constituency Proposal

- The constituency proposed the deletion of R741, valued at $730.70.
- The constituency noted that the procedure may not have been done in years.

Committee Comments

- The constituency withdrew this proposal.

5.7 Jxxx - Direct epiaortic ultrasound of ascending aorta (PFAF 21-D117)

Constituency Proposal

- The Constituency proposed a new fee for direct epiaortic ultrasound of ascending aorta, valued at $100.00.

Committee Comments

- The committee lacks evidence of the additional physician time and intensity beyond the surgical procedure for which the ultrasound is obtained.
- The committee does not support this proposal.

5.8 Jxxx - Coronary doppler/transit flow time measurement (PFAF 21-D118)

Constituency Proposal

- The Constituency proposed a new fee for coronary doppler/transit flow time measurement, valued at $100.00.

Committee Comments

- The committee lacks evidence of the additional physician time and intensity beyond the surgical procedure for which the ultrasound is obtained.
- The committee does not support this proposal.

5.9 Zxxx - Cell salvage/washing for intraoperative blood loss (PFAF 21-D119)

Constituency Proposal

- The Constituency proposed a new fee for cell salvage/washing for intraoperative blood loss, valued at $85.00.

Committee Comments

- The committee finds insufficient evidence to support the creation of a unique code in terms of the time, intensity, and work effort associated with the service.
- The committee does not support this proposal.

5.10 Exxx - Minimally invasive approach (PFAF 21-D120)

Constituency Proposal

- The Constituency proposed two new fees for minimally invasive and off pump approaches, each valued at $500.00.

Committee Comments

- There was insufficient evidence provided by the section justifying additional time for the procedures which would warrant creating new codes.
- The committee does not support this proposal.

5.11 Axxx - Cardiac surgical consultation for regional service (PFAF 21-D121)

Constituency Proposal

- The Constituency proposed a new fee for cardiac surgical consultations for regional service, valued at $90.30.

Committee Comments

- The Schedule of Benefits already has provisions for provider-to-provider consultations, CritiCall, and rules regarding billing when transfer of care occurs. This proposal would significantly alter those provisions and rules. It would therefore apply to many other specialties and require extensive consultation with other constituencies.
- The committee does not support this proposal.

5.12 G083 - Continuous venovenous haemodialysis – initial and acute (for the first 3 services) (PFAF 21-D122)

Constituency Proposal

- The Constituency proposed a revision to the payment rules for G083 to allow it to be billed during cardiopulmonary bypass.

Committee Comments

- The committee lacks sufficient evidence with respect to the added time and intensity associated with the provision of this service which would warrant the creation of a unique code for its provision during cardiac surgery.
- The committee does not support this proposal.

5.13 Rxxx – Surgical aortic valve replacement (PFAF 25-156)

Constituency Proposal

- The section proposed the creation of a new fee code for surgical aortic valve replacement as sole procedure.
- This service is performed in the setting of an open surgical aortic valve replacement and would not be applied to TAVI.

Committee Comments

- The committee sees a need to create separate codes for open cardiac valve procedures and percutaneous valve procedures.
- The committee will reach out to Cardiac Surgery and Cardiology with proposed new codes and Schedule language.

5.14 Exxx – MRP premium for hospital transfer admission (PFAF 25-157)

Constituency Proposal

- The constituency requested the creation of a new premium valued at 30% as an alternative to E082.

- The premium would be applicable for hospital to regional hospital transfer by the MRP at the receiving hospital.
- E082 is often rejected as E083 is billed by the MRP at source institution.

Committee Comments

- The committee is unclear why E082 is rejected when a patient is transferred to a different hospital corporation. The committee is exploring this and will reach out to the section as necessary.

5.15 Exxx – MRP Premium for ICU transfer (PFAF 25-158)

Constituency Proposal

- The constituency requested a premium valued at 30% for patients transferred from ICU to ward.
- E083 is frequently rejected in the circumstances described; an MRP premium should be payable.

Committee Comments

- The committee notes that the C142 fee code already pays a premium compared to other in-patient subsequent visit codes.
- The committee notes that physicians within a facility can determine amongst themselves the most appropriate physician to bill E083 that day given the division of work.
- The committee does not support the proposal.

5.16 Cxxx- ICU call-back fee code (PFAF 25-159)

Constituency Proposal

- The constituency requested the creation of an ICU call-back code for subsequent call backs into the ICU, modelled after C101.
- The section proposed a fee value of $10.30 for each subsequent call-back.

Committee Comments

- The committee believes the issue the section is trying to fix is not related to Schedule language and is therefore out of scope.
- The committee does not support this proposal.

5.17 Exxx – Surgical Endocarditis premium (PFAF 25-160)

Constituency Proposal

- The constituency proposed a new premium for surgical management of endocarditis, replacement or repair, repair of cardiac defects, debridement etc. This is meant to compensate for the complexity and time of surgical preoperative, intraoperative and postoperative care associated with this diagnosis.
- The proposed premium is valued at 50% and would be applicable to associated assessments, procedures and surgeries.

Committee Comments

- The committee does not support creating an E-code for consults and assessments.

- The committee supports the creation of an E-code for the surgical procedures and continues to deliberate on the value of the code. The committee will reach out to the constituency as required.

5.18 Z744, Z788, Z781 – Fee value changes to Decannulation/Cannulation Fee Codes (PFAF 25-161)

Constituency Proposal

- The constituency requested that the value of Z744, Z788, Z781 remain consistent with any other codes created to compensate for ECMO.
- The section noted that this proposal is related to intersectional relativity.
- The constituency noted that this PFAF was prompted by PFAF 23-113 from Thoracic Surgery.
- The section requested Z788 and E650 be increased to approximately $400.00.

Committee Comments

- The committee will keep this proposal in mind, should it decide to create any other codes to compensate for ECMO.
- The committee supports the proposed fee value changes to Z788 and E650, subject to fitting and relativity.

5.19 E671 Sternotomy - following previous sternotomy (PFAF 25-248)

Constituency Proposal

- The constituency noted that each repeat sternotomy is more complex than previous.
- For second and third repeat sternotomies, the section proposed a premium of 100% of the surgical fee value be applied to these procedures.

Committee Comments

- As analysis has demonstrated that the impact of this change would provide limited benefit to members, the committee does not support this proposal.

6 Cardiology

6.1 Exxx - Professional Practice Expense Recovery Fee for Out-of-Hospital Ambulatory Care (PFAF 23-299)

Constituency Proposal

- The constituency requested a new an add-on fee to consultations and assessments provided in an out-of-hospital ambulatory care setting (Fee value TBD); this is to reflect higher overhead costs in the community.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the

scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

6.2 Fee Relativity Submissions - Consultations and Assessments - Fee Value changes (PFAF 25-285, 25-286)

Constituency Proposal

- The constituency proposed increases to the following fee codes:

Fee Code	Descriptor	Current Value	Proposed New Value	Increase (%)
A605/C605	Consultation	$161.65	$181.85	12%
A603/CA603	Medical specific assessment	$81.55	$93.80	15%
A601/C601	Complex medical specific re-assessment	$70.90	$81.55	15%
A604/C604	Medical specific re-assessment	$61.25	$70.45	15%
A608	Partial assessment	$38.05	$47.55	25%
C608	Concurrent care, per visit	$34.10	$42.65	25%
C602	Subsequent visits – first five weeks, per visit	$34.50	$51.15	48%

Committee Comments

- The committee supports an increase in the value of these codes, subject to fitting and relativity.
- The committee notes that C608 and C602 will need to remain the same as inpatient visits for other medical specialties.

6.3 G581 - Transesophageal echocardiography (PFAF 25-288)

Constituency Proposal

- The constituency proposed an increase to G581 - Transesophageal echocardiography from $25.00 to $50.00 (100% increase).

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

6.4 G301 - Exercise studies during catheterization (PFAF 25-289)

Constituency Proposal

- The constituency proposed a fee value change for G301 - Exercise studies during catheterization from $122.40 to $600.00 (390%).

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

6.5 Gxxx - Transesophageal or intracardiac echocardiography for monitoring or guiding a procedure in the catheterization laboratory (PFAF 25-293)

Constituency Proposal

- The constituency proposed the creation of a new fee code for Transesophageal or intracardiac echocardiography for monitoring or guiding a procedure in the catheterization laboratory.
- This imaging requires the presence of dedicated imaging cardiologist (structural echocardiographer), separate from the interventional cardiologist performing the intervention, to obtain the necessary transoesophageal or intracardiac echocardiographic imaging.
- The proposed value is $425 for the first 60 minutes, then $150 for every additional 30 minutes

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

6.6 Gxxx - Complex PCI Procedures that exceed 90 minutes (PFAF 25-298)

Constituency Proposal

- The constituency noted that Complex PCI cases take considerably more time and incur several-fold increase in risk of morbidity and mortality due to a combination of technical, anatomical and procedural challenges.
- The constituency proposed a new fee code for PCI procedures exceeding 90 minutes.
- The proposed value is $400/Hour starting at 90 minutes from start of case to be paid in 15-min intervals.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

6.7 Exxx - Chronic Total Occlusion (CTO) PCI Premiums (PFAF 25-302)

Constituency Proposal

- The constituency requested a suite of new fee codes for Chronic Total Occlusion (CTO) PCI. Four premiums are proposed:

> *Code EXX1: Dual Access CTO Procedure: Premium Code to be billed for patients undergoing dedicated CTO Procedure which involved visualization of the culprit artery from antegrade and retrograde perspective -defined as achieving dual arterial access for the purpose of CTO PCI – biradial, radial-femoral, or bifemoral access*
>
> *Code EXX2: Retrograde PCI Premium: Retrograde CTO defined as wire and/or microcatheter attempt to cross a retrograde coronary collateral (any collateral including septal, epicardial or bypass graft collaterals) - cannot be billed unless dual access has been achieved for purpose of CTO PCI*
>
> *Code EXX3: Antegrade Dissection/Re-entry (ADR) Premium: ADR defined as entry into the subintimal space of the arterial wall and exit with a wire or specialized re-entry device (e.g. stingray, Recross, TwinPass, Sasuke, Triumph or other dual lumen catheter - cannot be billed unless dual access has been achieved for purpose of*

CTO PCI

Code EXX4: Intravascular Imaging Premium: Defined as use of intravascular imagine (Intravascular ultrasound (IVUS) or optical coherence Tomography (OCT) use during CTO PCI procedure - cannot be billed unless dual access has been achieved for purpose of CTO PCI.

- The following fee values are proposed:

Fee code	***Descriptor***	***Proposed fee value***
EXX1	*Dual Access CTO procedure*	*$500.00*
EXX2	*Retrograde PC*	*$500.00*
EXX3	*Dissection re-entry PCI*	*$250.00*
EXX4	*Utilization of intravascular Imaging during CTO PCI*	*$150.00*

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

6.8 Exx1, Exx1 - Mechanical Circulatory Support (MCS) Guided Complex PCI (PFAF 25-312)

Constituency Proposal

- The constituency proposed the creation of two new premiums for Mechanical Circulatory Support (MCS) devices during complex PCI procedures to maintain hemodynamic stability:
  - Exx1- Impella/Tandem Heart Case premium (over and above Impella/Tandem Heart Implant fee – R701), valued at $750.
  - Exx2- IABP Assisted Case Premium (over and above IABP implant code – Z780), valued at $250.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

6.9 Gxxx - Intracardiac echocardiography for electrophysiological procedural guidance. (PFAF 25-331)

Constituency Proposal

- The constituency proposed the creation of a new fee code for Intracardiac echocardiography for electrophysiological procedural guidance.
- The proposed fee value for this service is $150. The constituency notes however that for predominantly single operator procedure, the actual reimbursement will be at 50% as a secondary code ($75).

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

7 Cardiology (Member Group)

7.1 Exxx – Intravascular imaging premium (PFAF 25-347)

Constituency Proposal

- The member group proposed an imaging guidance premium added to PCI procedures completed with intravascular imaging.
- The premium proposed is valued at 35% and would apply to: Z434, G262, and G298.
- The member group notes that the premium is to compensate for increased procedural time required to perform these services.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

8 Chronic Pain

8.1 G384 - Infiltration of tissues for trigger point (PFAF 23-105)

8.2 G385 - For each additional site (to a maximum of 2) (PFAF 23-105)

Constituency Proposal

- The constituency requested the following fee increases:
  i. G384 Infiltration of tissues for trigger point, from $8.85 to $30.00, by 239.0 per cent
  ii. G385 For each additional site (to a maximum of 2), from $4.55 to $15.00, by 229.7 per cent.

Committee Comments

- The committee notes the constituency replaced this proposal with PFAF 25-241.

8.3 Exxx - when performed outside hospital, add to all nerve blocks and interventional pain injections (PFAF 25-030)

Constituency Proposal

- The constituency requested the creation of a tray fee for all nerve blocks peripheral/other injections and interventional pain injections.
- The proposed tray would include syringe, assortment of needles, antiseptic, sterile drape and local anesthetic and is limited to one per visit.
- The tray fee is proposed at a value of $11.55.

Committee Comments

- Topics related to this proposal overlap significantly with other injection fee codes which are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

8.4 Exxx - Platelet rich plasma (PRP) injections for osteoarthritis of knees (PFAF 25-038)

Constituency Proposal

- The constituency requested a new fee code for platelet rich plasma (PRP) injections for osteoarthritis of knees.
- The proposed service is limited to two treatments per year and is valued at $50.00.

Committee Comments

- The committee was not provided with evidence that this treatment is standard of care.
- The committee does not support this proposal.

8.5 Zxxx, Exxx - Botox injection fee for chronic migraines (PFAF 25-039)

Constituency Proposal

- The constituency requested a set of fee codes for botox injection from chronic migraine.
- Zxxx is proposed at a value of $40 for first injection
- Exxx is proposed at a value of $10 for each additional injection.
- The service would be eligible for the tray fee described in PFAF 25-030.

Committee Comments

- The committee continues to deliberate on this proposal and will reach out to the constituency as required.
- The committee notes that further consultation with the Neurology Section is required to aid in the committee's deliberations.

8.6 Multiple Fee Codes – Increase to Nerve Blocks and Pain Injections (PFAF 25-040)

Constituency Proposal

- The constituency proposed a broad 5% increase to all procedures in the nerve blocks for acute pain management, nerve blocks – interventional pain injections, and nerve blocks – peripheral/other injections sections (pages J71-J83 in OHIP Schedule of Benefits).

Committee Comments

- Topics related to this proposal overlap significantly with other injection fee codes which are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

8.7 Zxxx, Exxx - Prolotherapy injections into ligaments, joints and tendons in patients with chronic pain (PFAF 25-041)

Constituency Proposal

- The constituency proposed the creation of new fee codes for prolotherapy injections into ligaments, joints and tendons in patients with chronic pain, as follows:
    - Zxxx is proposed at a value of $30 for first injection

    - Exxx is proposed at a value of $20 for each subsequent injection.
- The service would be eligible for the tray fee described in PFAF 25-030.

Committee Comments

- Topics related to this proposal overlap significantly with other injection fee codes which are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

8.8 Zxx1, Zxx2 - erector spinae block for trunk pain – unilateral & bilateral (PFAF 25-042)

Constituency Proposal

- The constituency proposed new fee codes for erector spinae block for trunk pain.
- Zxx1- unilateral has a proposed fee value of $54.65.
- Zxx2 – bilateral has a proposed fee value of $81.95.

Committee Comments

- Topics related to this proposal overlap significantly with other injection fee codes which are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

8.9 G914, G915 Nerve Blocks - Interventional Pain Injections - Percutaneous diagnostic lumbar facet medial branch block with ultrasound guidance (PFAF 25-148)

Constituency Proposal

- The constituency proposed to adjust G914 and G915 description to include Cervical facet.
- Section proposed to remove payment rule #1 on page J76 in the OHIP Schedule of Benefits:

  ~~G914 is only eligible for payment when a fluoroscopically guided facet injection has been rendered for the same site(s) within the previous 12 month period by the same physician.~~ (deletions ~~strikethrough~~)

- The section proposed increasing the value of G914 to from $56.00 to $80.00 (43% increase), and G915 from $14.00 to $20.00 (43%).

Committee Comments

- Topics related to this proposal overlap significantly with other injection fee codes which are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

8.10 G384, G385 Injections or Infusions - Infiltration of tissues for trigger point (PFAF 25-241)

Constituency Proposal

- The constituency requested a fee value change for the following services:

- G384 - Injections or Infusions - Infiltration of tissues for trigger point from $8.85 to $30.00 (239% increase).
- G385 - Injections or Infusions - Infiltration of tissues for trigger point - for each additional site (to a maximum of 2), add. From $4.55 to $15.00 (230% increase).

Committee Comments

- Topics related to this proposal overlap significantly with other injection fee codes which are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

8.11 Gxxx Technical fee for OHP interventional procedures (PFAF 25-245)

Constituency Proposal

- The constituency requested a technical fee for every patient who attends OHP and receives interventional procedure. The proposed fee is valued at $100.00.

Committee Comments

- The committee notes that technical fees are outside of the PPC's mandate.
- Therefore, the committee does not support this proposal.

9 Critical Care Medicine

9.1 Critical Care Per Diem Menu of Fees (PFAF 23-247, 23-248)

Constituency Proposal

- The constituency requested a new critical care per diem fee listing 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 (OHIP Specialty "11") as follows:

Fee Code	New FC	Descriptor	Current	Proposed
G400	Gxxx	Day 1 Critical care	$223.10	$381.90
G401	Gxxx	Days 2-30 Critical care	$146.45	$250.69
G402	Gxxx	Days >30 Critical care	$58.60	$100.31
G557	Gxxx	Day 1 Comprehensive	$374.35	$516.70
G558	Gxxx	Days 2-30 Comprehensive	$223.50	$308.49
G559	Gxxx	Days >30 Comprehensive	$113.00	$155.97

Committee Comments

- The committee has explored ways to identify those patients whose intensity of care could be used as a different tier of critical care per diem codes, which would be predominantly billed by Specialty 11 physicians. We have not found any reliable method to do this.

- The committee notes that for this allocation, Specialty 11 physicians do not yet have a relativity score specific to them due to their recent creation as an OHIP specialty.
- The committee notes the section's desire to focus their allocation on other proposals.
- The committee continues to deliberate and will reach out to the constituency, as required.

9.2 Gxxx - ICU/NICU admission assessment is an initial visit rendered during evening time (17:00-24:00), to G400, G405, G557, G600, G603, G604, G610 or G620 (PFAF 23-249)

9.3 Gxxx - ICU/NICU admission assessment is an initial visit rendered during weekends and holidays time (07:00-24:00), to G400, G405, G557, G600, G603, G604, G610 or G620 (PFAF 23-250)

Constituency Proposal

- The constituency requested two new ICU/NICU admission assessment fees:
  i. Evening ICU/NICU admission assessment fee at $96.40 (equivalent to K994 + K962).
  ii. Weekend/Holiday ICU/NICU admission assessment fee at $111.40 (equivalent to K998 + K963).

Committee Comments

- With respect to PFAF 249, the committee notes that for patients admitted in the evening, the compensation is equivalent to patients admitted earlier in the day, despite fewer hours of care.
- The committee does not support PFAF 249.
- With respect to PFAF 250, the committee supports the proposal, subject to fitting and relativity.

9.4 Special Visit Premiums – Evening & Weekend (PFAF 21-D06)

Constituency Proposal

- The Section requested 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.

Committee Comments

- The committee notes that the section identifies this proposal to be redundant if the requested two new ICU/NICU admission assessment fees (PFAF 249/250) proceeds (above); therefore, this item is no longer required.
- The committee views the proposal as withdrawn.

9.5 A/C 715 - Consultation (PFAF 25-171)

Constituency Proposal

- The constituency proposed a fee value increase to A715 - Consultation from $175.55 to $210.66 (20% increase).

Committee Comments

- The committee supports the fee value increase, subject to fitting and relativity.

9.6 Exxx, G558, G557 - Comprehensive care (intensive care area) per diems (PFAF 25-174)

Constituency Proposal

- Initially, the constituency requested increases in fee values for the following services:
    - G558- Comprehensive care (intensive care area) - Physician-in-charge - 2nd to 30th day, inclusive, per diem from $228.90 to $274.68 (20.0% increase).
    - G557- Comprehensive care (intensive care area) - Physician-in-charge - 1st day from $383.45 to $460.14 (20.0% increase).
- The section notes that they are not requesting corresponding increases to G557/8/9, G559, G400/1/2, and G405/6/7.
- The section notes that if the PPC supports alterative approaches for critical care per-diem codes, this proposal may not be required (see PFAF 23-247 and 23-248 for more details).
- The section notes that those alternative proposals will mitigate impact on other sections.
- Following discussions with the PPC and OMA staff, the constituency modified this proposal to instead create an E-code MRP premium, valued at 20%.
    - Exxx payments are premiums payable to members of Section 11 for the nonprocedural aspects of comprehensive care the SOB describes and hence should be considered eligible for a premium.
    - The proposed premium would live in the Consultations and visits section in the Critical Care Medicine section of the schedule.

Committee Comments

- The committee notes the section's choice to withdraw the proposal regarding G558 and G557 and replace that with the creation of an E-code MRP premium to live in the Critical Care Consultations and Visits section of the Schedule of Benefits.
- The committee continues to deliberate on this proposal and will reach out to the section as required.

10 Dermatology

10.1 Complex Skin Cancer Specific Assessment (PFAF 23-149)

Constituency Proposal

- The constituency requested a new complex skin cancer specific assessment fee at $81.55 with the following payment requirements:
    1. Meet the criteria for a specific assessment.
    2. Meet one or more of the below criteria for a complex cancer assessment:
        a. High-risk melanoma, as defined by those melanomas which should be considered for sentinel node biopsy (e.g., T1b and higher stages)
        b. High-risk Basal cell carcinoma, defined as having morpheic pathologic subtype.
        c. Squamous cell carcinoma with a high risk for regional or distant metastasis (e.g., Stage 2 and above)
        d. Patients with field cancerization, defined as having at least 10 actinic keratoses

Committee Comments

- The committee proposes incorporating this assessment into A021 and understands that the section supports this approach (see comments on PFAF 23-156 below).

10.2 A020 - Complex dermatology assessment – revision (PFAF 23-156)

10.3 A021 - Advanced Dermatology Consultation - revision

Constituency Proposal

- The constituency requested revisions to the payment rules to A020 and A021 as follows:

a. Complex systemic disease with skin manifestations for at least one of the following:
i. sarcoidosis;
ii. systemic lupus erythematosus;
iii. dermatomyositis;
iv. scleroderma;
v. relapsing polychondritis;
vi. inflammatory bowel disease related diseases (~~i.e.~~ e.g. pyoderma gangrenosum, Sweet's syndrome, erythema nodosum);
vii. porphyria;
viii. autoimmune blistering diseases (e.g. pemphigus, pemphigoid, linear IgA);
ix. paraneoplastic syndromes involving the skin;
x. vasculitis (including Behcet's disease); or
xi. cutaneous lymphomas (including lymphomatoid papulosis).

or

b. Chronic pruritus with or without skin manifestations ~~(i.e.~~ e.g., prurigo nodularis).

or

c. Complex systemic drug reactions for at least one of the following:
i. drug hypersensitivity syndrome;
ii. erythema multiforme major; or
iii. toxic epidermal necrolysis.

or

d. "Complex psoriasis" or ~~"complex dermatitis"~~ "complex inflammatory dermatoses" as defined by at least one of the following criteria:
i. involvement of body surface area of greater than 30%;
ii. treatment with systemic therapy (e.g. methotrexate, acitretin, cyclosporine, biologics); or
iii. a visit that requires at least 15 minutes of direct patient encounter time

e. Complex skin cancer assessment is defined as one of the following:
i. High-risk melanoma, as defined by those melanomas who should be considered for sentinel node biopsy
(e.g., T1b and higher stages)

ii. High-risk Basal cell carcinoma, defined as having morpheic pathologic subtype.
iii. Squamous cell carcinoma with a high risk for regional or distant metastasis (eg. Stage 2 and above)
iv. Patients with field cancerization, defined as having at least 10 actinic keratoses
v. Patients with multiple dysplastic nevi and other skin neoplasms of uncertain behaviour

(Revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- The committee supports certain proposed revisions to A020 and A021:
  - The committee proposes editing section A and B to remove instances of "i.e." and instead listing the eligible diagnoses
  - The committee does not support expanding the diagnosis for section D as code A021 is a recent addition to the schedule, and insufficient data exist to determine the impact of the proposal.
  - The committee supports adding Section E to A020.
- The committee does not support adding section E to A021 as it is unclear whether there is increased physician workload associated with these conditions, prior to these diagnoses being made (during the consultation phase).

10.4 Exxx – Dermoscopy (PFAF 25-273)

Constituency Proposal

- The constituency proposed a new dermoscopy code in Ontario, modelled after the successful implementation in Manitoba, specifically for dermatologists, valued at $29.60.
- Dermatoscopy, or dermsocopy, a non-invasive diagnostic tool, allows dermatologists to assess and monitor skin lesions with a high degree of accuracy, significantly reducing the need for unnecessary biopsies.

Committee Comments

- The committee is of the opinion dermsocopy is an exam tool and therefore its use is bundled currently in consults and assessments.
- The committee does not support the proposal.

10.5 A/Cxxx - Repeat advanced consultation (PFAF 25-276)

Constituency Proposal

- The constituency proposed a new fee code for repeat advanced consultation valued at 85% of A021, $140.20.
- The service would have similar indications to A021 Advanced Dermatology Consultation, but would be structured as a repeat consultation, with a set of rules modelled after other repeat consultations in the Schedule of Benefits.

Committee Comments

- The committee notes that the standard approach in the Schedule of Benefits is to not have repeat codes for advanced or special consultations.

- If a physician is seeing a patient for the same diagnosis, they have available to them the complex assessment code.
- The committee does not support this proposal.

10.6 A/Cxx1, A/Cxx2 - Advanced Pediatric Dermatology Consultation and Advanced Pediatric Dermatology Assessment (PFAF 25-279, 25-283)

Constituency Proposal

- The constituency requested the creation of a new consultation and assessment code for paediatric dermatology.
- The proposed consultation code is for the investigation, diagnosis, and management of any of the following diseases of the integumentary system where the complexity of the condition requires the medical expertise of a specialist in Dermatology (02). The service has a proposed value of $181.45.
- The proposed assessment code is an assessment for the ongoing management of any of the following diseases where the complexity of the condition requires the continuing management by a dermatology specialist. The service has proposed value of $60.00.
- For each, the patient must be below the age of 18 at the service date and meet one of the following criteria:
    - congenital malformation syndrome or congenital anomalies; or
    - hemangioma, any site requiring consideration of systemic or surgical therapy; or
    - neurofibromatosis type 1 with complex skin manifestations; or
    - neoplasm of uncertain behaviour (such as complex congenital nevi, histiocytoses, multiple angiofibromas); or
    - other complex pediatric dermatologic conditions

Committee Comments

- The committee supports incorporating this proposal in the existing advanced consult and assessment codes and note that the age premium would apply.

11 Diagnostic Imaging

11.1 Interventional Radiology procedures except angioplasty and stenting codes (PFAF 23-024)

Constituency Proposal

- The constituency proposed an across-the-board fee increase of 25% to all Interventional Radiology (IR) procedures except angioplasty and stenting codes:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
J001	Miscellaneous Procedures - Arthrogram, tenogram or bursogram	$34.00	$42.50	$8.50	25.0%
J013	Miscellaneous Procedures - Lymphangiogram - Percutaneous trans- Hepatic cholangiogram	$121.25	$151.56	$30.31	25.0%

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
J018	Miscellaneous Procedures - Lymphangiogram - Sialogram	$52.25	$65.31	$13.06	25.0%
J023	Angiography - Embolization (e.g. for treatment of haemangioma or renal carcinoma) Intra- Arterial infusion of drugs e.g. for control of gastrointestinal haemorrhage - Claim appropriate angiographic procedural and radiological fees plus a per diem supervision fee of	$34.00	$42.50	$8.50	25.0%
J026	Angiography - Peripheral venogram - Direct puncture	$70.80	$88.50	$17.70	25.0%
J028	Miscellaneous Procedures - Lymphangiogram - Urethrogram and/or urethrocystogram and/or or intestinal conduit examination, cystogram	$34.00	$42.50	$8.50	25.0%
J029	Miscellaneous Procedures - Lymphangiogram - Vasogram	$69.00	$86.25	$17.25	25.0%
J033	Angiography - Peripheral venogram - Splenoportogram	$128.35	$160.44	$32.09	25.0%
J035	Angiography - Embolization (e.g. for treatment of haemangioma or renal carcinoma) - Pressure measurements during angiography	$34.00	$42.50	$8.50	25.0%
J039	Miscellaneous Procedures - Lymphangiogram -Renal cyst puncture	$140.40	$175.50	$35.10	25.0%
J040	Angiography - Embolization (e.g. for treatment of haemangioma or renal carcinoma) - First vessel, claim appropriate angiographic procedural and radiological fees plus	$121.25	$151.56	$30.31	25.0%
J041	Miscellaneous Procedures - Lymphangiogram - Percutaneous removal of intravascular and intraureteric foreign bodies	$339.90	$424.88	$84.98	25.0%
J045	Miscellaneous Procedures - Lymphangiogram - Percutaneous antegrade pyelogram	$140.55	$175.69	$35.14	25.0%
J046	Miscellaneous Procedures - Lymphangiogram - Percutaneous nephrostomy	$257.60	$322.00	$64.40	25.0%
J047	Angiography - Embolization (e.g. for treatment of haemangioma or renal carcinoma) - Each additional vessel catheterized and occluded per vessel	$56.80	$71.00	$14.20	25.0%
J051	Miscellaneous Procedures - Lymphangiogram - Percutaneous spinal cord puncture for syringogram	$108.90	$136.13	$27.23	25.0%
J055	Miscellaneous Procedures - Lymphangiogram - Percutaneous gastrostomy	$257.60	$322.00	$64.40	25.0%
J056	Angiography - By catheterization - Abdominal, thoracic, cervical or cranial - Transcatheter fibrinolytic therapy	$670.55	$838.19	$167.64	25.0%
J057	Miscellaneous Procedures - Lymphangiogram - Transjugular intrahepatic portosystemic shunt (TIPS)	$906.45	$1,133.06	$226.61	25.0%

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
J059	Miscellaneous Procedures - Lymphangiogram - Non-Vascular stenting	$116.90	$146.13	$29.23	25.0%
J060	Miscellaneous Procedures - Lymphangiogram - Nephrostogram	$34.00	$42.50	$8.50	25.0%
J061	Miscellaneous Procedures - Lymphangiogram - Percutaneous cecostomy	$257.60	$322.00	$64.40	25.0%
J062	Miscellaneous Procedures - Lymphangiogram - Percutaneous cholecystostomy	$257.60	$322.00	$64.40	25.0%
J063	Miscellaneous Procedures - Lymphangiogram - Percutaneous jejunostomy	$298.80	$373.50	$74.70	25.0%
J066	Angiography - By catheterization - Abdominal, thoracic, cervical or cranial - Renal angioplasty	$504.40	$630.50	$126.10	25.0%
J067	Angiography - Carotid angiogram - Spinal angiography for AV malformation, per vessel, maximum of 12 vessels per side	$44.00	$55.00	$11.00	25.0%
N570	Fractures of the Spine - Vertebroplasty (injection of bone cement) as sole procedure, first level	$655.25	$819.06	$163.81	25.0%
Z597	Miscellaneous Procedures - Intracavitary/intratumoural injections	$103.75	$129.69	$25.94	25.0%
Z331	Lungs and Pleura - Introduction - Thoracentesis - Aspiration for Diagnostic sample	$37.35	$46.69	$9.34	25.0%
Z332	Lungs and Pleura - Introduction - Thoracentesis - Aspiration with therapeutic drainage with or without Diagnostic sample	$68.10	$85.13	$17.03	25.0%
Z340	Lungs and Pleura - Incision - biopsy of lung, needle	$158.70	$198.38	$39.68	25.0%
Z594	Abdomen, Peritoneum and Omentum - Incision - Peritoneal abscess - Percutaneous abdominal abscess drainage including daily supervision, for one or more abscesses within the same abdominal quadrant or the pelvis	$331.90	$414.88	$82.98	25.0%
Z447	Cardiovascular - Venipuncture -revision same site	$85.25	$106.56	$21.31	25.0%
Z456	Cardiovascular - Venipuncture - Insertion of implantable central venous catheter	$193.40	$241.75	$48.35	25.0%

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity.

11.2 J182 - Diagnostic Ultrasound - Extremities - per limb (excluding vascular studies) (PFAF 21-D07)

Constituency Proposal

- The constituency proposed a fee increase to J182 from $14.95 to $29.90 (100 per cent).

- The constituency proposed a descriptor revision to J182 “per limb (excluding vascular study)” to “both extremity limbs”, thus removal of restriction to add doppler vascular study.

Committee Comments

- The committee was not provided sufficient evidence to support the proposed change.
- The committee does not support this proposal.
- The committee notes the constituency decision to withdraw this proposal.

11.3 J1xx Ultrasound - biophysical profile (BPP) (PFAF 21-D08)

Constituency Proposal

- The constituency proposed a new fee for a biophysical profile ultrasound - on or after 28 weeks gestation, valued at $30.00.

Committee Comments

- The committee was not provided sufficient evidence to support the proposed change.
- The committee does not support this proposal.

11.4 Xxxx - Image guided embolization for active bleeding from the GI tract (PFAF 25-031)

Constituency Proposal

- The constituency proposed a new fee code for Image guided embolization for active bleeding from the GI tract, valued at $2,000.00.
- This is a fee for image guided embolization for active bleeding from the GI tract, performed within a hospital Interventional Radiology Suite.

Committee Comments

- The committee supports the creation of a fee code for this service.
- The committee notes there is significant variation in the time required for this procedure. The committee will proceed with the creation of a time-based code for this service.

11.5 Xxxx - Image-guided placement of a chest drain in Interventional Radiology (PFAF 25-032)

Constituency Proposal

- The constituency requested a new fee code for Image-guided placement of a chest drain in Interventional Radiology valued at $300.00.
- Under this proposal, the code is for chest drains are inserted in Interventional Radiology under image guidance for: 1. pneumothorax, 2. Pleural collections including empyema.
- The Section notes intrasectional relativity issues and the need to increase fees for Interventional radiology.

Committee Comments

- The committee notes that insufficient evidence was provided to justify the creation of this fee code when Z341 already exists.
- The committee does not support this proposal.

11.6 Xxxx - Image-guided embolization (PFAF 25-033)

Constituency Proposal

- The constituency proposed the creation of a new fee code for image guided embolization valued at 1,100.00.
- The service is described as:

    1. Uterine Artery Embolization - Used for image-guided embolization of symptomatic uterine fibroids, performed by fellowship-trained interventional radiologists, and performed in an IR suite with fluoroscopy and DSA capabilities.
    2. Prostate Artery Embolization - Used for image-guided embolization of symptomatic prostate enlargement performed by fellowship-trained interventional radiologists, and performed in an IR suite with fluoroscopy and DSA capabilities.

Committee Comments

- The committee supports the creation of a fee code for this service.
- The committee notes there is significant variation in the time required for this procedure. The committee will proceed with the creation of a time-based code for this service.

11.7 Xxxx - Tube check/ Sinogram under fluoroscopy. (PFAF 25-034)

Constituency Proposal

- The constituency proposed a new fee code for Exchange/replacement of a nephrostomy, cholecystectomy, pleural, abscess or biliary drain under fluoroscopic guidance performed in an IR suite, valued at $250.00.

Committee Comments

- The committee supports editing J064 to include this procedure and increasing the value to match the value of J052.

11.8 Xxxx - Interpretation of x-ray to estimate bone age (PFAF 25-035)

Constituency Proposal

- The constituency proposed the creation of a new fee code Interpretation of an x-ray specifically to determine the patient's estimated bone age, valued at $40.00.

Committee Comments

- The committee supports adjusting X057 to be equivalent in value to X055, and X058 to be equivalent with X220.
- The committee notes this should be payable only when a radiologist personally reviews the patient images compared to the reference atlas to determine patient bone age.

11.9 Jxx1, Jxx2 - 3D breast tomosynthesis views of breast (PFAF 25-046)

Constituency Proposal

- The constituency proposed two new fee codes for 3D tomosynthesis of breast, Jxx1 unilateral valued at $15.00 and Jxx2, bilateral valued at $30.00.

Committee Comments

- The committee proposes mammogram codes (X172, X178, X184, X185) be edited to also be billed for 3D breast tomosynthesis.

11.10 Jxxx - Thoracic duct embolization. (PFAF 25-047)

Constituency Proposal

- The constituency requested the creation of a new fee code for Thoracic duct embolization, valued at $2000.00.
- The service involves lymphangiogram with successful puncture and cannulation of the retroperitoneal lymphatics followed by coil/glue embolization of the verified chylous leak.

Committee Comments

- The committee supports the creation of a fee code for this service.
- The committee notes there is significant variation in the time required for this procedure. The committee will proceed with the creation of a time-based code for this service.

11.11 Xxxx - Dosimetry Planning for TARE (PFAF 25-050)

Constituency Proposal

- The constituency requested a new fee code to remunerate for Dosimetry Planning for Transarterial radio embolization (TARE), valued at $750.00.
- The service involves dosimetry calculations following the Mapping procedure of a TARE procedure, in preparation for delivery of procedure.

Committee Comments

- This proposal is currently out of scope for PPC as TARE is remunerated through Cancer Care Ontario, outside of the Schedule of Benefits.

11.12 J182 -Diagnostic ultrasound, per limb (excluding vascular study) (PFAF 25-051)

Constituency Proposal

- The constituency proposed a revision to the descriptor to J182 (page G10), as follows:

  Extremities
  ~~- per limb~~ per joint (excluding vascular study)

  (deletions ~~strikethrough~~, revisions underlined)

- Current rules only allow a single joint per side to be paid, per day. This change would allow for imaging of multiple scans per side (e.g., left elbow and left wrist) during the same visit.

Committee Comments

- The committee proposes a new fee code to be billed with J182 when two or more large joints on the same limb are imaged on the same day.
- The fee value would be set at 25% of the value of J182 to support costing analysis and future review.

11.13 Xxxx - MR Elastography, Fat and Iron quantification. (PFAF 25-082)

Constituency Proposal

- MRE is a specialized MRI exam that provides information on liver stiffness and fibrosis.
- The constituency proposed a new fee code for MR Elastography performed for qualification of fat and/or iron deposition in the liver, valued at $73.35.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

11.14 G370 - Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath (PFAF 25-083)

Constituency Proposal

- The constituency proposed a fee value change for G370 - Injection of bursa, or injection and/or aspiration of joint, from $20.25 to $50.00 (147% increase)

Committee Comments

- Topics related to this proposal are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

12 Emergency Medicine

12.1 Relativity fee value changes to Z-fee code affecting I&D and Suturing Codes (PFAF 23-135)

Constituency Proposal

- The constituency requested multiple fee code increases due to relativity for the following codes:

Fee Code	2023 Fee Value	Section Proposed % Increase	PPC Proposed % Increase	PPC Proposed Value
Z101	$25.75	20.00%	20.00%	$30.90
Z173	$30.35	19.93%	19.93%	$36.40
Z174	$40.80	19.98%	19.98%	$48.95
Z104	$20.10	120.65%	120.65%	$44.35
Z106	$44.35		19.95%	$53.20
Z103	$44.35		19.95%	$53.20

Z102	$44.35	19.95%	19.95%	$53.20
Z172	$66.60		19.97%	$79.90
Z105	$66.00		19.92%	$79.15
Z107	$108.00		19.95%	$129.55
Z108	$72.00		19.93%	$86.35
Z154	$35.90	20.06%	20.06%	$43.10
Z175	$35.90	20.06%	20.06%	$43.10
Z176	$20.00	20.00%	20.00%	$24.00
Z177	$71.30	19.99%	19.99%	$85.55
Z179	$50.40	20.04%	20.04%	$60.50
Z190	$101.45	20.01%	20.01%	$121.75
Z191	$77.30	19.99%	19.99%	$92.75
Z192	$154.95		20.01%	$185.95

Committee Comments

- The committee supports an increase in these codes and will proportionately increase all related codes as well, subject to fitting and relativity. Please see the table above for details.

12.2 Axxx - Emergency Medicine Specialist Consultation (PFAF 23-141)

12.3 Axxx - Extended Emergency Medicine Specialist Consultation (PFAF 23-142)

12.4 Axxx - Comprehensive Emergency Medicine Specialist Consultation (PFAF 23-143)

12.5 Various new Consultation and Assessment codes (PFAF 23-188 to 23193)

Constituency Proposal

- The constituency requested new consultation and assessment fee code for Emergency Medicine specialists (OHIP Specialty “12”) as follows:

PFAF	Fee code	Descriptor	Proposed fee value	Note
141	Axxx	Emergency Medicine Specialist Consultation	$106.80	Per GP16
142	Axxx	Extended Emergency Medicine Specialist Consultation	178.00	Per GP16 & minimum of seventy-five (50) minutes of direct contact
143	Axxx	Comprehensive Emergency Medicine Specialist Consultation	$267.00	Per GP16 & minimum of seventy-five (75) minutes of direct contact
188	Axx1	Emergency Medicine Specialist Limited Consultation	$68.17	As per GP19
189	Axx2	Emergency Medicine Specialist Repeat Consultation	$68.17	As per GP19

PFAF	Fee code	Descriptor	Proposed fee value	Note
190	Axx3	Emergency Medicine Specialist Medical Specific Assessment	$52.82	As per GP23
191	Axx4	Emergency Medicine Specialist Medical Specific Re-assessment	$39.67	As per GP23
192	Axx5	Emergency Medicine Specialist Complex Medical Specific Re-assessment	$45.92	As per GP24
193	Axx6	Emergency Medicine Specialist Partial Assessment	$24.64	As per GP25

- The fee codes would be restricted to emergency medicine specialists for a patient not eligible for an applicable emergency department "H" prefix code and who provides all the elements of the underlying consultation and assessment fee. Examples include emergency medicine specialists providing a consultation outside of the emergency department (e.g., hospital, out-patient), or when operating under special visit premium rules.
- Proposed payment rules:
    1. Only be billed by FRCPC emergency medicine specialists (OHIP Specialty "12")
    2. Only be used for patients not eligible for an emergency department "H" prefix code.

Committee Comments

- The committee does not support establishing new fee codes for Emergency Medicine specialists for services rendered outside of an emergency department.
- The committee notes that when operating under SVP rules, Emergency physicians can bill the applicable "A" assessment or consultation fee codes.
- The committee does not support this proposal.

12.6 H055 - Consultation - Emergency Department Physician on Duty (PFAF 23-182)

Constituency Proposal

- The constituency requested that the payment requirements for billing H055 be revised to include physicians with CCFP(EM)designations; H065 would apply for all other physicians.

Committee Comments

- Consultation codes are allocated by OHIP specialty.
- The committee does not support the proposal.

12.7 H065 - Consultation in Emergency Medicine (PFAF 23-186)

Constituency Proposal

- The constituency requested a fee value change from $81.25 to $97.50, by 20.0 per cent.
- H065 has fallen out of relativity with other general practice consultations as well as the H055 (Emergency Medicine specialist consultation).

Committee Comments

- The committee notes that this was withdrawn when the constituency submitted PFAF 25-272.

12.8 Relativity fee value changes to Emergency Medicine Assessment H-fee codes (PFAF 23-199)

Constituency Proposal

- The constituency requested multiple fee value changes due to relativity:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
H101	Monday to Friday - Daytime (08:00h to 17:00h) - Minor assessment	$17.10	$17.60	$0.50	2.9%
H102	Monday to Friday - Daytime (08:00h to 17:00h) - Comprehensive assessment and care	$43.05	$44.35	$1.30	3.0%
H103	Monday to Friday - Daytime (08:00h to 17:00h) - Multiple systems assessment	$40.00	$41.20	$1.20	3.0%
H104	Monday to Friday - Daytime (08:00h to 17:00h) - Re-assessment	$17.10	$17.60	$0.50	2.9%
H131	Monday to Friday - Evenings (17:00h to 24:00h) - Minor assessment	$20.95	$21.60	$0.65	3.1%
H132	Monday to Friday - Evenings (17:00h to 24:00h) - Comprehensive assessment and care	$52.55	$54.15	$1.60	3.0%
H133	Monday to Friday - Evenings (17:00h to 24:00h) - Multiple systems assessment	$47.45	$48.85	$1.40	3.0%
H134	Monday to Friday - Evenings (17:00h to 24:00h) - Re-assessment	$20.95	$21.60	$0.65	3.1%
H151	Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Minor assessment	$26.35	$26.60	$0.25	0.9%
H152	Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Comprehensive assessment and care	$66.15	$66.80	$0.65	1.0%
H153	Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Multiple systems assessment	$58.90	$59.50	$0.60	1.0%
H154	Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Re-assessment	$26.35	$26.60	$0.25	0.9%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
H121	Nights (00:00h to 08:00h) - Minor assessment	$30.70	$31.00	$0.30	1.0%
H122	Nights (00:00h to 08:00h) - Comprehensive assessment and care	$76.95	$77.70	$0.75	1.0%
H123	Nights (00:00h to 08:00h) - Multiple systems assessment	$68.00	$68.70	$0.70	1.0%
H124	Nights (00:00h to 08:00h) - Re-assessment	$30.70	$31.00	$0.30	1.0%

Committee Comments

- The committee notes that this was withdrawn when PFAF 25-265 was submitted.

12.9 H100 - Emergency department investigative ultrasound (PFAF 23-155)

Constituency Proposal

- The constituency requested descriptor and payment rule revisions to H100.
- Proposed descriptor:
  An Emergency Department investigative 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. a specialist in Diagnostic Radiology is not available to render an urgent interpretation; and~~
  2. the procedure is rendered for a patient that is clinically suspected of having at least one of the following life-threatening conditions:
     a. pericardial tamponade
     b. cardiac standstill
     c. intraperitoneal haemorrhage associated with trauma
     d. ruptured abdominal aortic aneurysm
     e. ruptured ectopic pregnancy
     f. pneumothorax
     g. pulmonary edema
     h. shock

     OR

     a patient is clinically suspected of having at least one of the following emergent conditions and the corresponding diagnostic POCUS is performed to improve the quality and/or timeliness of patient care:
     a. Retinal Detachment – ocular POCUS
     b. Cholecystitis – gallbladder POCUS
     c. DVT – DVT POCUS
     d. Renal Stone – Renal POCUS

- Proposed payment rules:

1. H100 is limited to ~~two (2)~~ three (3) services per patient per day where the second or third service is rendered as a follow-up to the first service for the same condition(s).

~~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 ultra sound images described by H100 are eligible for payment.~~

Note:
H100 is only eligible for payment when it is rendered using equipment that meets the following minimum technical requirements:

1. Images must be of a quality acceptable to allow a different physician who meets standards for training and experience to render the service to arrive at the same interpretation;
~~2. Scanning capabilities must include B-and M-mode; and~~
2. The trans-abdominal probe must be at least 3.5MHz or greater.

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 ~~two (2)~~ 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:

1. See page GP50 for the definition of an "Emergency Department Physician".
2. Current standards and minimum requirements for training and experience for Emergency Department investigative ultrasound ~~may be found at the Canadian Emergency UltrasoundSociety website at the following internet link: [http://www.ceus.ca.]~~ are CPoCUS IP certification (CPoCUS - Canadian Point of Care Ultrasound Society) or equivalent.

(Revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- When point of care ultrasound was introduced as a payable service in the Emergency Department, there was a limited opportunity for training and a more limited scope for its use. This is no longer the case.
- Upon review of literature and the Royal College learning objectives for Emergency Medicine, the committee considers POCUS to be an element of the patient assessment.
- The issue of Point of Care ultrasound in patient care settings outside of the Emergency Department as well as image guidance for procedures needs to also be taken into consideration, meaning the proposed change would have broad implications across the Schedule of Benefits and require broad consultation with all affected sections.
- The committee does not support the proposed descriptor changes.

- The committee does not support the proposed fee increase to H100 based on comparison to other comparable ultrasound services.
- On receipt of the constituency's response, as requested, the committee had further deliberations on the proposal, and reached the above conclusions. The committee acknowledges the constituency's disagreement with the committee's conclusions.

12.10 Hxxx - Emergency Department Point-of-Care Ultrasound for static or dynamic guidance (PFAF 23-272)

Constituency Proposal

- The constituency requested a new fee code for emergency department point-of-care ultrasound for static or dynamic guidance paid at $32.10.
- This would be for the following procedures:
    a. central line insertion,
    b. fracture reduction,
    c. foreign body removal,
    d. joint injection or aspiration for diagnostic or therapeutic purposes.

- Procedural ultrasound requires a higher level of practice and skill than diagnostic POCUS due to the nature of sterile technique and the dynamic nature of the scans.

Constituency Feedback

- The section provided the following feedback. The decision to withdraw this proposal was informed by:
    - feedback from the committee
    - the previous assumption that a year 3 increase would be less than 3%
    - the section's efforts to modify H100

Committee Comments

- After consultation with the committee, the constituency withdrew this proposal.

12.11 D015 - Dislocations - Glenohumeral joint - closed reduction without anaesthetic (PFAF 23-271)

Constituency Proposal

- The constituency requested a fee value change from $49.20 to $83.00, by 68.7 per cent.

Constituency Feedback

- The section provided the following feedback. The decision to withdraw this proposal was informed by:
    - the previous assumption that a year 3 increase would be less than 3%
    - the section did not support the PPC's suggestions to combine the two codes for shoulder reduction.

Committee Comments

- After consultation with the committee, the constituency withdrew this proposal.

12.12 H113 - Emergency department service premium - daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays, per patient visit (PFAF 23-236)

12.13 H13X - Monday to Friday - Evenings (17:00h to 24:00h) and H15X - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) (PFAF 21-D09)

Constituency Proposal

- The Section requested 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 Thursday ~~Friday~~ - 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

  2. **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

  3. **H113 - Friday Evenings (17:00h to 24:00h), daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays**

  (Revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

12.14 Gxxx - Emergency department pelvic exam with speculum (PFAF 21-D10)

Constituency Proposal

- The constituency requested the creation of a new fee code with a fee value equal to G365 ($12.00), with the following descriptor:
  "Gxxx - Emergency department pelvic exam with speculum"
- First proposed as revision to an existing code (G365 Pap smear), the Section has modified this proposal to create a unique code for a gynaecological exam with use of a speculum in the emergency department, noting issues with overlapping practice.
- It is noted that this proposal helps to address a gender equity issue.

Committee Comments

- The committee supports this proposal subject to Schedule of Benefits language, fitting, and relativity.

12.15 A0xx – ED General Assessment (PFAF 25-084)

Constituency Proposal

- The constituency proposed a new fee code for a General Assessment provided by an ED physician using special visit premiums.
- The service is otherwise modelled after the A003.
- The proposed value for this service is 87.35 (the same fee value as A003).

Committee Comments

- The committee notes there are alternate methods by which the section could determine which A003s were billed by physicians on duty in the emergency department.
- Therefore, it is not necessary to create a new code to obtain the data sought by this PFAF.
- The committee does not support this proposal.

12.16 A0xx – ED Intermediate Assessment (PFAF 25-085)

Constituency Proposal

- The constituency proposed a new fee code for an intermediate assessment provided in conjunction with a special visit premium by an emergency physician on duty in an emergency department
- The service is otherwise modelled after the A007.
- The proposed value for this service is 37.95 (the same fee value as A007).

Committee Comments

- The committee notes there are alternate methods by which the section could determine which A007s were billed by physicians on duty in the emergency department.
- Therefore, it is not necessary to create a new code to obtain the data sought by this PFAF.
- The committee does not support this proposal.

12.17 H1X2 - Comprehensive Assessment and Care (PFAF 25-188)

Constituency Proposal

- The constituency proposed revising H102, H122, H132, and H152 to be complex assessment codes instead of comprehensive assessment codes.
- Section also proposed to increase value of H102, H122, H132, and H152. Details on the proposed fee values can be found in PFAF 25-265.

Committee Comments

- The committee notes that the proposed rule changes would greatly broaden the usage of these fee codes.
- The committee is unable to cost this change accurately.
- The committee does not support this proposal.

12.18 Axxx – Intermediate Assessment – Emergency Department Sign-over and Disposition (PFAF 25-254)

Constituency Proposal

- The constituency proposed the creation of a new fee code for Intermediate Assessment provided by an emergency physician on duty in an emergency department for the final disposition (either discharge or referral to a consultant) of a patient received as a sign-over from another physician.
- The proposed fee code is valued at $50.00.

Committee Comments

- When the changes contained in PFAF 25-277 are implemented, the committee believes that the work described in this PFAF will be adequately compensated through the reassessment fee codes.
- The committee does not support this proposal.

12.19 Gxxx – Critical Care Fee Value Changes (PFAF 25-263)

Constituency Proposal

- The constituency proposed fee value changes to the following critical care codes: G395, G391, G521, G523 and G522.
- The section notes the need to maintain relativity with H codes, as well as to ensure that higher intensity work such as that covered by the G codes is adequately remunerated.
- The proposed value changes are as follows:

Fee code	Description	Fee Value	Proposed Fee Value	% Increase
G395	Critical Care, OTHER CRITICAL CARE - Amount payable per physician per patient for the first three physicians - first ¼ hour (or part thereof)	$57.45	$66.70	16.10%
G391	Critical Care - Amount payable per physician per patient for the first three physicians - after first ¼ hour per ¼ hour (or part thereof)/Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof)	$30.60	$35.40	15.69%
G521	Critical Care, LIFE THREATENING CRITICAL CARE - Amount payable per physician per patient for the first three physicians: first ¼ hour (or part thereof)	$111.80	$128.80	15.21%

G523	Critical Care, LIFE THREATENING CRITICAL CARE - Amount payable per physician per patient for the first three physicians: second ¼ hour (or part thereof)	$57.65	$65.48	13.58%
G522	Critical Care, LIFE THREATENING CRITICAL CARE - Amount payable per physician per patient for the first three physicians: after first ½ hour, per ¼ hour (or part thereof)	$38.00	$43.70	15.00%

Committee Comments

- The committee supports a value change to the fee codes contained in this PFAF, subject to fitting and relativity.

12.20 Hxxx – Intrasectional Relativity Fee Value Changes (PFAF 25-265, 25-269)

Constituency Proposal

- The constituency proposed an intrasectional relativity exercise to adjust fee values of existing H-codes.
- The constituency applied the following principles to determine proposed fee values:
    - Increase of base code H103 by 15%
    - Re-assessments and minor assessments are valued at 50% of the intermediate assessment (H1x3)
    - Comprehensive (or complex) assessments are valued at 1.25x an intermediate assessment
    - Evenings pay a premium of 35%
    - Weekends (Friday 5pm - Monday 8am, excluding weekend nights) pay a premium of 50%
    - Nights (7 days per week) pay a premium of 75%
- The proposed fee values are presented here:

Feecode	Descriptor	Fee Value	Proposed Fee Value	% Increase
H101	GP/FP (00) - Monday to Friday - Daytime (08:00h to 17:00h) - Minor assessment	$17.10	$23.00	34.50%
H102	GP/FP (00) - Monday to Friday - Daytime (08:00h to 17:00h) - Comprehensive assessment and care	$43.05	$57.50	33.57%
H103	GP/FP (00) - Monday to Friday - Daytime (08:00h to 17:00h) - Multiple systems assessment	$40.00	$46.00	15.00%
H104	GP/FP (00) - Monday to Friday - Daytime (08:00h to 17:00h) - Re-assessment	$17.10	$23.00	34.50%
H121	GP/FP (00) - Nights (00:00h to 08:00h) - Minor assessment	$30.70	$40.25	31.11%
H122	GP/FP (00) - Nights (00:00h to 08:00h) - Comprehensive assessment and care	$76.95	$100.65	30.80%

H123	GP/FP (00) - Nights (00:00h to 08:00h) - Multiple systems assessment	$68.00	$80.50	18.38%
H124	GP/FP (00) - Nights (00:00h to 08:00h) - Re-assessment	$30.70	$40.25	31.11%
H131	GP/FP (00) - Monday to Friday - Evenings (17:00h to 24:00h) - Minor assessment	$20.95	$31.05	48.21%
H132	GP/FP (00) - Monday to Friday - Evenings (17:00h to 24:00h) - Comprehensive assessment and care	$52.55	$77.65	47.76%
H133	GP/FP (00) - Monday to Friday - Evenings (17:00h to 24:00h) - Multiple systems assessment	$47.45	$62.10	30.87%
H134	GP/FP (00) - Monday to Friday - Evenings (17:00h to 24:00h) - Re-assessment	$20.95	$31.05	48.21%
H151	GP/FP (00) - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Minor assessment	$26.35	$34.50	30.93%
H152	GP/FP (00) - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Comprehensive assessment and care	$66.15	$86.25	30.39%
H153	GP/FP (00) - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Multiple systems assessment	$58.90	$69.00	17.15%
H154	GP/FP (00) - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Re-assessment	$26.35	$34.50	30.93%

Committee Comments

- The committee notes the excellent work involved in this submission, which addresses intrasectional relativity in a thorough manner.
- The committee supports this proposal, subject to fitting.

12.21 H112, H113 – ED After Hours Service Premiums (PFAF 25-269)

Constituency Proposal

- The constituency proposed fee value changes to night and weekend premiums for when any 'other' service is rendered by the Emergency Department Physician in premium hours.
- The proposed change to these service premiums is as follows:

Fee Code	Descriptor	Fee value	New Fee Value	% Increase
H112	GP/FP (00) - Emergency department service premium - nights (00:00h to 08:00h), per patient visit	$35.15	$52.70	49.93%
H113	GP/FP (00) - Emergency department service premium - daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays, per patient visit	$20.35	$33.80	66.09%

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

12.22 H11x – New ED After Hours Service Premium Mon-Thurs 1700-2400 (PFAF 25-270)

Constituency Proposal

- The constituency proposed the creation of a new evening premium for work Mon-Thurs 1700-2400 in the ED when assessments can not be claimed.
- The proposed fee value is $23.65.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

12.23 H055, H065 – Consultations – Fee Value Changes (PFAF 25-272)

Constituency Proposal

- The constituency proposed fee increases to the following fee codes:
- H055 – Emergency Medicine Consultation (Emergency Medicine Section of Schedule) from 106.80 to 137.25 (28.5% increase).
- H065 - Consultation in Emergency Medicine (Family Practice and Practice in General Section of Schedule) – from 81.25 to 120.25 (48% increase).
- The section notes that consultations are out of relativity with other services in the schedule.

Committee Comments

- The committee supports an increase to these fee codes, subject to fitting and relativity.

12.24 H105 – Interim Admission Orders (PFAF 25-274)

Constituency Proposal

- In order to maintain relativity with other services, the constituency proposed a fee value change to H105 – Interim Admission Orders, from 26.25 to 29.05 (10.6% increase).
- The section noted that this fee code is important for the work of rural physicians given the time spent admitting patients.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

12.25 H1x4 –Re-assessment (PFAF 25-277)

Constituency Proposal

- The constituency proposed the revision of re-assessments rendered in an emergency department or Hospital Urgent Care clinic at least two hours after the original assessment or re-assessment.
- Specifically, the constituency proposed revisions to payment rules for Re-assessments on page A12, as follows:

Payment rules:
~~1.This service is not eligible for payment under any of the following circumstances:~~
~~a.for discharge assessments;~~
~~b.when the patient is admitted by the Emergency Department Physician; or~~
~~c.when the reassessment leads directly to a referral for consultation.~~
2.This service is limited to three per patient per day and two per physician per patient per day. Services in excess of these limits are not eligible for payment

(deletions ~~strikethrough~~)

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

12.26 Z756 – Fecal disimpaction - no anaesthetic (PFAF 25-319)

Constituency Proposal

- The constituency proposed a fee value change to Z756 – Fecal disimpaction - no anaesthetic from $36.80 to $46.00 (25% increase).
- The section noted that the time associated with the work and its unpleasant nature warrant an increase in fee value, on the basis of intrasectional relativity.

Committee Comments

- The committee supports this proposal, subject to fitting, relativity, and development of appropriate schedule language.

13 Endocrinology & Metabolism

13.1 Endocrinology & Metabolism Consultation and Assessment fee increases (PFAF 23-038)

Constituency Proposal

- The constituency requested an across-the-board fee increase to their consultation and visit fees as follows:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A155	Endocrinology - Consultation	$165.30	$181.85	$16.55	10.01%
A153	Endocrinology - Medical specific assessment	$84.60	$93.05	$8.45	9.99%
A151	Endocrinology - Complex medical specific re-assessment	$74.80	$82.30	$7.50	10.03%
A154	Endocrinology - Medical specific re-assessment	$62.85	$69.15	$6.30	10.02%
A158	Endocrinology - Partial assessment	$39.10	$43.00	$3.90	9.97%
A760	Endocrinology and Metabolism - Complex Endocrine neoplastic disease assessment	$90.75	$99.85	$9.10	10.03%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A156	Endocrinology - Repeat consultation	$105.25	$115.80	$10.55	10.02%

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity.

13.2 K046 - Diabetes team management (PFAF 23-038)

Constituency Proposal

- The constituency requested a 20 per cent fee increase (from $115.00 to $138.00) to K046.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

13.3 K045 - Diabetes management by a specialist (PFAF 23-039)

Constituency Proposal

- The constituency requested:
  i. A reduction in the minimum number of visits needed to bill K045 from 4 to 3, and
  ii. A fee increase from $76.20 to $83.80, by 10 per cent

Committee Comments

- K045 was designed to compensate for care of more complex patients who require more frequent visits. Therefore, the committee does not support the proposal to decrease the number of visits required.
- The committee supports the proposed fee value change, subject to fitting and relativity.

14 Endocrinology & Metabolism (Member Group)

14.1 E078 - Chronic Disease Assessment Premium to include transgender and/or gender diverse person (PFAF 25-339, 25-340)

Constituency Proposal

- The group proposed a revision to the E078 chronic diseases assessment premium, valued at 50%, to include transgender and/or gender diverse person on hormone therapy visits.
- Specifically, the proposal requested a revision such that diagnostic code 302 be eligible for billing with E078.
- The group notes that this revision would reflect the workload and complexity associated with providing chronic and comprehensive care (gender-affirming interventions) within the scope of transgender medicine.

Committee Comments

- The committee does not believe that being a transgender person or a gender diverse person constitutes having a chronic disease.
- The committee does not support this proposal.

15 Fee-for-Service Family Physician (MIG)

15.1 Exxx - Unattached patient premium (PFAF 23-046)

Constituency Proposal

- The constituency requested a new 15% premium for family doctors who care for an unattached patient who does not have a primary care physician.
- This would be billable by any family doctor who cares for an unattached patient who does not have a primary care family physician.

Committee Comments

- No evidence has been provided that these patients require a greater time or intensity, on average, that would justify a higher payment.
- The committee does not support this proposal.

15.2 Community-based infrastructure premium-for office-based practices (out of hospital) and in-basket (PFAF 23-047)

Constituency Proposal

- The constituency requested a new fee code Kxxx Community-based infrastructure premium-for office-based practices (out of hospital) and in-basket paid at 20% for family doctors who work in a community (non-hospital based practice); this is to reflect higher overhead costs in the community.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

15.3 Exxx - Chronic Disease Assessment Premium (PFAF 23-048)

Constituency Proposal

- The constituency requested a new fee code Exxx 50% chronic disease assessment premium with the following criteria:
  i. restricted to family physicians
  ii. same diagnostic codes as E078
- This premium would be restricted to family doctors.

Committee Comments

- The committee has no evidence that this would address an intra-sectional relativity issue within primary care.
- The committee does not support this proposal.

15.4 General & Family Practice time-based "K" prefix fee codes relativity adjustment (various, excluding K023) (PFAF 23-049)

Constituency Proposal

- The constituency requested a 7 per cent across-the-board fee increases to various GP/FP time-based K-codes, except K023 Palliative care support. The following fee codes were identified:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
K002	Interviews - 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	$70.10	$74.70	$4.60	7.0%
K003	Interviews - Interviews with Children's Aid Society (CAS) or legal guardian on behalf of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent, per unit	$70.10	$74.70	$4.60	7.0%
K005	Primary mental health care - Individual care, per unit	$70.10	$74.70	$4.60	7.0%
K006	Hypnotherapy - Individual care, per unit	$70.10	$74.70	$4.60	7.0%
K007	Psychotherapy - Individual care, per unit	$70.10	$74.70	$4.60	7.0%
K008	Interviews - Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities, per unit	$70.10	$74.70	$4.60	7.0%
K013	Counselling - Individual care - first three units of K013 and K040 combined per patient per provider per 12-month period, per unit	$70.10	$74.70	$4.60	7.0%
K014	Counselling - Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons, per unit	$70.10	$74.70	$4.60	7.0%
K015	Counselling - Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons, per unit	$70.10	$74.70	$4.60	7.0%
K022	HIV primary care, per unit	$70.10	$74.70	$4.60	7.0%
K028	STD management, per unit	$70.10	$74.70	$4.60	7.0%
K029	Insulin Therapy Support (ITS), per unit	$70.10	$74.70	$4.60	7.0%
K032	Specific neurocognitive assessment	$70.10	$74.70	$4.60	7.0%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
K037	Fibromyalgia/chronic fatigue syndrome care, per unit	$70.10	$74.70	$4.60	7.0%
K040	Counselling - 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	$70.10	$74.70	$4.60	7.0%
K680	Substance abuse - extended assessment, per unit	$70.10	$74.70	$4.60	7.0%

Committee Comments

- The committee supports a value change to the fee codes listed above, subject to fitting and relativity.

15.5 Kxxx - Monthly Management Fee for Focused Practice Family Doctors (exception of Addiction and Palliative Medicine) – Initial and follow-up (PFAF 23-050)

Constituency Proposal

- The constituency requested a new monthly management fee for focused practice family doctors for monthly management of complex patients. The new fee would be modelled after the Opioid Agonist Maintenance Program (OAMP) monthly management fees – intensive and maintenance (K682 and K683):
    i. Same rules as K682 and K683
    ii. Same fee value as K682 ($45) and K683 ($38)

Committee Comments

- It is unclear to the committee what work this code would be remunerating which is not part of existing consultations and assessments both in person and virtual.
- The committee does not support this proposal.

15.6 Multiple Fee Codes– Fee value changes (PFAF 25-290, 25-294, 25-300)

Constituency Proposal

- The constituency has proposed value changes the follow fee codes:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A007	GP/FP (00) - Intermediate assessment or well baby care	$37.95	$50.10	32.0%
A003	GP/FP (00) - General assessment	$87.35	$100.45	15.0%

K005	GP/FP (00) - Primary mental health care - Individual care, per unit	$70.10	$84.10	20.0%

Committee Comments

- The committee supports a value change for these codes, subject to fitting, relativity, and consideration of the requests made by the SGFP.
- Please see PFAF 23-023 in Section on General and Family Practice for details.

15.7 Exxx – After-hours services premium (PFAF 25-317)

Constituency Proposal

- The constituency proposed the creation of an after-hours services premium for FFS physicians to incent care during unsociable hours modelled after the Q012 - Primary care after-hours fee.
- The proposed premium is eligible for payment for patients seen by a FFS MD during regular after-hours services held after 5pm on weekdays or any time on weekends or statutory holidays.
- The proposed premium is valued at 30%

Committee Comments

- The Q012 is part of a compensation package available to physicians who provide longitudinal patient care as part of a patient enrollment model (PEM). Physicians who do not currently participate in patient enrollment models have the option to join such a model, if feasible.
- The constituency agreed that there is no mechanism by which one can determine which physicians not participating in a PEM are providing longitudinal care and which are not.
- The committee does not support this proposal.

16 Gastroenterology

16.1 E098 - Chronic Disease Assessment Premium (PFAF 23-195)

Constituency Proposal

- The constituency requested to direct approximately 70% of their year 3 allocation to increase the E098 fee code.
- Increase the premium to approximately 30%-35% depending on allocation fund availability.

Committee Comments

- The committee notes this proposal was replaced with PFAF 25-154.

16.2 Exxx - Total excision of very large sessile polyp or lesion (>3cm) of the upper GI tract using endoscopy mucosal resection (EMR) technique through oesophageoscopy-gastroscopy, with or without duodenoscopy, and may include fulguration and hemostasis, each (PFAF 23-196)

Constituency Proposal

- The constituency requested to create a new fee code for the intervention for removal of early gastric cancer or gastric dysplastic lesion, paid at $227.65.
- Proposed Payment Rules:
    1. May only be claimed for polyps or lesions greater than 3cms in size requiring submucosal injection and piecemeal resection.
    2. May only be claimed with Z399, Z400, or Z527
    3. May not be claimed for pedunculated polyps
    4. May not be claimed for lesion removed via endoscopic submucosal dissection (ESD).
    5. Benefits includes placement of clips or hemostatic technique at the time of polypectomy.
    6. May be claimed in addition to E674, E675, E703, or E799, if polyps are removed from different sites.
    7. Limited to EMR that takes minimum 30 minutes to complete the procedure.
    8. A maximal of 2 services are eligible for payment per patient per day.

Committee Comments

- The committee notes this proposal was replaced with PFAF 25-255.

16.3 Exxx - Radiofrequency Ablation for Barrett's Esophagus (PFAF 23-200)

Constituency Proposal

- The constituency requested a new fee for Radiofrequency Ablation for Barrett's Esophagus, paid at $215.00
- Proposed Payment Rules
    1. Only payable to gastroenterologists and general surgeons, who have been trained to perform this procedure.
    2. Only payable in conjunction with Z399 procedure.
    3. Only payable to diagnostic code 530 (Diseases of Esophagus, Stomach and Duodenum: Esophagitis, cardiospasm, ulcer of esophagus; strictures, stenosis, or obstruction of esophagus)

Committee Comments

- The committee notes this proposal was replaced with PFAF 25-253.

16.4 E785 - Multiple screening biopsies (>34 sites) for malignant changes in ulcerative colitis, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555…add (PFAF 23-202)

Constituency Proposal

- The constituency requested a revision to the descriptor for E785, along with proposed payment rules as follows:

  multiple ~~screening~~ biopsies <u>for surveillance of inflammatory bowel disease-associated colorectal cancer or dysplasia</u> ~~(> 34 sites) for malignant changes in ulcerative colitis~~, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555..... add

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

  Proposed Payment Rules:

1) Must be billed with diagnostic code 555 (Crohn's disease), 556 (ulcerative colitis), and 576 (primary sclerosing cholangitis).
2) Fee applies to multiple random screening biopsies (>34 sites) for malignant changes in inflammatory bowel disease, or targeted biopsies using 1) Dye-chromoendoscopy (DCE), 2) virtual chromoendoscopy (VCE) with narrow band imaging (NBI), or
3) high-definition white-light-endoscopy (HD-WLE) with HD-iScan, or equivalent. Not payable to standard definition white light endoscopy (SD-WLE).

Committee Comments

- The committee notes this proposal was replaced by PFAF 25-256.

16.5 Oesophageal Studies: Proposed revisions and fee increases (PFAF 23-203, 23-208, 23-211)

16.6 G350 - Gastroenterology - Oesophageal motility study(ies) with manometry

16.7 G251 - Oesophageal Studies - Oesophageal pH study for reflux, with installation of acid

16.8 G351 - Oesophageal Studies - Oesophageal pH study for reflux, with installation of acid, with 24 hour monitoring

16.9 G354 - Oesophageal Studies - Anal-rectal manometry

Constituency Proposal

- The constituency requested the following:

PFAF	Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
208	G350	oesophageal motility study(ies) with manometry	$76.05	$95.00	$18.95	24.9%
203	G251	oesophageal pH study for reflux, with installation of acid	$27.05	Delete	-$27.05	-100.0%
208	G351	oesophageal p H study for reflux, with installation of acid, with 24-hour monitoring	$31.85	$50.00	$18.15	57.0%
211	G354	Anal-rectal manometry	$38.50	$60.00	$21.50	55.8%

Committee Comments

- The committee recommends combining G251 and G351. The descriptor for G351 would be expanded and G251 would be deleted.
- The committee notes that PFAF 23-208 was replaced by PFAF 25-153.
- The committee notes that PFAF 23-211 was replaced by PFAF 25-151.

16.10 E749 - when Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z512, Z555 or Z580 rendered in private office, add (PFAF 23-213)

Constituency Proposal

- The constituency requested the following changes to E749,
  i. Fee value increase from $22.35 to $24.50, by 9.6 per cent, and
  ii. Payment rule revised as follows:

E749 is NOT eligible for payment in a hospital or Independent Health Facility

(Revisions underlined)

Committee Comments

- The committee supports the proposed payment rule change.
- A review of billing data failed to demonstrate that the proposed value change would address an intrasectional relativity issue.
- The committee does not support the value change proposed.

16.11 Consultation and Assessment Fees (PFAF 23-228)

Constituency Proposal

- The constituency requested that their consultation and assessment fee codes be at the same values as internal medicine consultation and assessment fee codes

Fee Code	Current or Proposed Descriptor	Current	Proposed fee value	$ Increase	% Increase
A415	Gastroenterology - Consultation	$157.00	$164.90	$7.90	5.0%
A413	Gastroenterology - Medical specific assessment	$80.35	$81.55	$1.20	1.5%
C415	Gastroenterology - Non-emergency hospital in-patient services - Consultation	$157.00	$164.90	$7.90	5.0%

Committee Comments

- The committee notes this proposal is replaced by PFAF 25-155.

16.12 G353 – Oesophageal acid perfusion test and/or provocative drug testing (PFAF 25-150)

Constituency Proposal

- The constituency proposed revising the service's descriptor to modernize and match current practice, as follows:

  "Oesophageal provocation testing including: acid perfusion, ~~test and/or~~ provocative drug testing, multiple rapid swallows, rapid drink challenge or solid bolus swallows"
  (revision underline, deletions ~~strikethrough~~)

- The section proposed that the value of G353 be increased from $28.75 to $35.00 (21.7% increase).

Committee Comments

- The committee supports the descriptor changes.
- The committee supports the fee value change subject to fitting and relativity.

16.13 G354 – Anal-rectal manometry (PFAF 25-151)

Constituency Proposal

- The section proposes changing the descriptor for G354 from "Anal-rectal manometry", to "Anorectal manometry study"
- The constituency proposed the fee value of G354 be increased from 38.50 to 61.80 (60.5% increase).
- The constituency noted that the service is undervalued relative to comparators.

Committee Comments

- The committee supports the descriptor changes.
- The committee supports the fee value change subject to fitting and relativity.

16.14 G351 – Oesophageal pH study for reflux (PFAF 25-152)

Constituency Proposal

- The constituency proposed a revision to the descriptor for G351 as follows:

  "~~O~~esophageal ~~pH study for~~ reflux monitoring study for ~~with installation of acid, with~~ 24 hours or longer ~~monitoring~~"

  (revision underline, deletions ~~strikethrough~~)

- The constituency proposed a fee value change to G351 from $31.85 to $51.50 (61.7% increase)
- The constituency noted that the service is undervalued relative to comparators.

Committee Comments

- The committee supports the proposed descriptor changes.
- The committee supports the fee value change, subject to fitting and relativity.

16.15 G350 – Oesophageal Studies - Oesophageal motility study(ies) with manometry (PFAF 25-153)

Constituency Proposal

- The constituency proposed modifying the descriptor for G350 as follows:

  ~~Oesophageal~~ "Esophageal motility study(ies) with manometry and/or impedance planimetry."

  (revision underline, deletions ~~strikethrough~~)

- The constituency proposed a fee value increase from $76.05 to $97.85 (28.7% increase)
- The constituency noted that the service is undervalued relative to comparators.

Committee Comments

- The committee supports the proposed descriptor changes.
- The committee supports the fee value change, subject to fitting and relativity.

16.16 E098 – Gastroenterology chronic disease assessment premium (PFAF 25-154)

Constituency Proposal

- The constituency proposed raising the value of the Gastroenterology chronic disease assessment from 28% to 50%.
- The constituency proposed revising the payment rule C (page A99) to allow applying this premium to assessments for patients with malnutrition (263), and Celiac disease (579).

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

16.17 Multiple Fee Codes - Consultation and Assessment Fee Value Changes (PFAF 25-155)

Constituency Proposal

- The constituency proposed increases to Gastroenterology consultation and assessment codes, as follows:

Fee Code	Descriptor	Fee Value	Proposed New Fee	% Increase
A411	Gastroenterology (41) - Complex medical specific re-assessment	$70.90	**$75.25**	**6.14%**
A413	Gastroenterology (41) - Medical specific assessment	$80.35	**$85.30**	**6.16%**
A414	Gastroenterology (41) - Medical specific re-assessment	$61.25	**$65.00**	**6.12%**
A415	Gastroenterology (41) - Consultation	$157.00	**$166.60**	**6.11%**
A416	Gastroenterology (41) - Repeat consultation	$105.25	**$111.70**	**6.13%**
A418	Gastroenterology (41) - Partial assessment	$38.05	**$40.40**	**6.18%**
A545	Gastroenterology (41) - Limited consultation	$105.25	**$111.70**	**6.13%**
C411	Gastroenterology (41) - Complex medical specific re-assessment	$70.90	**$75.25**	**6.14%**
C412	Gastroenterology (41) - Subsequent visits - first five weeks, per visit	$34.10	**$36.20**	**6.16%**
C413	Gastroenterology (41) - Medical specific assessment	$80.35	**$85.30**	**6.16%**
C414	Gastroenterology (41) - Medical specific re-assessment	$61.25	**$65.00**	**6.12%**
C415	Gastroenterology (41) - Consultation	$157.00	**$166.60**	**6.11%**
C416	Gastroenterology (41) - Repeat consultation	$105.25	**$111.70**	**6.13%**

C417	Gastroenterology (41) - Subsequent visits - sixth to thirteenth week inclusive (maximum 3 per patient per week, per visit	$34.10	**$36.20**	**6.16%**
C418	Gastroenterology (41) - Concurrent care, per visit	$34.10	**$36.20**	**6.16%**
C419	Gastroenterology (41) - Subsequent visits - after thirteenth week (maximum 6 per patient per month), per visit	$34.10	**$36.20**	**6.16%**
C545	Gastroenterology (41) - Limited consultation	$105.25	**$111.70**	**6.13%**

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

16.18 Kxxx – Home Parenteral Nutrition Team Management Fee (PFAF 25-243)

Constituency Proposal

- The constituency proposed a parenteral Nutrition team management fee for the continuing care and management of a patient who is registered in a Home Parental Nutrition Program.
- This is a fee that will be billed weekly to reimburse the clinician most responsible for the patient's care.
- The proposed fee value is $33.00 per patient per week.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

16.19 Exxx - Complex extended assessment add-on (PFAF 25-246)

Constituency Proposal

- The constituency proposed the creation of an add-on fee code that would be billed by a physician who is seeing a patient in follow-up assessment in the ambulatory care setting, where the duration of the direct patient contact with the patient exceeds 45 minutes.
- The section proposed the following payment rules:
    1. There must be a concomitant claim for a follow-up assessment (A411, A413, A414, or A418)
    2. The patient must not be admitted to a hospital
    3. The physician cannot have submitted a claim on the same day for that patient for any endoscopic orprocedural service
    4. This code is not applicable if there is a concomitant claim for the E098 fee code
    5. A physician cannot make a claim for this service more that 2 times in any seven-day period.
    6. The physician must provide documentation that there was at least 45 minutes of direct patient contact time, and must retain evidence supporting the reported time
- The proposed value for the add-on code is $22.50.

Committee Comments

- The committee does not support this specific proposal but continues to explore time informed consults and assessments as a major initiative.

16.20 Gxxx - Radiofrequency Ablation for Dysplastic Barrett's Esophagus (PFAF 25-253)

Constituency Proposal

- The constituency proposed a new fee code for use of endoscopic application of radiofrequency to ablate Barret''s esophagus when there is known dysplasia.
- The constituency proposed the following payment rules:

  1.Only payable to gastroenterologists and general surgeons who have been trained to perform this procedure.
  2.Only payable to diagnostic code 530 (Diseases of Esophagus, Stomach and Duodenum: Esophagitis, cardiospasm, ulcer of esophagus; strictures, stenosis, or obstruction of esophagus)
  3. Only payable in conjunction with Z399, Z515, or Z527 procedure
- The proposed fee value is $215.00.

Committee Comments

- The committee supports the creation of the fee code and the proposed fee value, subject to fitting and relativity.

16.21 Exxx - Total excision of very large sessile polyp or lesion (>3cm) of the upper GI tract using endoscopy mucosal resection (EMR) (PFAF 25-255)

Constituency Proposal

- The constituency proposes an add on code for total excision of very large sessile polyp or lesion (>3cm) of the upper GI tract using endoscopy mucosal resection (EMR) technique through oesophageoscopy-gastroscopy, with or without duodenoscopy, and may include fulguration and hemostasis.
- The proposed fee code is an add-on to Z399, Z400, or Z527, at a value of $227.65 each.

Committee Comments

- The committee notes that schedule language needs to specify that to bill this code, a polyp or lesion must be greater than 3cm.
- The committee supports the proposed fee value, subject to fitting and relativity.

16.22 E785 - multiple screening biopsies (> 34 sites) for malignant changes in ulcerative colitis, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555..... add (PFAF 25-256)

Constituency Proposal

- The constituency proposed the fee the code's descriptor be re-written as:

  "Multiple biopsies for surveillance of inflammatory bowel disease-associated colorectal cancer or dysplasia, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, or Z555…add"
- The constituency proposes the following payment rules:

1.Must be billed with diagnostic code 555 for Crohn's disease, 556 for ulcerative colitis, and 576 for primary sclerosing cholangitis.
2. Fee applies to multiple random screening biopsies (>34 sites) for malignant changes in inflammatory bowel disease, or targeted biopsies using 1) Dye-chromoendoscopy (DCE), 2) virtual chromoendoscopy (VCE) with narrow band imaging (NBI), or 3) high-definition white-light-endoscopy (HD-WLE) with HD-iScan, or equivalent. Not payable to standard definition white light endoscopy (SD-WLE).

Committee Comments

- The committee supports this proposal.

17 Gastroenterology (Member Group)

17.1 E798 - Management of complicated upper gastrointestinal bleeding by any technique in hemodynamically unstable patients with active bleeding during endoscopy (PFAF 25-341)

Member Group Proposal

- The group proposed a revision to the E798 fee code for the procedure of management of complicated upper gastrointestinal bleeding by any technique in hemodynamically unstable patients with active bleeding during endoscopy and that it be co-billable with Z584.
- The proposal stated that management of bleeding is not limited to gastroscopy and colonoscopy procedures; enteroscopy is generally performed to specifically identify and manage bleeding lesions and should therefore be eligible for payment of this code.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

17.2 E797- Management of uncomplicated upper or lower gastrointestinal bleeding by any technique (e.g. laser, injection, diathermy, banding etc.) (PFAF 25-342)

Member Group Proposal

- The group proposed a revision to the E797 fee code for the procedure of management of uncomplicated upper or lower gastrointestinal bleeding by any technique and that it be co-billable with Z584.
- The proposal stated that management of bleeding is not limited to gastroscopy and colonoscopy procedures; enteroscopy is generally performed to specifically identify and manage bleeding lesions and should therefore be eligible for payment of this code.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

17.3 Double Balloon Enteroscopy (Specialized Enteroscopy) (PFAF 25-343)

Member Group Proposal

- The group proposed the creation of a new fee code for double balloon enteroscopy, valued at $450 as the minimum for a 60-minute procedure and valued at an additional $100 for procedures longer than 90 minutes.
- This procedure is a specialized enteroscopy that permits investigation and treatment of diseases deep in the small bowel beyond reach of conventional endoscopy.
- This group stated that this procedure entails greater complexity and time as compared to a small bowel push enteroscopy (Z584), which is costed at $185.15.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

17.4 G332 - Capsule Endoscopy (PFAF 25-344)

Member Group Proposal

- The group proposed an increase to the fee code G332 from $122.50 to $185 (an increase of 51.02%).
- The group argued that the current payment does not reflect workload or complexity.
- The group also proposed a revision to the payment rule G332.
- Specifically, the group requested the deletion of the following payment rule:

  ~~- G332 is only insured when rendered for the purpose of identifying gastrointestinal bleeding of obscure origin when all appropriate conventional techniques have failed to identify a source.~~

  (deletions ~~strikethrough~~)

- The group stated that this is outdated, and capsule is standard of care for other indications (e.g. Peutz-Jeghers syndrome, small bowel Crohn's beyond reach of conventional endoscopy, small bowel tumors, etc…).

Committee Comments

- The committee supports a change in the value of this fee code, subject to fitting and relativity.
- The committee supports the proposed rule change and recommends that commentary be added to reference current practice guidelines.

17.5 Exxx - Electrohydraulic Lithotripsy for treatment of choledocholithiasis (PFAF 25-345)

Member Group Proposal

- The group proposed the creation of a new fee code for Electrohydraulic Lithotripsy for treatment of choledocholithiasis, valued at $175.

- This service is for patients with choledocholithiasis which has been unsuccessfully treated by standard ERCP techniques such as balloon extraction, basket extraction, or mechanical lithotripsy.

Committee Comments

- The committee was not provided with evidence that this procedure significantly changes the time for the overall management of choledocholithiasis.
- The committee supports the creation of this E-code, but at a lower fee value to be determined by fitting and relativity.

18 General & Family Practice

18.1 Relativity fee value changes to various visit codes (PFAF 23-023)

Constituency Proposal

- The constituency requested several increases to fee codes listed in the table below.
- The constituency updated PFAF 23-023 with new fee value changes when allocation became known.

Fee Code	Descriptor	Fee Value	New Proposed Fee Value	% Increase
A001	GP/FP (00) - Minor assessment	$23.75	$26.97	13.6%
A002	GP/FP (00) - Enhanced 18 month well baby visit	$62.20	$74.64	20.0%
A003	GP/FP (00) - General assessment	$87.35	$96.09	10.0%
A004	GP/FP (00) - General re-assessment	$38.35	$39.42	2.8%
A005	GP/FP (00) - Consultation	$87.90	$90.36	2.8%
A006	GP/FP (00) - Repeat consultation	$45.90	$47.19	2.8%
A007	GP/FP (00) - Intermediate assessment or well-baby care	$37.95	$45.54	20.0%
A008	GP/FP (00) - Mini assessment	$13.05	$13.42	2.8%
A010	GP focused practice consultation by Video	$87.90	$90.36	2.8%
A011	GP focused practice repeat consultation by Video	$45.90	$47.19	2.8%
A100	GP/FP (00) - General/Family physician emergency department assessment	$76.90	$79.05	2.8%
A770	Geriatrics (07) - Extended comprehensive geriatric consultation	$401.30	$412.54	2.8%
A771	GP/FP (00) - Certification of death	$20.60	$21.18	2.8%
A777	GP/FP (00) - Intermediate assessment - Pronouncement of death	$37.95	$45.54	20.0%
A888	GP/FP (00) - Emergency department equivalent - partial assessment	$37.95	$45.54	20.0%
A900	GP/FP (00) - Complex house call assessment	$54.50	$65.40	20.0%

A905	GP/FP (00) - Limited consultation	$73.25	$75.30	2.8%
A906	GP focused practice limited consultation by Video	$73.25	$75.30	2.8%
A911	GP/FP (00) - Special family and general practice consultation	$150.70	$154.92	2.8%
A912	GP/FP (00) - Comprehensive family and general practice consultation	$226.05	$232.38	2.8%
A914	GP focused practice comprehensive consultation by Video	$226.05	$232.38	2.8%
A917	GP/FP (00) - Focused practice assessment (FP) - Sport medicine FPA	$37.95	$45.54	20.0%
A933	GP/FP (00) - On-call admission assessment	$79.90	$82.14	2.8%
A945	GP/FP (00) - Special palliative care consultation	$159.20	$163.66	2.8%
A947	GP/FP (00) - Focused practice assessment (FP) - Sleep medicine FPA	$37.95	$39.01	2.8%
A960	SVP - Physician Office - Weekdays (07:00 - 17:00) - Travel Premium	$36.40	$37.42	2.8%
A962	SVP - Physician Office - Evenings (17:00 - 24:00) Mon-Fri - Travel Premium	$36.40	$37.42	2.8%
A963	SVP - Physician Office - Sat., Sun and Holidays (07:00 - 24:00) - Travel Premium	$36.40	$37.42	2.8%
A964	SVP - Physician Office - Nights (00:00 - 07:00) - Travel Premium	$36.40	$37.42	2.8%
A967	GP/FP (00) - Focused practice assessment (FP) - Care of the elderly FPA	$37.95	$45.54	20.0%
A990	SVP - Physician Office - Weekdays (07:00-17:00) - First Person Seen	$20.00	$20.56	2.8%
A994	SVP - Physician Office - Evenings (17:00-24:00) Mon-Fri - First Person Seen	$60.00	$72.00	20.0%
A996	SVP - Physician Office - Nights (00:00-07:00) - First Person Seen	$100.00	$102.80	2.8%
B962	SVP - Patient's Home - (17:00 - 24:00) Mon-Fri Non-elective - Travel Premium	$36.40	$43.68	20.0%
B963	SVP - Patient's Home - Sat., Sun. and Holidays (07:00 - 24:00) Non-elective - Travel Premium	$36.40	$43.68	20.0%
B964	SVP - Patient's Home - (00:00 - 07:00) Non-elective - Travel Premium	$36.40	$37.42	2.8%
B966	SVP - Palliative Care Home Visit - Travel Premium	$36.40	$43.68	20.0%
B988	SVP - Geriatric Home Visit - excluding Nights (00:00 - 07:00) - First Person Seen	$82.50	$99.00	20.0%
B990	SVP - Patient's Home - Non-Elective Weekdays (07:00-17:00) and Elective home visit - First Person Seen	$27.50	$33.00	20.0%
B992	SVP - Patient's Home - Weekdays (07:00- 17:00) with Sacrifice of Office Hours - First Person Seen	$44.00	$52.80	20.0%

B993	SVP - Patient's Home - Sat., Sun. and Holidays (07:00 - 24:00) Non-elective - First Person Seen	$82.50	$84.81	2.8%
B994	SVP - Patient's Home - (17:00- 24:00) Mon-Fri Non-elective - First Person Seen	$66.00	$79.20	20.0%
B996	SVP - Patient's Home - (00:00-07:00) Non-elective - First Person Seen	$110.00	$132.00	20.0%
B997	SVP - Palliative Care Home Visit - Nights (00:00 - 07:00) - First Person Seen	$110.00	$113.08	2.8%
B998	SVP - Palliative Care Home Visit - excluding Nights (00:00 - 07:00) - First Person Seen	$82.50	$90.75	10.0%
C002	GP/FP (00) - Subsequent visits - first five weeks, per visit	$34.10	$35.05	2.8%
C003	GP/FP (00) - General assessment	$87.35	$89.80	2.8%
C006	GP/FP (00) - Repeat consultation	$45.90	$47.19	2.8%
C007	GP/FP (00) - Subsequent visits - sixth to thirteenth week inclusive (maximum 3 per patient per week, per visit	$34.10	$35.05	2.8%
C009	GP/FP (00) - Subsequent visits - after thirteenth week (maximum 6 per patient per month), per visit	$34.10	$35.05	2.8%
C121	Additional visits due to intercurrent illness, per visit	$34.10	$35.05	2.8%
C122	Subsequent visits by the Most Responsible Physician (MRP) - day following the hospital admission assessment	$61.15	$62.86	2.8%
C123	Subsequent visits by the Most Responsible Physician (MRP) - second day following the hospital assessment	$61.15	$62.86	2.8%
C124	Subsequent visits by the Most Responsible Physician (MRP) - day of discharge	$61.15	$62.86	2.8%
C771	GP/FP (00) - Certification of death	$20.60	$21.18	2.8%
C777	GP/FP (00) - Intermediate assessment - Pronouncement of death	$37.95	$39.01	2.8%
C905	GP/FP (00) - Limited consultation	$74.25	$76.33	2.8%
C911	GP/FP (00) - Special family and general practice consultation	$150.70	$154.92	2.8%
C912	GP/FP (00) - Comprehensive family and general practice consultation	$226.05	$232.38	2.8%
C933	GP/FP (00) - On-call admission assessment	$79.90	$82.14	2.8%
C960	SVP - Hospital In-patient - Weekdays (07:00 - 17:00) - Travel Premium	$36.40	$43.68	20.0%
C961	SVP - Hospital In-patient - Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours - Travel Premium	$36.40	$37.42	2.8%
C962	SVP - Hospital In-patient - Evenings (17:00- 24:00) Mon - Fri - Travel Premium	$36.40	$43.68	20.0%
C963	SVP - Hospital In-patient - Sat., Sun and Holidays (07:00 - 24:00) - Travel Premium	$36.40	$43.68	20.0%

C986	SVP - Hospital In-patient -Sat., Sun., and Holidays (07:00-24:00) - First Person Seen	$75.00	$77.10	2.8%
C987	SVP - Hospital In-patient - Sat., Sun., and Holidays (07:00-24:00) - Additional Person(s) seen	$75.00	$77.10	2.8%
C990	SVP - Hospital In-patient - Weekdays Daytime (07:00-17:00) - First Person Seen	$20.00	$24.00	20.0%
C993	SVP - Hospital In-patient - Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours - Additional Person(s) seen	$40.00	$48.00	20.0%
C995	SVP - Hospital In-patient - Evenings (17:00-24:00) Mon-Fri - Additional Person(s) seen	$60.00	$61.68	2.8%
C997	SVP - Hospital In-patient - Nights (00:00-07:00) - Additional Person(s) seen	$100.00	$102.80	2.8%
D014	Shoulder, Arm and Chest - Dislocations - Acromio-clavicular/sterno-clavicular - no reduction	$67.80	$69.70	2.8%
D016	Shoulder, Arm and Chest - Dislocations - Glenohumeral joint - closed reduction with anaesthetic	$111.40	$114.52	2.8%
E079	GP/FP (00) - Initial discussion with patient re: smoking cessation - Initial discussion with patient, to eligible services, add	$15.55	$15.99	2.8%
E080	Assessments - First visit by Primary Care Physician after hospital discharge premium, to other service listed in payment rule 5, add	$25.25	$25.96	2.8%
E391	Fractures of the Spine - vertebroplasty, each additional level, to N570 or E388, add	$252.95	$260.03	2.8%
E430	Papanicolaou Smear - when Papanicolaou smear is performed outside of hospital, to G365, add	$11.95	$14.34	20.0%
E431	Papanicolaou smear - when Papanicolaou smear is performed outside of hospital, to G394, add	$11.95	$14.34	20.0%
E542	when performed outside hospital, to G328, G378, G367, G370, R040, R041, R048, R049, R050, R094, R160, R161, R162, R163, R164, R165, S003, S006, Z080, Z081, Z082, Z083, Z084, Z085, Z096, Z101, Z103, Z104, Z106, Z114, Z116, Z122, Z123, Z124, Z125, Z126, Z12	$11.55	$13.86	20.0%
E545	Vasectomy - when performed outside hospital, add	$11.55	$13.86	20.0%
F005	Hand and Wrist - Fractures - Phalanx - closed reduction	$99.25	$102.03	2.8%
F007	Hand and Wrist - Fractures - Phalanx - open reduction	$298.45	$306.81	2.8%
F008	Hand and Wrist - Fractures - Metacarpal - no reduction, one or more, rigid immobilization	$49.20	$50.58	2.8%
F009	Hand and Wrist - Fractures - Metacarpal - closed reduction	$99.25	$102.03	2.8%
F018	Hand and Wrist - Fractures - Scaphoid - no reduction, rigid immobilization	$49.20	$50.58	2.8%

F027	Elbow and Forearm - Fractures - Radius - distal, e.g. Colles', Smith's, or Barton's fracture - no reduction, rigid immobilization	$67.75	$69.65	2.8%
F028	Elbow and Forearm - Fractures - Radius - distal, e.g. Colles', Smith's, or Barton's fracture - closed reduction, under local or regional anaesthetic	$109.45	$112.51	2.8%
F031	Elbow and Forearm - Fractures - Radius or ulna - no reduction, rigid immobilization	$81.30	$83.58	2.8%
F034	Elbow and Forearm - Fractures - Olecranon - no reduction, rigid immobilization	$126.25	$129.79	2.8%
F046	Elbow and Forearm - Fractures - Radius - distal, e.g. Colles', Smith's, or Barton's fracture - closed reduction, under general anaesthetic	$149.35	$153.53	2.8%
F056	Foot and Ankle - Fractures - Phalanx - no reduction - rigid immobilization	$49.20	$50.58	2.8%
F061	Foot and Ankle - Fractures - Metatarsus - one or more	$49.20	$50.58	2.8%
F062	Foot and Ankle - Fractures - Metatarsus - with rigid immobilization	$67.75	$69.65	2.8%
F066	Foot and Ankle - Fractures - Tarsus excluding os calcis - no reduction - rigid immobilization	$98.10	$100.85	2.8%
F074	Foot and Ankle - Fractures - Ankle - no reduction - rigid immobilization	$67.75	$69.65	2.8%
F075	Foot and Ankle - Fractures - Ankle - closed reduction	$144.80	$148.85	2.8%
F078	Fibula and Tibia - Fractures - Tibia with or without fibula - no reduction, rigid immobilization	$115.95	$119.20	2.8%
F082	Fibula and Tibia - Fractures - Fibula - no reduction, rigid immobilization	$67.75	$69.65	2.8%
F095	Femur - Fractures - Closed reduction - traction - adultor adolescent	$407.35	$418.76	2.8%
G009	Laboratory Medicine - Miscellaneous Tests - Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)	$4.45	$4.90	10.1%
G014	Laboratory Medicine - Miscellaneous Tests - Rapid streptococcal test	$5.70	$6.84	20.0%
G202	Allergy - Hyposensitisation - each injection	$4.45	$9.00	102.3%
G212	Allergy - Hyposensitisation - when sole reason for visit (including first injection)	$9.75	$15.00	53.9%
G271	Anticoagulant supervision - long-term, telephone advice, per month	$12.75	$13.11	2.8%
G313	Electrocardiography (ECG) - Electrocardiogram - twelve lead - professional component - must include written interpretation	$4.45	$4.57	2.7%

G328	Aspiration of bursa or complex joint, with or without injection	$39.80	$47.76	20.0%
G329	Aspiration of bursa or complex joint, with or without injection - each additional bursa or complex joint, to a maximum of 2	$20.25	$24.30	20.0%
G365	Papanicolaou Smear - periodic	$12.00	$15.00	25.0%
G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	$20.25	$22.99	13.5%
G371	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath - each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5	$19.90	$21.89	10.0%
G372	Injections or Infusions - with visit (each injection)/each additional injection	$3.89	$6.50	67.1%
G373	Injections or Infusions - sole reason (first injection)	$6.75	$13.50	100.0%
G375	Injections or Infusions, INTRALESIONAL INFILTRATION - one or two lesions	$8.85	$10.62	20.0%
G377	Injections or Infusions, INTRALESIONAL INFILTRATION - 3 or more lesions	$13.30	$15.96	20.0%
G378	Insertion of intrauterine contraceptive device	$39.95	$47.94	20.0%
G384	Injections or Infusions - Infiltration of tissues for trigger point	$8.85	$9.10	2.8%
G385	Injections or Infusions - Infiltration of tissues for trigger point - for each additional site (to a maximum of 2), add.	$4.55	$4.68	2.9%
G391	Critical Care - Amount payable per physician per patient for the first three physicians - after first ¼ hour per ¼ hour (or part thereof)/Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof)	$30.60	$31.46	2.8%
G394	Papanicolaou Smear - additional for: -follow-up of abnormal pap smear; or-follow-up of inadequate pap smear; or-annually in a patient who is immunocompromised, e.g. HIV-positive or taking long-term immunosuppressants; or - a patient with a history of oncog	$12.00	$14.40	20.0%
G395	Critical Care, OTHER CRITICAL CARE - Amount payable per physician per patient for the first three physicians - first ¼ hour (or part thereof)	$57.45	$59.06	2.8%
G398	Pessary - Medical management of prolapse - initial pessary fitting or re-fitting as required. This service is eligible for payment in addition to any applicable consultation or assessment. Maximum one per patient per 12-month period	$63.65	$65.43	2.8%
G403	Particle repositioning maneuvre for benign paroxysmalpositional vertigo	$21.15	$21.74	2.8%

G511	Telephone management regarding a patient receiving palliative care at home, per call	$17.75	$18.25	2.8%
G521	Critical Care, LIFE THREATENING CRITICAL CARE - Amount payable per physician per patient for the first three physicians: first ¼ hour (or part thereof)	$111.80	$122.98	10.0%
G538	IMMUNIZATION - Other immunizing agents not listed above	$5.80	$9.00	55.2%
G552	Removal of intrauterine contraceptive device	$20.00	$24.00	20.0%
G590	IMMUNIZATION - Influenza agent	$5.65	$9.00	59.3%
G593	COVID-19 vaccine	$13.00	$13.36	2.8%
G700	Basic fee-per-visit premium for procedures marked (+)	$5.60	$9.00	60.7%
G840	IMMUNIZATION - Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP-IPV) - paediatric	$5.40	$9.00	66.7%
G841	IMMUNIZATION - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric	$6.35	$9.00	41.7%
G842	IMMUNIZATION - Hepatitis B (HB)	$5.40	$9.00	66.7%
G843	IMMUNIZATION - Human Papillomavirus (HPV)	$5.40	$9.00	66.7%
G844	IMMUNIZATION - Meningococcal C Conjugate (Men-C)	$5.40	$9.00	66.7%
G845	IMMUNIZATION - Measles, Mumps, Rubella (MMR)	$5.40	$9.00	66.7%
G846	IMMUNIZATION - Pneumococcal Conjugate	$5.40	$9.00	66.7%
G847	IMMUNIZATION - Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult	$5.40	$9.00	66.7%
G848	IMMUNIZATION - Varicella (VAR)	$5.40	$9.00	66.7%
H055	Emergency Medicine (12) - Consultation	$106.80	$109.79	2.8%
H104	GP/FP (00) - Monday to Friday - Daytime (08:00h to 17:00h) - Re-assessment	$17.10	$20.52	20.0%
H122	GP/FP (00) - Nights (00:00h to 08:00h) - Comprehensive assessment and care	$76.95	$79.10	2.8%
H153	GP/FP (00) - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Multiple systems assessment	$58.90	$70.68	20.0%
H960	SVP - Emergency Department by Emergency Department Physician - Weekdays Daytime (07:00-17:00) - Travel Premium	$36.40	$37.42	2.8%
H962	SVP - Emergency Department by Emergency Department Physician - Evenings (17:00-24:00) Mon-Fri - Travel Premium	$36.40	$37.42	2.8%
H963	SVP - Emergency Department by Emergency Department Physician - Sat., Sun. & Holidays (07:00-24:00) Travel Premium	$36.40	$37.42	2.8%
H964	SVP - Emergency Department by Emergency Department Physician Nights (00:00-07:00) - Travel Premium	$36.40	$37.42	2.8%

H981	SVP - Emergency Department by Emergency Department Physician - Weekdays Daytime (07:00-17:00) - Additional Person(s) seen	$20.00	$20.56	2.8%
H984	SVP - Emergency Department by Emergency Department Physician - Evenings (17:00-24:00) Mon-Fri - First Person Seen	$60.00	$61.68	2.8%
H985	SVP - Emergency Department by Emergency Department Physician - Evenings (17:00-24:00) Mon-Fri - Additional Person(s) seen	$60.00	$61.68	2.8%
H986	SVP - Emergency Department by Emergency Department Physician - Nights (00:00-07:00) - First Person Seen	$100.00	$102.80	2.8%
H988	SVP - Emergency Department by Emergency Department Physician - Sat., Sun. & Holidays (07:00-24:00) - First Person Seen	$75.00	$77.10	2.8%
H989	SVP - Emergency Department by Emergency Department Physician - Sat., Sun. & Holidays (07:00-24:00) - Additional Person(s) seen	$75.00	$77.10	2.8%
K002	GP/FP (00) - Interviews - 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	$70.10	$79.60	13.6%
K003	GP/FP (00) - Interviews - Interviews with Children's Aid Society (CAS) or legal guardian on behalf of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent, per unit	$70.10	$79.60	13.6%
K004	GP/FP (00) - Psychotherapy - Family - 2 or more family members in attendance at the same time, per unit	$76.10	$78.23	2.8%
K005	GP/FP (00) - Primary mental health care - Individual care, per unit	$70.10	$79.60	13.6%
K006	GP/FP (00) - Hypnotherapy - Individual care, per unit	$70.10	$79.60	13.6%
K007	GP/FP (00) - Psychotherapy - Individual care, per unit	$70.10	$72.06	2.8%
K008	GP/FP (00) - Interviews - Diagnostic interview and/or counselling with child and/or parent for psychological problems or learning disabilities, per unit	$70.10	$79.60	13.6%
K012	GP/FP (00) - Psychotherapy - Group - per member - first 12 units per day - 4 people, per unit	$17.65	$18.14	2.8%
K013	GP/FP (00) - Counselling - Individual care - first three units of K013 and K040 combined per patient per provider per 12-month period, per unit	$70.10	$79.60	13.6%
K015	GP/FP (00) - Counselling - Counselling of relatives - on behalf of catastrophically orterminally ill patient - 1 or more persons, per unit	$70.10	$79.60	13.6%
K017	GP/FP (00) - Periodic health visit - child	$45.25	$49.78	10.0%

K019	GP/FP (00) - Psychotherapy - Group - per member - first 12 units per day - 2 people, per unit	$35.10	$36.08	2.8%
K020	GP/FP (00) - Psychotherapy - Group - per member - first 12 units per day - 3 people, per unit	$23.35	$24.00	2.8%
K022	GP/FP (00) - HIV primary care, per unit	$70.10	$79.60	13.6%
K023	GP/FP (00) - Palliative care support, per unit	$74.70	$79.60	6.6%
K024	GP/FP (00) - Psychotherapy - Group - per member - first 12 units per day - 5 people, per unit	$14.55	$14.96	2.8%
K028	GP/FP (00) - STD management, per unit	$70.10	$79.60	13.6%
K029	GP/FP (00) - Insulin Therapy Support (ITS), per unit	$70.10	$79.60	13.6%
K030	GP/FP (00) - Diabetic management assessment (DMA)	$40.55	$46.04	13.5%
K031	GP/FP (00) - Mandatory blood testing act - Physician report - Completion of Form 1 - Physician report in accordance with the Mandatory Blood Testing Act	$102.50	$105.37	2.8%
K032	GP/FP (00) - Specific neurocognitive assessment	$70.10	$79.60	13.6%
K033	GP/FP (00) - Counselling - Individual care - additional units per patient per provider per 12-month period, per unit	$49.35	$56.04	13.6%
K037	GP/FP (00) - Fibromyalgia/chronic fatigue syndrome care, per unit	$70.10	$79.60	13.6%
K038	GP/FP (00) - Long-Term Care application - Completion of Long-Term Care health report form	$45.15	$46.41	2.8%
K039	GP/FP (00) - Smoking cessation follow-up visit	$33.45	$127.11	280.0%
K040	GP/FP (00) - Counselling - 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	$70.10	$79.60	13.6%
K041	GP/FP (00) - Counselling - 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	$50.20	$51.61	2.8%
K070	GP/FP (00) - Home care application - Application	$31.75	$34.93	10.0%
K071	GP/FP (00) - Home care supervision - Acute home care supervision (first 8 weeks following admission to home care program)	$21.40	$22.00	2.8%
K072	GP/FP (00) - Home care supervision - Chronic home care supervision (after the 8th week following admission to the home care program)	$21.40	$22.00	2.8%
K077	Geriatrics (07) - Geriatric telephone support, per unit	$40.05	$41.17	2.8%
K121	GP/FP (00) - Hospital in-patient case conference, per unit	$32.45	$33.36	2.8%

K124	GP/FP (00) - Long-term care/CCAC case conference, per unit	$32.45	$33.36	2.8%
K130	GP/FP (00) - Periodic health visit - adolescent	$77.20	$87.66	13.6%
K131	GP/FP (00) - Periodic health visit - adult age 18 to 64 inclusive	$56.95	$64.67	13.6%
K132	GP/FP (00) - Periodic health visit – adult 65 years of age and older	$80.95	$91.92	13.6%
K133	Periodic health visit for adults with Intellectual and Developmental Disabilities (IDD)	$160.00	$164.48	2.8%
K140	GP/FP (00) - Chronic disease shared appointment - per patient - maximum 8 units per patient per day - 2 patients, per unit	$35.10	$36.08	2.8%
K623	GP/FP (00) PSY (19) Certification of mental illness - Form 1 - Application for psychiatric assessment	$117.05	$120.33	2.8%
K680	GP/FP (00) - Substance abuse - extended assessment, per unit	$70.10	$79.60	13.6%
K703	GP/FP (00) - Geriatric out-patient case conference, per unit	$32.45	$33.36	2.8%
K705	GP/FP (00) - Long-term care - high risk patient conference, per unit	$32.45	$33.36	2.8%
K706	GP/FP (00) - Convalescent care program case conference	$32.45	$33.36	2.8%
K708	GP/FP (00) - Multidisciplinary cancer conference - MCC Participant, per patient	$32.45	$33.36	2.8%
K730	GP/FP (00) - Physician to physician telephone consultation - Referring physician	$32.45	$33.36	2.8%
K731	GP/FP (00) - Physician to physician telephone consultation - Consultant physician	$41.85	$43.02	2.8%
K732	GP/FP (00) - CritiCall telephone consultation - Referring physician	$32.45	$33.36	2.8%
K736	GP/FP (00) - Physician on duty in an emergency department or a hospital urgent care clinic - CritiCall telephone consultation - Referring physician	$32.45	$33.36	2.8%
K738	GP/FP (00) - Physician to physician e-consultation – Referring physician	$16.00	$16.45	2.8%
K960	SVP -Emergency Department - Weekdays (07:00-17:00) - Travel Premium	$36.40	$37.42	2.8%
K962	SVP -Emergency Department Evenings (17:00-24:00) Mon-Fri - Travel Premium	$36.40	$37.42	2.8%
K963	SVP -Emergency Department Sat., Sun. & Holidays (07:00-24:00) - Travel Premium	$36.40	$37.42	2.8%
K991	SVP -Emergency Department - Weekdays (07:00-17:00) - Additional Person(s) seen	$20.00	$20.56	2.8%
K994	SVP -Emergency Department - Evenings (17:00-24:00) Mon-Fri Travel Prem - First Person Seen	$60.00	$61.68	2.8%

K996	SVP hospital emergency department (00:00h - 07:00h) - First Person Seen	$100.00	$102.80	2.8%
K997	SVP hospital emergency department (00:00h - 07:00h) - Additional Person(s) seen	$100.00	$120.00	20.0%
K998	SVP Emergency Department - Sat., Sun and Holidays (07:00 - 24:00) - First Person Seen	$75.00	$77.10	2.8%
P003	Prenatal Care - General assessment (major prenatal visit)	$80.35	$91.24	13.6%
P004	Prenatal Care - Minor prenatal assessment	$38.15	$43.32	13.6%
P005	Prenatal Care - Prenatal care - Antenatal Preventative Health Assessment	$47.70	$49.04	2.8%
P008	Labour - Delivery - Postnatal care in office	$36.85	$44.22	20.0%
P009	Labour - Delivery - Attendance at labour and delivery	$498.70	$512.66	2.8%
Q040	GP/FP (00) - Diabetes management incentive (DMI)	$60.00	$66.00	10.0%
Q042	Smoking Cessation Counselling Fee	$7.50	$7.71	2.8%
Q043	New Patient Fee Abnormal Colorectal Cancer (CRC)/ Increased Risk Payment Based on age of patient - 75 years of age and over	$230.00	$236.44	2.8%
Q590	Basic Flu Shot Fee Per Visit Premium	$5.10	$9.00	76.5%
Q593	COVID-19 Vaccine Sole Reason Premium	$5.60	$5.76	2.9%
Q888	Weekend Access for FHO Patients	$37.95	$45.54	20.0%
Q998	SVP - Other (non-professional setting not listed) - Sat., Sun. And Holidays (07:00-24:00) - First Person Seen	$75.00	$77.10	2.8%
R031	Malignant Lesions Including Biopsy of Each Lesion - Single or Multiple Sites - Other areas - Curettage, electrodesiccation or cryosurgery - single lesion	$55.05	$66.06	20.0%
R032	Malignant Lesions Including Biopsy of Each Lesion - Single or Multiple Sites - Other areas - Curettage, electrodesiccation or cryosurgery - two lesions	$90.70	$93.24	2.8%
R033	Malignant Lesions Including Biopsy of Each Lesion - Single or Multiple Sites - Other areas - Curettage, electrodesiccation or cryosurgery - three or more lesions	$181.55	$186.63	2.8%
R049	Malignant Lesions including Biopsy of Each Lesion - Single or Multiple Sites - Face or neck - Simple excision - two lesions	$139.20	$143.10	2.8%
R165	EXCISION OF PRE-MALIGNANT LESIONS INCLUDING Biopsy OF EACH LESION – SINGLE OR MULTIPLE SITES - Other areas - Simple excision - three or more lesions	$143.55	$172.26	20.0%
U960	SVP - Hospital Out-Patient Department - Weekdays (07:00 - 17:00) - Travel Premium	$36.40	$37.42	2.8%
U961	SVP - Hospital Out-Patient Department - Weekdays (07:00-17:00) with Sacrifice of Office Hours - Travel Premium	$36.40	$37.42	2.8%

U962	SVP - Hospital Out-Patient Department - Evenings (17:00-24:00) Mon-Fri - Travel Premium	$36.40	$37.42	2.8%
U963	SVP - Hospital Out-Patient Department - Sat., Sun., and Holidays (07:00-24:00) - Travel Premium	$36.40	$37.42	2.8%
U964	SVP - Hospital Out-Patient Department - Nights (00:00-07:00) - Travel Premium	$36.40	$37.42	2.8%
U990	SVP - Hospital Out-Patient Department - Weekdays (07:00 - 17:00) - First Person seen	$20.00	$20.56	2.8%
U991	SVP - Hospital Out-Patient Department - Weekdays Daytime (07:00-17:00) - Additional Person(s) seen	$20.00	$20.56	2.8%
U992	SVP - Hospital Out-Patient Department - Weekdays (07:00-17:00) with Sacrifice of Office Hours - First Person seen	$40.00	$41.12	2.8%
U993	SVP - Hospital Out-Patient Department - Weekdays (07:00-17:00) with Sacrifice of Office Hours - Additional Person(s) seen	$40.00	$41.12	2.8%
U994	SVP - Hospital Out-Patient Department - Evenings (17:00-24:00) Mon-Fri) - First Person Seen	$60.00	$61.68	2.8%
U995	SVP - Hospital Out-Patient Department - Evenings (17:00-24:00) Mon-Fri) - Additional Person(s) seen	$60.00	$61.68	2.8%
U996	SVP - Hospital Out-Patient Department - Nights (00:00-07:00) - First Person Seen	$100.00	$102.80	2.8%
U997	SVP - Hospital Out-Patient Department - Nights (00:00-07:00) - Additional Person(s) seen	$100.00	$102.80	2.8%
U999	SVP - Hospital Out-Patient Department - Sat., Sun., and Holidays (07:00-24:00) - Additional Person(s) seen	$75.00	$77.10	2.8%
W002	GP/FP (00) - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month, per visit	$34.10	$35.05	2.8%
W010	GP/FP (00) - GER (07) - Monthly management of a Nursing Home or Home for the Aged Patient - Monthly management fee (per patient per month)	$115.25	$118.48	2.8%
W102	GP/FP (00) - Admission assessment - Type 1	$69.35	$71.29	2.8%
W109	GP/FP (00) - Periodic health visit	$70.50	$72.47	2.8%
W771	GP/FP (00) - Certification of death	$20.60	$21.18	2.8%
W777	GP/FP (00) - Intermediate assessment - Pronouncement of death	$37.95	$39.01	2.8%
W872	GP/FP (00) - Nursing home or home for the aged - palliative care, per visit	$34.10	$35.05	2.8%
W882	GP/FP (00) - Chronic care or convalescent hospital - palliative care, per visit	$34.10	$40.92	20.0%
W912	GP/FP (00) - Comprehensive family and general practice consultation	$226.05	$232.38	2.8%

W961	SVP - Long-Term Care Institution - Weekdays (07:00-17:00) with Sacrifice of Office Hours - Travel Premium	$36.40	$37.42	2.8%
W962	SVP - Long-Term Care Institution - Evenings (17:00-24:00) Mon-Fri - Travel Premium	$36.40	$37.42	2.8%
W964	SVP - Long-Term Care Institution - Nights (00:00-07:00) - Travel Premium	$36.40	$37.42	2.8%
W990	SVP - Long-Term Care Institution - Weekdays (07:00 - 17:00) - First Person Seen	$20.00	$20.56	2.8%
W991	SVP - Long-Term Care Institution - Weekdays (07:00 - 17:00) - Additional Person(s) seen	$20.00	$20.56	2.8%
W992	SVP - Long-Term Care Institution - Weekdays (07:00-17:00) with Sacrifice of Office Hours - First Person Seen	$40.00	$41.12	2.8%
W993	SVP - Long-Term Care Institution - Weekdays (07:00-17:00) with Sacrifice of Office Hours - Additional Person(s) seen	$40.00	$41.12	2.8%
W995	SVP - Long-Term Care Institution - Evenings (17:00-24:00) Mon-Fri - Additional Person(s) seen	$60.00	$61.68	2.8%
W996	SVP - Long-Term Care Institution - Nights (00:00-07:00) - First Person Seen	$100.00	$102.80	2.8%
W998	SVP - Long-Term Care Institution - Sat., Sun.& Holidays (07:00-24:00) - First Person Seen	$75.00	$90.00	20.0%
Z080	Wound and ulcer debridement - Debridement of wounds(s) and/or ulcer(s) extending into subcutaneous tissue - one	$20.00	$24.00	20.0%
Z081	Wound and ulcer debridement - Debridement of wounds(s) and/or ulcer(s) extending into subcutaneous tissue - two	$30.00	$36.00	20.0%
Z082	Wound and ulcer debridement - Debridement of wounds(s) and/or ulcer(s) extending into subcutaneous tissue - three	$45.00	$54.00	20.0%
Z083	Wound and ulcer debridement - Debridement of wounds(s) and/or ulcer(s) extending into subcutaneous tissue - four or more	$60.00	$72.00	20.0%
Z084	Debridement of wound(s) and/or ulcer(s) extending into any of the following structures: tendon, ligament, bursa and/or bone - one	$60.00	$72.00	20.0%
Z085	Debridement of wound(s) and/or ulcer(s) extending into any of the following structures: tendon, ligament, bursa and/or bone - two or more	$90.00	$108.00	20.0%
Z101	Skin and Subcutaneous Tissue - Abscess or haematoma - Local anaesthetic - subcutaneous - one	$25.75	$30.90	20.0%
Z106	Skin and Subcutaneous Tissue - Abscess or haematoma - Local anaesthetic - subcutaneous - ischiorectal or pilonida	$44.35	$53.22	20.0%

Z110	Extensive debridement of onychogryphotic nail involving removal of multiple laminae	$17.45	$20.94	20.0%
Z113	Skin and Subcutaneous Tissue -Biopsy (ies) - any method, when sutures are not used	$29.60	$35.52	20.0%
Z114	Skin and Subcutaneous Tissue - Foreign body removal - local anaesthetic	$25.25	$30.30	20.0%
Z116	Skin and Subcutaneous Tissue -Biopsy (ies) - any method, when sutures are used	$29.60	$35.52	20.0%
Z117	Malignant Lesions Including Biopsy Of Each Lesion - Single Or Multiple Sites - Chemical and/or cryotherapy treatment of skin lesions - Chemical and/or cryotherapy treatment, one or more lesions	$11.65	$13.98	20.0%
Z119	EXCISION OF PRE-MALIGNANT LESIONS INCLUDING Biopsy OF EACH LESION – SINGLE OR MULTIPLE SITES - Cryotherapy treatment of at least 5 pre-malignant actinic keratosis lesions on the same day, not to include freeze-thaw cycles	$29.00	$34.80	20.0%
Z122	EXCISION (WITH OR WITHOUT Biopsy) / LESIONS - SINGLE OR MULTIPLE SITES - Group 3 - cyst, haemangioma, lipoma - Face or neck - Local anaesthetic - single lesion	$38.50	$39.58	2.8%
Z125	Skin and Subcutaneous Tissue - Group 3 - cyst, haemangioma, lipoma - Other areas - Local anaesthetic - single lesion	$32.00	$38.40	20.0%
Z128	Simple, partial or complete, nail plate excision requiring anaesthesia - one	$33.10	$39.72	20.0%
Z130	Radical, including destruction of nail bed - one	$62.75	$75.30	20.0%
Z131	Radical, including destruction of nail bed - multiple	$82.65	$84.96	2.8%
Z154	Repair of lacerations - up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers	$35.90	$43.08	20.0%
Z164	EXCISION (WITH OR WITHOUT Biopsy) / LESIONS - SINGLE OR MULTIPLE SITES - Group 2 - nevus - Removal by excision and suture - three or more lesions	$44.25	$53.10	20.0%
Z173	Skin and Subcutaneous Tissue - Abscess or haematoma - Local anaesthetic - subcutaneous - two	$30.35	$36.42	20.0%
Z175	Repair of lacerations - 5.1 to 10 cm	$35.90	$43.08	20.0%
Z176	Repair of lacerations - up to 5 cm	$20.00	$24.00	20.0%
Z177	Repair of lacerations - 5.1 to 10 cm if on face and/or requires tying of bleeders and/or closure in layers	$71.30	$85.56	20.0%
Z187	Complex laceration repair, face	$92.30	$110.76	20.0%
Z188	Anatomical area other than face (except zone 1 repair of digit) - Complex laceration repair, anatomical area other than face, (except digit, zone 1 repair)	$92.30	$110.76	20.0%

Z189	Zone 1 repair of digit - Complex repair, digit, zone 1 repair, without soft tissue loss, per digit	$92.30	$110.76	20.0%
Z190	Repair of lacerations - 10.1 to 15 cm if on face and/or requires tying of bleeders and/or closure in layers	$101.45	$121.74	20.0%
Z203	CASTS - Arm, forearm or wrist	$24.10	$24.77	2.8%
Z226	Musculoskeletal System Surgical Procedures - Incision and Drainage - Soft tissue or bursae	$97.35	$100.08	2.8%
Z463	Removal of Norplant	$65.30	$67.13	2.8%
Z770	Endometrial sampling	$37.85	$38.91	2.8%
Z847	Cornea - Removal embedded foreign body - local anaesthetic - one foreign body	$33.00	$33.92	2.8%

Committee Comments

- The committee supports the proposal, subject to fitting and relativity.
- Please see the joint proposal listed under Paediatrics (PFAF 25-062) for updated values on the injections and Infusions fee codes listed above.

18.2 Exxx - Complexity Modifier for Comprehensive Family Practice (PFAF 23-183)

Constituency Proposal

- The constituency requested a new fee code complexity modifier for comprehensive Family Practice that pays a 50% premium added to a visit fee.
- The complexity modifier premium would be billed by family physicians providing longitudinal, comprehensive care or focused practice physicians that are seeing patients with complex medical issues.
- Conditions would be the same as those billed by specialists for the E078A fee code, however the constituency recommends adding Menopause, Arrythmia to the list of conditions.
- Record keeping should satisfy the base code (A007, A003, A9xx).

Committee Comments

- The committee does not support the creation of this new fee, as there is insufficient evidence that this proposal would address an intra-sectional relativity issue.

18.3 Exxx - Complexity Add on Fee to A007 (PFAF 21-D11)

Constituency Proposal

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

Committee Comments

- The committee could only proceed with this proposal if it could be costed very accurately. The committee does not see any method by which such an estimate could be achieved and guaranteed.

- The committee does not support this proposal at this time but continues to explore time informed consultations and assessments as one of our longer-term major projects.

18.4 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) (PFAF 21-D12)

Constituency Proposal

- The constituency requested a new gender add-on premium to K131 and K132 at a premium of 20 per cent.

Committee Comments

- The committee supports this proposal, subject to fitting and prioritization, and drafting schedule language.

18.5 Services provided after hours in small rural hospitals (PFAF 21-D13)

Constituency Proposal

- The constituency 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%.

Committee Comments

- This proposal pertains to a contract change and falls outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.

18.6 K030 – Diabetic management assessment (DMA) (PFAF 25-180)

Constituency Proposal

- The constituency proposed a revision to the K030 payment rules.
- The constituencies' proposed revisions to K030's payment rules can be seen below:
  - To allow a second fee code to be billed (eg. A001, A007) when a second issue is managed during a diabetic visit, provided there are two different services performed with two different diagnostic codes.
- The constituency stated the ability to bill A007 with K030 recognizes patient preference to address all their health concerns and issues in one visit. It was also stated that this proposal will provide intra-sectional relativity improvement for FFS physicians to bill both codes.

Committee Comments

- The proposed change would have broad implications across the Schedule of Benefits and require broad consultation with all affected sections.
- The committee does not support this proposal.

18.7 E079 – Initial discussion with patient re: smoking cessation (PFAF 25-182)

Constituency Proposal

- The constituency proposed a revision to the E079 fee code descriptor and payment rules.
- The constituencies' proposed revisions to E079's descriptor and payment rules can be seen below:

  Proposed New Descriptor:

  E079 - Initial discussion with patient re: smoking cessation is the service rendered to a patient who currently smokes tobacco and/or cannabis and/or cigars or vapes by the primary care physician most responsible for their patient's ongoing care, in accordance with the guidelines and subject to the conditions below.

  Proposed New Payment Rules:

  1. E079 is only eligible for payment when rendered in conjunction with ~~one of~~ the following services: A001, A003, A004, A005, A006, A007, A008, A905, K005, K007, K013, K017, K130, K131, K132, P003, P004, P005, P008, W001, W002, W003, W004, W008, W010, W102, W104, W107, W109, W121, or K030.

     (revisions underlined, deletions ~~strikethrough~~)

- The constituency stated many diabetic patients are also smokers, making smoking cessation an essential component of diabetes management. Allowing physicians to allocate additional time during diabetes visits to address smoking cessation would improve patient outcomes by integrating both interventions efficiently.
- The constituency additionally stated smoking-related harms extend beyond traditional tobacco use. The risks associated with cannabis smoking, cigar smoking, and vaping are comparable to those of cigarette smoking, contributing to poor health outcomes and increased complications.

Committee Comments

- The committee does not support expanding payment rule 1.
- The committee does not support expanding E079 to include cannabis, as insufficient evidence was provided to demonstrate equivalent lung health harms.
- The committee continues to deliberate regarding the other proposed changes.

18.8 E542 – Removal of sutures (PFAF 25-183)

Constituency Proposal

- The constituency proposed a value increase to the E542 fee code, as well as a revision to the code's payment rules.
- The constituency proposed a fee value increase to the E542 fee code, from $11.55 to $13.86 (20.0%).
- The constituency proposed the following payment rule revisions to the E542 fee code:
  1. Allow E542 to be billed for removal of sutures when initial procedure is done by the same physician or a physician within their group or in an emergency department.

2. Tray fee to be billed for suture removal.

- The constituency stated there is currently no fee code for the removal of sutures and therefore the tray fee (E542) is not billable when removing sutures. The community family physician is responsible for the costs associated with a suture removal kit and associated consumables. Currently family physicians are only eligible to bill A001 although E542 is billed with numerous other procedural codes to cover the cost of supplies.

Committee Comments

- The committee notes that if this proposal were approved, it would need to apply to all physicians who remove sutures and thus broad consultation would be necessary.
- The committee notes that suture removal kits cost significantly less than E542 pays.
- The committee notes that the proposed value change to E542 would apply to many sections and thus broad consultation would be necessary.
- The committee does not support the proposal.

18.9 Axxx – Menopause care (PFAF 25-184)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for menopause care, this includes the assessment of current symptoms and treatment planning, and ongoing care.
- The constituency proposed the new fee code be valued at $90.00.
- The constituency proposed the following fee code descriptor and payment rules for the new fee code:

  Proposed Descriptor and Payment Rules:
  Axxx - Menopause Health Assessment (or Assessment for active/symptomatic perimenopause and menopause):

  1. Includes a patient history, an inquiry into and examination of all relevant parts or systems, and advice to the patient.
  2. May be claimed for patients who are experiencing symptoms of perimenopause or menopause, and who require an assessment of symptoms, complications, interactions that could stem from perimenopause or menopause.
     Billable up to 4 times per year.
     - Documentation of history and relevant physical findings, appropriate counselling relevant to peri-menopause or menopause is required.

Committee Comments

- The committee believes that the work of the proposed code is already compensated by existing assessment and counselling codes.
- The committee notes that the values of these codes will be increasing and thus compensation will be close to the proposed value for the services provided.

- The committee does not support this proposal.

18.10 E430 – Papanicolaou Smear - when papanicolaou smear is performed outside of hospital, to G365, add (PFAF 25-185)

Constituency Proposal

- The constituency proposed a value increase to the E430 fee code, as well as a revision to the code's payment rules.
- The constituency proposed a fee value increase to the E430 fee code, from $11.95 to $14.34 (20.0%).
- The constituency proposed the following fee code descriptor and payment rule revision:
  - Allow E430 to be billed when a pelvic exam is done in office with the use of a speculum and no pap smear is performed.
  - Allow E430 to be billed with A001 & A007 when a pelvic exam with speculum is required to appropriately assess the patient.
  - Do not allow E430 to be billed with A003, K131 or K132.
  - Must document appropriate physical exam findings and noting that speculum was used during exam.
- The constituency stated performing a gynecological examination during an office visit requires additional time and the use of a speculum. These exams are most often done by female physicians as the is a predominance of female physicians caring for female patients. Secondly, the costs of supplies associated with doing a gynecological exam with speculum is not compensated when a pap smear is not performed.
- The constituency also stated this proposal will assist in meeting the mandate of gender pay equity and compensation for supplies that are required to perform a speculum examination.

Committee Comments

- The committee supports this proposal, but notes that this needs to be a unique fee code set in relativity with E430.

18.11 Axxx – Longitudinal Gender Affirming Care Visit (Follow-up visit) (PFAF 25-186)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for the provision of follow up care (after initial consultation) for gender affirming care.
- The constituency proposed the new fee code to be valued at $79.60.
- The constituency proposed that the new fee code will apply to follow-up visits with patients who are undergoing gender-affirming care, including hormone therapy, surgical preparation and postoperative care, and other services necessary for safe medical, social and legal gender transition.

- The constituency proposed the new fee code can only be billed with the 259 diagnostic code (Other endocrinological disorder). Constituency also stated documentation on follow up and appropriate counselling on gender affirming care is required.
- The constituency stated the proposed fee code reflects the specialized knowledge and training required to provide these services effectively. Unlike routine family practice visits, gender-affirming care involves an understanding of transgender health issues, hormone therapy protocols, psychosocial dynamics of gender transition, and surgical pathways, all of which require additional training and clinical experience.

Committee Comments

- The committee notes that one of the primary rationales for creating this code separate from K013 involves the FHO access bonus.
- The committee defers deliberations until the future state of 'impact on access bonus' is known (following the outcome of the current arbitration process).

18.12 Axxx – Well-baby care (PFAF 25-189)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for the periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or patient's representative regarding health care.
- The constituency proposed the new fee code be valued at $60.00. The constituency stated the provision of well-baby care continues to evolve, becoming more complex and the addition of new vaccines, requires additional time and resources for parent counselling.
- The constituency proposed the following descriptor for the new fee code:

  Axxx - The periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or patient's representative regarding health care.
- The constituency stated the new fee code will replace all A007 billings with the 916 diagnostic code.

Committee Comments

- The committee was not provided with data to indicate that well baby care requires additional physician time or expertise.
- The committee does not support this proposal.

18.13 Major Initiative - Northern Ontario Service Premium Billing Code (MI 25-12)

Constituency Proposal

- The constituency proposed a Northern Ontario service premium service billing code.

- The constituency stated that issues in accessing healthcare and nutritive food sources, in addition to the region's harsh natural environment, all serve to compound the number of individuals in Northern Ontario presently suffering from physical and mental health complications.
- The constituency stated that Northern Ontario healthcare facilities experience exceptional challenges due to a lack of accessibility for appropriately trained specialists, in addition to experienced difficulties in recruiting and retaining competent staff, done at an additional effort and cost to them.
- The constituency requested that initial discussions/considerations should ideally be around trialling billing code usage by:
  a) Physicians who are physically located in Northern Ontario.
  b) Certain sections whose services in Northern Ontario are significantly low upon comparison.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

19 General & Family Practice (Member Group)

19.1 Exxx - Community based infrastructure premium for office-based practice (PFAF 23-308)

Member Group Proposal

- The member group requested a new fee code Exxx Community Based Infrastructure Premium for Office Based Practice that pays 35% premium out of basket.
- This premium would only apply to services performed in a community clinic; this is to reflect higher overhead costs in the community.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

19.2 Administrative support time-based code (PFAF 23-309)

Member Group Proposal

- The member group requested a time-based fee code for administrative support that pays $37.15 per 15 minutes.
- Proposed payment rule: Time based unit, eligible for 4 units per 100 rostered patients in capitation model or 4 units per 80 in person patient visits per week in fee for service model.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

19.3 Multiple GP/FP visit fee relativity changes (PFAF 23-310)

Member Group Proposal

- The member group requested fee value increases of 160 per cent to all fee value changes requested by the Section of General & Family Practice (PFAF 23).
- The constituency also requested several additional fee value increases of 160 per cent to the following fee codes:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
K023	Palliative Care Support (per unit)	$74.70	$194.22	$119.52	160%
G512	Palliative Care Case Management Fee	$67.75	$176.15	$108.40	160%
A/C945	Special Palliative Care Consultation	$159.20	$413.92	$254.72	160%
B966	Travel Premium	$36.40	$94.64	$58.24	160%
B997	First Person Seen Night	$110	$286.00	$176.00	160%
B998	First Person seen anytime except night	$82.50	$214.50	$132.00	160%
A005	Consultation	$87.90	$228.54	$140.64	160%
A905	Limited Consultation	$73.25	$190.45	$117.20	160%
G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	$20.25	$52.65	$32.40	160%
G371	Each additional bursa, joint, ganglion or tendon sheath	$19.90	$51.74	$31.84	160%
E542	When performed outside hospital	$11.15	$28.99	$17.84	160%
Z116	Biopsy any method when sutures are used	$29.60	$76.96	$47.36	160%
Z113	Biopsy any method when sutures are not used	$29.60	$76.96	$47.36	160%
E430/431	When PAP smear is performed outside of hospital	$11.95	$31.07	$19.12	160%
G365	Periodic PAP	$12.00	$31.20	$19.20	160%
G394	PAP if previously abnormal/inadequate	$12.00	$31.20	$19.20	160%
Z770	Endometrial Sampling	$37.85	$98.41	$60.56	160%
G378	IUD Insertion	$39.95	$103.87	$63.92	160%
Z106	Abscess, I+D ischiorectal/pilonidal	$44.35	$115.31	$70.96	160%
Z101	Abscess, hematoma I+D	$25.75	$66.95	$41.20	160%

- The methodology of adjustment multiplies current rates by the OMA multiplier of 2.6. The rationale for this adjustment involves adjusting for the gradual defunding of fee codes by the MOH and to restore sustainability to Community Based Family Medicine Practice and to help recruit and retain family physicians providing comprehensive family medicine care in a landscape of a primary care crisis in Ontario.

Committee Comments

- The committee does not support this proposal as it would take these codes out of relativity with other family practice codes. The committee will consider increases to these fee codes in alignment with requests made by the section on general and family practice.

19.4 Exxx - Additional medical issue add-on (PFAF 23-311)

Member Group Proposal

- The member group requested a new fee code Exxx Additional medical issue add-on paid at $37.95.
- Proposed payment rule: This code can be billed in addition to another service such as A007 when an additional medical issue is addressed during the visit.
- Multiple medical issues in the same visit require additional time as well as increased complexity of assessment, physical exam, synthesis of information, diagnosis and treatment plan as well as administrative work that is not currently funded.

Committee Comments

- Visit fees do not include any limits on the number of medical issues that can be addressed.
- The committee does not support this proposal.

20 General Internal Medicine

20.1 A/C130 - Comprehensive internal medicine consultation (PFAF 23-020)

Constituency Proposal

- The constituency requested a revision to A/C130 Comprehensive internal medicine consultation.
- Proposed descriptor:

> This service is a consultation rendered by a specialist in internal 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~~ <u>rendering the consultation, including time spent before, during and after patient contact,</u> exclusive of time spent rendering any other separately billable intervention to the patient.
>
> (Revisions <u>underlined</u>, deletions ~~strikethrough)~~

- Pre service/post service can be very time consuming, including reviewing the chart on a computer to collect all the necessary information, calling and updating families, dictation, follow up on lab results as they come back.

Committee Comments

- Professional fees in the Schedule of Benefits are currently tied to the provision of direct patient care. Indirect patient care and general administration costs that are elements of a service are not eligible for separate fee codes.
- The proposal represents a large system-wide issue that involves the entire profession and potentially a significant re-rewriting of the Schedule of Benefits.
- The committee does not support this proposal.

20.2 Most Responsible Physician (MRP) Premiums (E082, E083 and E084) (PFAF 21-D36)

20.3 Hospitalist Premium (PFAF 21-D29)

20.4 Cxxx - Inpatient transfer of care (PFAF 21-D30)

20.5 Admission Assessment – General Requirements - Payment Rule 3 amendment (PFAF 21-D31)

20.6 Cxxx - Day of discharge, medically complex patient (PFAF 21-D32)

20.7 Wxx2 - MRP day of discharge, medically complex patient, long term care or chronic care facility (PFAF 21-D32)

Constituency Proposal

- The Constituency requested:
    - E084 premium be increased to 95% (from 45%)
    - Elimination of (a) E082 payment rule #2 and (b) E083 and E084 payment rule #4
    - Inclusion of C121, W002 and W132 as an eligible code for E083 and E084 premiums.
    - Revise to the list of qualifying services for the Hospitalist Premium to include W002 (Chronic care or convalescent hospital – first 4 subsequent visits), C121(Additional visits due to intercurrent illness), and W121 (Additional visits due to intercurrent illness) and a reduction to the total requirement of qualifying services and required days of service by 50%.
    - Create a new fee for inpatient transfer of care at $31.35 payable to the Most Responsible Physician (MRP) who is transferring care of a medically complex patient to another oncoming MRP.
    - Amend the Admission Assessment – General Requirements - Payment Rule 3 (GP40), such that (1) general or specific assessments or reassessment are eligible for payment per physician per admission when care is transferred from one physician to another physician, (2) Such assessments related to transfer of care should be limited to once a week (Monday-Sunday), and (3) E083 or E084 should apply to these codes to reflect the MRP (Most Responsible Physician) providing the service.
    - Create a new medically complex patient - day of discharge fee of $106.85 with the same service elements as C124, or a fee increase to C124 from $61.15 to $106.85.
    - Create new MRP day of discharge fees for inpatients in chronic care settings, similar to MRP discharge fees for hospital inpatients; Wxx1 MRP day of discharge (equal to C124 at $61.15) and Wxx2 MRP day of discharge, medically complex patient (equal to Cxx at $106.85)

Committee Comments

- The committee notes that there is a provision within the 2021 Physician Services Agreement to establish a hospitalist APP.
- Some of these proposals involve significant changes which affect many physician groups aside from hospitalists, and would require consultation with those groups.
- The committee does not support these proposals but notes that there is overlap with other proposals contained within the Hospital Medicine section of this report.

20.8 Kxxx - Interprofessional Rounds (PFAF 21-D35)

Constituency Proposal

- The constituency requested a new time-based code for interprofessional rounds at a fee of $31.35 per 10-minute increments.

Committee Comments

- Interprofessional rounds involve activities which are included as specific elements of assessments such as:
    - Discussing a patient with other professionals to arrive at an opinion as to the nature of the patient's condition,
    - Monitoring the condition of the patient,
    - Discussion with and providing advice and information to the patient or the patient's representative,
    - Making arrangements for follow-up care.
- Unbundling these activities from assessments would be complex and would impact use of allocation for other sections.
- Changes in compensation for inpatient care may be better achieved by adjusting the value of existing codes to better compensate for the additional time associated with interprofessional rounding.
- The committee also notes that current discussions regarding a hospitalist APP are ongoing and may have implications for this proposal.
- The committee does not support this proposal.

20.9 Multiple Fee Codes - Fee Value Changes to Consultations and Visits (PFAF 25-216)

Constituency Proposal

- The constituency proposed increases to Internal Medicine consultation, assessment and subsequent visit fee codes.
- The sections noted that the proposal addresses intrasectional relativity. Their work was informed by a member survey.
- The constituency noted that proposal 23-019, D33 and D34 from Report Draft #2 specified increases to fee codes: A/C 135 and MRP Subsequent visit codes. These values were requested be updated with the values herein. As such PFAFs 23-019, 21-D33 and 21-D34 are redundant and have been dropped.
- The proposed fee value changes are as follows:

Code	Description	Current Value	Proposed Value	% increase
A/C135	Internal and Occupational Medicine (13) - Consultation	$164.90	$194.58	18%
A/C133	Internal and Occupational Medicine (13) - Medical specific assessment	$81.55	$97.86	20%
A/C131	Internal and Occupational Medicine (13) - Complex medical specific re-assessment	$70.90	$85.08	20%
A138	Internal and Occupational Medicine (13) - Partial assessment	$38.05	$45.66	20%
A/C134	Internal and Occupational Medicine (13) - Medical specific re-assessment	$61.25	$73.50	20%
A/C130	Internal and Occupational Medicine (13) - Comprehensive internal medicine consultation	$310.45	$366.35	18%
A/C435	Internal and Occupational Medicine (13) – Limited Consultation	$105.25	$124.20	18%
Subsequent visits by the Most Responsible Physician (MRP)				
C122	…day following the hospital admission assessment.	$61.15	$67.27	10%
C123	…second day following the hospital assessment.	$61.15	$67.27	10%
C124	…day of discharge	$61.15	$67.27	10%
C132	…first five weeks	$34.10	$37.51	10%
C137	…sixth to thirteenth week inclusive (maximum 3 per patient per week).	$34.10	$37.51	10%
C139	…after thirteenth week (maximum 6 per patient per month)	$34.10	$37.51	10%
C138	…concurrent care	$34.10	$37.51	10%
C142	…first subsequent visit by the MRP following transfer from an Intensive Care Area	$61.15	$67.27	10%
C143	…second subsequent visit by the MRP following transfer from an Intensive Care Area.	$61.15	$67.27	10%

Committee Comments

- The committee supports a value change to all the codes listed, subject to fitting and relativity.
- The committee proposes the internal medicine office assessment premium be incorporated into the base value of the codes to which it currently applies. Please see “Deletion of Internal Medicine Office Assessment Premium” under PPC initiatives for more information.

21 General Surgery

21.1 E515 - Incision of abscess or hematoma when performed as sole procedure under general anaesthetic in an operating room but not in an emergency department or emergency department equivalent. (PFAF 23-269)

Constituency Proposal

- The constituency initially requested a new fee code as a minimal fee for procedure performed in an operating room under a general anesthetic, paid at $200.00.
- This fee is to remedy the gross discrepancy that an assistant and an anaesthetist will both make 3-4 times as much as the operating surgeon in a number of cases.
- As a counterproposal, the constituency instead requested to extend an existing premium (E515) to a set of procedural codes in the hopes of remedying the discrepancy they identified.
- Under the new proposal, E515 would be extended to the following codes: Z758, Z541, Z574, Z115, Z080, Z081, Z082, Z083, Z084, Z085, Z128, Z129, Z130, Z131, Z538, Z535, Z536, Z592, Z752, Z753, Z754, Z545, Z546, Z566, Z757, Z575, Z576, Z548, Z550.

Committee Comments

- The committee supports this proposal for the following codes: Z758, Z541, and Z574, subject to fitting, relativity, and rewriting of schedule language for E515.
- The committee does not support the proposal for the remaining codes as committee analysis indicates those codes very rarely involve a general anesthetic and therefore would provide a limited benefit to members.

21.2 Exxx - Suffix modifier for selected codes for a second general surgeon assisting another general surgeon (PFAF 23-275)

Constituency Proposal

- The constituency requested a new premium for a second general surgeon assisting another general surgeon that pays 75 per cent of the same code the primary surgeon bills.
- This code would not to be used by fellows in a training capacity, not to be used by other assistants, not be used by general surgeons whose primary role is assisting in surgery. It would only be used by general surgeons whose non-assist billings are more than their assist billings and only available for the following fee 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,

Committee Comments

- The committee thanks the section for their comprehensive feedback.
- The committee does not support this proposal as it is not consistent with the two-surgeon model currently in the Schedule of Benefits.

21.3 Rxxx - Same as R226 but for soft tissue sarcoma for general surgeons (PFAF 23-276)

Constituency Proposal

- The constituency requested a new fee code similar to R226 biopsy of suspected sarcoma, or resection of a complex bone or complex soft tissue tumour(s) intended for soft tissue sarcoma surgeons with same fee as R226 ($100.00 per 15 minutes).
- A small number of subspecialty surgeons are performing these procedures, that will be time based, same as the orthopedic sarcoma code. This has already been approved by the OHIP on an IC basis and is modernization of the Schedule, as advised by the OHIP office.

Committee Comments

- The committee supports revising R226 to include soft tissue sarcoma surgeries performed by qualified general surgeons.
- The committee notes General Surgery's support.
- The committee notes that no concerns have been raised by other relevant constituencies.

21.4 E673 - Lysis of extensive intra-abdominal adhesions, add (PFAF 23-282)

Constituency Proposal

- The constituency requested a fee value change to E673 lysis of extensive intra-abdominal adhesions from $62.05 to $124.10, by 100 per cent.
- The requirements are at least an hour of adhesiolysis and does not include time spent beyond that. In certain cases, the adhesiolysis can take longer than the primary operation.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

21.5 S332 - Herniotomy - Umbilical - adolescent or adult (PFAF 23-283)

Constituency Proposal

- The constituency requested a fee value change to S332 herniotomy - Umbilical - adolescent or adult from $300.00 to $324.21, by 8.1 per cent, and a revision to its descriptor to include "with or without resection of incarcerated/strangulated contents".
- With this change the constituency also requested the deletion of:
    - E756 - with resection of strangulated contents, add $24.50.
    - E757 - without resection of strangulated contents, add $55.25.
- The suggested changes reflect a modernization of the Schedule in keeping with current clinical practice and address relative fee values in this section of the Schedule.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity, and notes that the paediatric code (S333) should be changed in the same manner.

21.6 A034 - Partial assessment (PFAF 21-D14)

21.7 A033 - Specific assessment (PFAF 21-D15)

21.8 A0xx - Assessments of greater than 30 minutes (PFAF 21-D16)

Constituency Proposal

- The constituency requested 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)
    - Create new code A0xx – assessments of greater than 30 minutes at a fee of $67.75.

Committee Comments

- The proposal represents a large system-wide change that involves the entire profession and potentially a significant re-rewrite to the Schedule as it would require redefining partial and specific assessments.
- The committee does not support this proposal at this time but continues to explore time informed consultations and assessments as one of our longer-term major projects.

21.9 G375, G377, and G383 – Injections or infusions, intralesional infiltration fee codes (PFAF 25-141)

Constituency Proposal

- The constituency proposed a revision to the G375, G377, and G383 fee code descriptors and payment rules. The proposed revisions can be seen below:

  Proposed New Descriptors:

  G375 - Injections or Infusions, intralesional therapy directly injected into the cancer lesion for treatment of in transit metastasis – one or two lesions.

  G377 - Injections or Infusions, intralesional therapy directly injected into the cancer lesion for treatment of in transit metastasis – 3 or more lesions.

  G383 - Injections or Infusions, intralesional therapy directly injected into the cancer lesion for treatment of in transit metastasis – extensive.

  (revisions underlined, deletions ~~strikethrough~~)

- The constituency also proposed an increase in the value of the G375, G377, and G383 fee codes. The proposed increased values can be seen below:

Code	Current Description	Current Value	Proposed Value	% increase
G375	Injections or Infusions, INTRALESIONAL INFILTRATION - one or two lesions	$8.85	$25.00	182.5%

G377	Injections or Infusions, INTRALESIONAL INFILTRATION - 3 or more lesions	$13.30	$50.00	275.9%
G383	Injections or Infusions, INTRALESIONAL INFILTRATION - extensive (see General Preamble GP8)	I.C.	$100.00	

- The constituency stated the current fee paid is not reflective of the work being done and when we bill IC the amounts are often rejected with no explanation.

Committee Comments

- The committee notes that this constituency bills less then 1% of these codes. The committee does not support this proposal.

21.10 R912 – Neck lymph nodes- Ilioinguinal, radical resection (PFAF 25-166)

Constituency Proposal

- The constituency proposed an increase in value to the R912 fee code, from $489.30 to $733.95 (50.0%).
- The constituency stated a deep groin dissection is a deep pelvic iliac dissection. The deep groin includes the external iliacs region up to the bifurcation of the external and internal iliac as well as all of the obturator nodes. This is done through a separate incision and with a retroperitoneal approach and is quite challenging.
- The constituency noted the R915 fee code as a comparator which is valued at $1,120.80.

Committee Comments

- The committee supports this proposal in principle subject to fitting and relativity.
- The committee notes that in correspondence with the constituency, it is agreed that R913 and R914 should increase so that they maintain relativity with R912.

21.11 Rxx1 &Rxx2 – Skin and nipple sparing mastectomies performed with immediate breast reconstruction for malignancy or prophylactic high risk female patients (PFAF 25-202)

Constituency Proposal

- The constituency proposed the introduction of two new fee codes for skin and nipple sparing mastectomies performed with immediate breast reconstruction for malignancy or prophylactic high risk female patients. The constituencies proposed descriptors and fee code values can be seen below:
    - Rxxx - Skin sparing mastectomies performed with immediate breast reconstruction for malignancy or prophylactic high risk female patients. Proposed value: $660.00.
    - Rxx2 - Nipple sparing mastectomies performed with immediate breast reconstruction for malignancy or prophylactic high risk female patients. Proposed value: $825.00.
- The constituency proposed the following payment rules accompany the new proposed fee codes:

1. Can not be billed for male mastectomies for cancer or gynecomastia.
2. Can not be billed for gender affirming surgery or delayed breast reconstruction

- The constituency stated These procedures will be performed in typically high-volume breast surgery practices and after training in advanced oncoplastic techniques. Skin sparing mastectomies when compared to simple mastectomy take approximately twice as long, while nipple sparing approximately 2.5 times as long.
- The constituency noted that physicians currently bill the R117 fee code for a nipple sparing mastectomy but the R117 fee code is undervalued and should be deleted if these new codes are introduced.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency, as required.

21.12 Rxxx – Aesthetic mastectomy (flat closure) (PFAF 25-205)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for an aesthetic mastectomy (flat closure) procedure.
- The constituency prosed the new fee code be valued a $572.70. This is equivalent to R108 + R004 ($330.00 + $242.70).
- The constituency stated the proposed new fee code was submitted to combine the relative existing codes that represent the complexities of this procedure (R108 and R004).
- The constituency proposed the following descriptor with the new fee code:

  Rxxx - For aesthetic flat closure where the surgeon describes:

  1. extensive undermining for local advancement flaps >10cm to obliterate the inferior or lateral excess flap deformities associated with simple mastectomies.
     Or
  2. Techniques such as modified M-plasty, fishtail closure etc.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency, as required.

21.13 E676 – BMI modifier for mastectomies and axillary surgery (PFAF 25-206)

Constituency Proposal

- The constituency proposed a revision to the E676 fee code's payment rules to allow the following fee codes to qualify for the 25% BMI premium:
  - R108 – Mastectomy, female (with or without Biopsy) – simple.
  - R109 - Mastectomy, radical or modified radical (with or without Biopsy).
  - Rxx1 – Skin sparing mastectomies (see PFAF 25-202).
  - Rxx2 – Nipple sparing mastectomies (see PFAF 25-202).
  - Rxxx – Aesthetic mastectomy, flat closure (see PFAF 25-205).

- R913 - Axillary or inguinal lymph nodes - radical resection, unilateral.
- E505 - Operations of the Breast - Mastectomy - with limited axillary node sampling, to R148 or R149, R108 or R117, R111 add.
- Z427 - Lymph Channels, Biopsy - Sentinel node Biopsy, per draining basin.

- The constituency stated mastectomies are technically more challenging in higher BMI patients and axillary surgery even more so.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency, as required.

21.14 Multiple fee codes – Increase to various general surgery rectum and intestine fee codes (PFAF 25-208)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following general surgery rectum and intestine fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
General Surgery - Rectum & Intestine fee codes (PFAF 25-208)					
S166	Intestines (except rectum) Excision - Resection with anastomosis- small and large intestine terminal ileum, cecum and ascending colon (right hemicolectomy)	$899.85	$989.85	$90.00	10.0%
S167	Intestines (except rectum) Excision - Resection with anastomosis- Large intestine - any portion	$877.95	$965.75	$87.80	10.0%
E796	Rectum/intestines (except rectum) - With mobilization of splenic flexure, to S167, S218 add	$102.40	$112.65	$10.25	10.0%
S169	Intestines (except rectum) Excision - Resection with anastomosis- Total colectomy with ileo-rectal anastomosis	$1,313.65	$1,445.02	$131.37	10.0%
S171	Intestines (except rectum) Excision - Resection with anastomosis- Left hemicolectomy with anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection & mobilization of splenic flexure)	$1,128.10	$1,240.90	$112.80	10.0%

S213	Rectum - Excision - Proctectomy - Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	$1,204.50	$1,324.95	$120.45	10.0%
S214	Rectum - Excision - Proctectomy - Abdomino-Perineal resection or pull through	$1,524.20	$1,676.25	$152.05	10.0%
S215	Rectum - Excision - Two surgeon team - Abdominal surgeon	$1,107.50	$1,329.00	$221.50	20.0%
S216	Rectum - Excision - Two surgeon team - Perineal surgeon	$459.05	$550.85	$91.80	20.0%
S226	Rectum - Repair - Rectal prolapse - Perineal repair - Major	$356.50	$481.30	$124.80	35.0%
S227	Rectum - Repair - Rectal prolapse - Abdominal approach	$688.75	$929.80	$241.05	35.0%

- The constituency stated in a previous sectional exercise looking at relativity amongst our subspecialty groups, colorectal surgery was identified as falling below the "average" for all general surgeons with respect to remuneration for their category of codes.
- The constituency proposed a 10% increase to codes that are also billed by non-subspeciality general surgeons and between a 20-35% increase for codes mostly billed by surgeons with colorectal subspecialty training.

Committee Comments

- The committee supports the proposed fee value increases, subject to fitting and relativity.

21.15 Exxx – Addition of a modifier code to S213 for coloanal anastomosis (PFAF 25-209)

Constituency Proposal

- The constituency proposed the introduction of a new E modifier fee code for coloanal anastomosis to the S213 fee code, valued at 25% of the S213 fee code.
- The constituency stated S213 is a proctectomy code for "low anterior resection" which can be performed by many general surgeons when the disease is in the upper rectum. For disease in

the mid to low rectum, most of these are being referred to a colorectal subspecialist. In these "ultra-low" cases, often the colon needs to be resected down to the level of the anus, and thus a colonial anastomosis is required.

- The constituency proposed the following descriptor and payment rules for the new fee code:
  Proposed Descriptor:
  Exxx – for coloanal anastomosis to S213 add 25%

  Proposed Payment Rules:
  1. Only applicable to S213.
  2. Current add on code E808 can still be applied.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

21.16 S251 – Rectum - Fistula-in-ano (PFAF 25-215)

21.17 Sxxx – Ligation of Intersphincteric Fistula Tract (LIFT) and/or Endorectal Advancement Flap (ERAF) for definitive repair (PFAF 25-223)

21.18 Exxx – Recurrent or complex perianal fistulizing disease (PFAF 25-225)

Constituency Proposal

- The constituency proposed a revision and fee value change to the S251 fee code.
- The constituency would like to disaggregate S251 to better capture varying degrees of complexity, and a fee value increase from $213.15 to $234.47 (by 10.0%). The proposed suite of fee codes is:

- S251 – Fistula in ano - exploration of fistula tract and insertion of Seton drain and/or fistulotomy

  (revisions underlined)

- Sxxx – Ligation of Intersphincteric Fistula Tract (LIFT) and/or Endorectal Advancement Flap (ERAF) for definitive repair, paid at $339.50.
- Exxx – Recurrent or complex perianal fistulizing disease, paid at 25% premium to S251 or Sxxx.

Committee Comments

- The committee supports these proposals but would not include complex perianal fistulizing disease in the E code. The E code would only be for a recurrent disease.
- Final fee value is subject to fitting and relativity.

21.19 Sxxx – Completion Cholecystectomy (PFAF 25-228)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for the completion of a complete cholecystectomy.

- The constituency proposed the new fee code to be valued at $1,100.00.
- The constituency stated that there is currently no fee code for this operation, the S287 fee code is for a standard cholecystectomy but a completion cholecystectomy is much more complex, and physicians should be remunerated more for this operation.
- The constituency listed several billing requirements for this new fee code:
    - The operative report should indicate that the patient has had a previous subtotal or partial cholecystectomy, and that this operation involves removal of all the remnant gallbladder.
    - The operative report should indicate if the operation can be performed laparoscopic or laparoscopic assisted, it should be clearly documented.
    - The fee code should be billed at HPB Centres of Excellence, and the referring doctor should be another General Surgeon or a Gastroenterologist.
    - The fee code should be eligible for the E793 modifier if it can be performed laparoscopically.

Committee Comments

- The committee supports the creation of the new code.
- The committee continues to deliberate on the appropriate fee value and Schedule language and will reach out to the constituency as required.

21.20 S309 – Distal - body, tail with splenectomy with or without anastomosis (PFAF 25-230)

Constituency Proposal

- The constituency proposed a revision to the S309 fee code descriptor and a value increase from $986.05 to $1,400.00 (42.0%).
- The constituency listed the following proposed rules to reflect updated medical practices associated with S309:
- This would include left-sided pancreatectomies where any portion of the body or tail of the pancreas is resected with removal of the spleen.
    - Central pancreatectomies would be included in this billing code.
    - The pancreatojejunostomy that is part of a central pancreatectomy would not be billable on top of this code.
    - New E codes for concomitant resection of a vein and artery are also needed (as with Whipple procedure and total pancreatectomy).

Committee Comments

- The committee supports changing the descriptor and will explore with the section appropriate Schedule language.
- The committee supports the proposed value change, subject to fitting and relativity.

21.21 S267, S270, and S271 – Liver hepatectomy - Formal anatomical resection (PFAF 25-231)

Constituency Proposal

- The constituency proposed a revision to the S267, S270, and S271 fee code descriptors and an increase to the fee code values.
- The constituency stated the proposed descriptor revisions is to reflect the updated medical practice associated with these fee codes.
- It was also stated that the proposed value changes were made to improve intersectional relativity. The suggested fee for these codes is based on the average of the liver fee codes in the three provinces with the highest rates of compensation for these operations. The average of these three Provinces is approximately 23% higher than Ontario's for liver resections. All three codes are approximately adjusted based on this 23% benchmark.
- The proposed descriptor revisions and value changes can be seen below:

- S267 – Liver - Hepatectomy - ~~Formal anatomical resection~~ - three or four liver segments.
  - From $1,652.15 to $2,000.00 (21.1%).
- S270 – Liver - Hepatectomy - ~~Formal anatomical resection~~ - one or two liver segments.
  - From $1,426.05 to $1,700.00 (19.2%).
- S271 – Liver - Hepatectomy - ~~Formal anatomical resection~~ - five or more liver segments.
  - From $1,938.50 to $2,400.00 (23.8%).

(deletions ~~strikethrough~~)

Committee Comments

- The committee supports the proposed descriptor change.
- The committee supports a proposed fee value changes subject to fitting and relativity

21.22 Exxx – Portal Lymphadenectomy (PFAF 25-235)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for a Portal Lymphadenectomy operation.
- The constituency proposed the new fee code should be a E code specific to liver resection codes (S267, S269, S270, S271, S275, and S291) with a proposed value of $287.63.
- The constituency proposed the new fee code have the following billing restrictions:
  - The fee code should only be billable by HPB surgeons working in one of the Ontario Health designated centres of excellence.
  - The operative report for a liver resection must include a description of a formal portal lymphadenectomy which includes removal of all lymphatic tissue surrounding the common bile duct/ hepatic artery and portal vein.
- The constituency stated there is no current fee code for this operation. HPB surgeons often use S292 (common duct stricture, dissection and or resection) for this operation. However, the resection required for a proper portal lymphadenectomy is much more extensive than needed for a benign common duct stricture. Portal lymphadenectomy is not standard of care for every

liver resection, and therefore, should be remunerated above the codes for liver resection when indicated.

Committee Comments

- The committee supports the creation of the code and the proposed fee value, subject to fitting and relativity.

21.23 Exxx – Repeat Liver Resection (PFAF 25-237)

Constituency Proposal

- The constituency proposed the introduction of a new E modifier fee code for repeat liver resection procedures.
- The constituency proposed this fee code be valued at 25% of liver resection codes. The constituency stated the proposed 25% value was made to compensate for the additional complexity involved, redo operations are very complex due to adhesions of the liver to the diaphragm, bowel, and the major portal vasculature and the retroperitoneum.
- The constituency proposed the following payment rules:
    a. Fee code is billable at HPB Centres of Excellence.
    b. Only patients who have had S267, S270, and S271 previously billed are eligible for this new E code.
    c. HPB surgeons are eligible to bill this new E code more than once.
    d. The new E code is a modifier of S267, S270, and S271 which is allowed to be billed again if combined with the new redo-liver E-code.

Committee Comments

- The committee supports the creation of the new fee code. The committee continues to deliberate on the proposed value and will reach out to the constituency, as required.

21.24 S299 – Distal- body, tail with preservation of the spleen with or without anastomosis (PFAF 25-238)

Constituency Proposal

- The constituency proposed a value increase to the S299 fee code, from $1,250.00 to $1,700.00 (36.0%).
- The constituency stated this proposed value change will improve intersectional relativity. The constituency used fee code values from Alberta and Manitoba as comparators to determine their proposed value increase.

Committee Comments

- The committee supports changing the descriptor and will explore with the section appropriate Schedule language.
- The committee supports a value change, subject to fitting and relativity.

21.25 S298 – Total pancreatectomy with splenectomy (PFAF 25-239)

Constituency Proposal

- The constituency proposed a value increase to the S299 fee code, from $1,270.20 to $3,385.00 (166.5%).
- The constituency stated this proposed value change will improve intersectional relativity. The constituency used fee code values from Alberta as comparators to determine their proposed value increase.
- The constituency noted this operation should only be billed by hepatobiliary surgeons working in one of the 12 current Ontario Health centres of excellence.

Committee Comments

- The committee supports changing the descriptor and will explore with the section appropriate Schedule language.
- The committee supports a value change, subject to fitting and relativity.

21.26 S300 – Pancreatectomy - "Whipple type" procedure (PFAF 25-240)

Constituency Proposal

- The constituency proposed a value increase to the S300 fee code, from $2,457.35 to $3,385.00 (37.8%).
- The constituency stated this proposed value change will improve intersectional relativity. The constituency used the average “Whipple” fee code value from the three provinces with the highest rate of compensation for this operation as the comparator value.
- The S300 fee code should only be billable if performed at one of the CCO HPB Centres of Excellence.

Committee Comments

- The committee supports changing the descriptor and will explore appropriate Schedule language with the constituency.
- The committee supports a value change, subject to fitting and relativity.

21.27 Multiple Fee Codes – General Surgery Consult and Assessment Fee Value Changes (PFAF 25-280)

Constituency Proposal

- The constituency proposed increases to General Surgery consult and assessment codes, as follows:

Fee Code	Descriptor	Fee Value	Proposed New Fee	$ Change	% Change
A035	General Surgery - Consultation	$96.20	$105.80	$9.60	10.0%

A935	Surgical specialties - Special surgical consultation (03, 04, 06, 08, 09, 17, 20, 23, 24, 35, 64)	$163.20	$179.50	$16.30	10.0%
A036	General Surgery - Repeat consultation	$64.10	$70.50	$6.40	10.0%
A033	General Surgery - Specific assessment	$47.30	$52.05	$4.75	10.0%
A034	General Surgery - Partial assessment	$28.60	$31.45	$2.85	10.0%

Committee Comments

- The committee supports the proposed fee code value increases subject to fitting and relativity.

21.28 Multiple Fee Codes – General Surgery Acute Care Surgery Fee Value Changes (PFAF 25-282)

Constituency Proposal

- The constituency proposed increases to General Surgery acute care surgery codes, as follows:

Fee Code	Descriptor	Fee Value	Proposed New Fee	$ Change	% Change
S139	Stomach - Suture - Gastrorrhaphy (for perforated gastric or duodenal ulcer or wound)	$672.75	$740.00	$67.25	10.0%
S175	Intestines (except rectum) - Intestinal obstruction (mechanical) - One stage - Without resection	$712.35	$783.60	$71.25	10.0%
S176	Intestines (except rectum) - Intestinal obstruction (mechanical) - One stage - With entero- Enterostomy	$894.85	$984.35	$89.50	10.0%
S177	Intestines (except rectum) - Intestinal obstruction (mechanical) - One stage - With resection	$1,055.25	$1,160.80	$105.55	10.0%
S180	Intestines (except rectum) - Intestinal obstruction (mechanical) - One stage - With enterotomy	$824.80	$907.30	$82.50	10.0%
S204	Miscellaneous - Appendix - Incision and drainage of abscess	$239.20	$263.10	$23.90	10.0%
S207	Appendix - Appendectomy with or without perforation	$458.60	$504.45	$45.85	10.0%
Z541	Rectum - Manipulation - Dilation and/or disimpaction or removal of foreign body under general anaesthetic (as sole procedure)	$58.15	$63.95	$5.80	10.0%
S321	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - for acute trauma	$587.10	$645.80	$58.70	10.0%

E733	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - With repair of intestine - Single add	$142.40	$156.65	$14.25	10.0%
E734	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - Multiple and/or with resection add	$211.15	$232.25	$21.10	10.0%
E735	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - With splenectomy (partial or complete) add	$284.75	$313.25	$28.50	10.0%
E736	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - With repair of lacerated liver add	$187.90	$206.70	$18.80	10.0%
E739	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - With repair of diaphragm add	$122.05	$134.25	$12.20	10.0%
E723	Abdomen, Peritoneum and Omentum - Incision - Laparotomy - With repair of lacerated spleen add	$284.80	$313.30	$28.50	10.0%

Committee Comments

- The committee supports the proposed fee code value increases subject to fitting and relativity.

21.29 Sxxx – Transanal total mesorectal excision (TaTME) with proctosigmoidectomy and anastomosis below peritoneal reflection -Single Surgeon technique (PFAF 25-287)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for Transanal total mesorectal excision (TaTME) with proctosigmoidectomy and anastomosis below peritoneal reflection.
- The constituency proposed the new fee code to be valued at $2,448.75. The constituency used the S213 and S214 fee codes as comparator codes.
- The constituency proposed the following billing restrictions:
    - Fee code should be billed by Colorectal Surgeons and Surgical Oncologists with colorectal subspecialty expertise and TaTME training.
    - This code should not be eligible for concurrent payment with S213, S214, S215 or S216.
    - This code should be eligible for payment with obesity premium.
    - This code should be eligible for 2 surgical assistants.
    - The consent or operative report must include:
        - Consent for TaTME approach (this will limit usage of the platform to high volume centers who routinely discuss the technique, risks/benefits, and quality assurance metrics with patients rather than adding the technique ad hoc during an operation.
        - Clear description of utilization of a transanal platform (either TAMIS (transanal minimally invasive surgery) or TEMS (transanal endoscopic microsurgery)).
        - Clear description of total mesorectal excision (TME) and re-anastomosis either transanally or transabdominally.

Committee Comments

- The committee supports the creation of the code and the proposed fee value subject to fitting and relativity.

21.30 Sxxx – Transanal total mesorectal excision (TaTME) with proctosigmoidectomy and anastomosis below peritoneal reflection - 2 Surgeon technique, Abdominal Surgeon (PFAF 25-297)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for Transanal total mesorectal excision (TaTME) with proctosigmoidectomy and anastomosis below peritoneal reflection.
- The constituency proposed the new fee code to be valued at $950.00. The constituency used the S214 and S215 fee codes as comparator codes.
- The constituency proposed the following billing restrictions:
    - This code should be billed by Colorectal Surgeons, Surgical Oncologists, and General Surgeons proficient in colorectal resections.
    - This code should not be eligible for concurrent payment with S213, S214, S215 or S216.
    - This code should be eligible for payment with obesity and laparoscopic premiums.
    - This code should be eligible for 2 surgical assistants.
    - The operative report should indicate mobilization of sigmoid colon and upper rectum.
    - The surgeon may choose an open or laparoscopic approach depending on patient and technical factors.

Committee Comments

- The committee supports the creation of the fee code.
- The committee supports the proposed fee value, subject to fitting and relativity.

21.31 Sxxx – Transanal total mesorectal excision (TaTME) with proctosigmoidectomy and anastomosis below peritoneal reflection - 2 Surgeon technique, Perineal Surgeon (PFAF 25-301)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for Transanal total mesorectal excision (TaTME) with proctosigmoidectomy and anastomosis below peritoneal reflection.
- The constituency proposed the new fee code to be valued at $1,498.75. The constituency used the S213, S214, and S216 fee codes as comparator codes.
- The constituency proposed the following billing restrictions:
    - This code should be billed by Colorectal Surgeons and Surgical Oncologists with colorectal subspecialty expertise and TaTME training.
      This code should not be eligible for concurrent payment with S213, S214, S215, S216 or, E793.
    - This code should be eligible for payment with obesity premium.

- The consent or operative report must include:

a. Consent for TaTME approach (this will limit usage of the platform to high volume centers who routinely discuss the technique, risks/benefits, and quality assurance metrics with patients rather than adding the technique ad hoc during an operation.
b. Clear description of utilization of a transanal platform (either TAMIS (transanal minimally invasive surgery) or TEMS (transanal endoscopic microsurgery)).
c. Clear description of total mesorectal excision (TME) and re-anastomosis either transanally or transabdominally.

Committee Comments

- The committee supports the creation of the fee code.
- The committee supports the proposed fee value, subject to fitting and relativity.

22 General Surgery (Member Group)

22.1 Sxxx - Temporary abdominal closure with or without abdominal washout (PFAF 23-312)

Member Group Proposal

- The member group requested a new fee code Sxxx Temporary abdominal closure with or without abdominal washout, paid at $376.25.
- Proposed payment rule:
  - Include placement/removal of temporary abdominal closure devices and abdominal washout in patients with an open abdomen with or without fascial closure.
  - The procedure can be performed up to 10 times per hospital stay and remunerated at 100% each time. Limited to patients admitted to an intensive care unit or whose post operative disposition is the intensive care unit.
  - This code would be in addition to other billable procedures but would replace the use of exploratory laparotomy or repair of hernia codes currently used in this context.
- This is a high-risk and complex procedure usually performed in critically ill patients.
- This procedure would be limited to trauma surgeons or high-volume general surgeons at tertiary and quaternary care centers with the required surgical and critical care expertise.
- Currently, these necessary re-operations, where no other billable procedure occurs, are variably remunerated under the Schedule of Benefits with non-specific codes such as exploratory laparotomy (S312 at $485.25) or hernia repair (S340 at $370.95, S344 at $500.00).

Committee Comments

- The committee supports the proposal in principle except that this should apply to all qualified surgeons and is a standalone procedure, subject to fitting and relativity.

22.2 M116 - Fixation for trauma for repair of chest wall (PFAF 25-338)

Member Group Proposal

- The group proposed an increase to the fee code M116 (fixation for trauma; repair of chest wall) from $350 to $550 (an increase of 57.14%).

- The group argued that the current payment does not reflect workload or complexity.
- The group also proposed that M116 be eligible for billing with E683, valued at 35%, due to the frequent need for associated VATs, as stated by the constituency.

Committee Comments

- The committee supports the proposed modification so that E683 will apply.
- The committee supports the proposed value change, subject to fitting and relativity.

23 General Thoracic Surgery

23.1 E618 - Lungs and pleura - with decortication of remaining lobe(s), add (PFAF 23-041)

Constituency Proposal

- The constituency proposed a fee increase to E618 from $121.85 to $365.55 (200 per cent) and the following descriptor revision:

> E618 - with decortication of remaining lobe(s) or major thoracic lysis of adhesions (over 1 hour)
>
> (Revisions underlined)

Committee Comments

- The committee supports in principle changing E618 to include major thoracic lysis of adhesions, minimum time of 60 minutes, subject to fitting.

23.2 M143 - Lobectomy, may include radical mediastinal node dissection or sampling (PFAF 23-051)

23.3 M144 - Segmental resection, including segmental bronchus and artery (PFAF 23-052)

23.4 M145 - Wedge resection of lung (PFAF 23-133)

Constituency Proposal

- The constituency proposed the following fee increases for M143, M144 and M145. The committee added M142 to this list to maintain relativity. After allocation became known, the section increased the proposed fee value changes from 7% to 20%:

Fee code	Descriptor	Current value	Proposed value	$ Increase	% Increase
M143	Lobectomy, may include radical mediastinal node dissection or sampling	$1402.60	$1683.12	$280.52	20%
M144	Segmental resection, including segmental bronchus and artery	$1441.75	$1730.10	$288.35	20%
M145	Wedge resection of lung	$843.40	$1012.08	$168.68	20%
M142	Pneumonectomy	$1700.00	$2040.00	$340.00	20%

Committee Comments

- The committee supports a value change to these fee codes, subject to fitting and relativity.

23.5 Rxxx - Open or VATS drainage of pericardial effusion for Cardiac Tamponade (PFAF 23-053)

Constituency Proposal

- The constituency proposed a new fee for open or VATS drainage of pericardial effusion for Cardiac Tamponade, valued at $800.00.
- The fee would be restricted to drainage of pericardial effusion for unstable patients with documented clinical or Echocardiographic signs of tamponade. Must have clear documentation of instability and confirmed or suspected tamponade.

Committee Comments

- The committee supports this proposal at a value of $400, as that value is consistent with the physician workload as described by the section, relative to other procedures.
- Exact value is subject to fitting.

23.6 E683 - when performed thoracoscopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach (PFAF 23-054)

23.7 M138 - Hilar lymph node or lung biopsy with full thoracotomy (PFAF 23-108)

Constituency Proposal

- The constituency requested a revision to allow E683 to be eligible with the following common thoracic surgical procedures:
    - M135 Decortication,
    - M134 Thoracotomy/thoracoscopy for haemorrhage/empyema,
    - M138 Hilar lymph node or lung biopsy with full thoracotomy

Committee Comments

- Given the section's response indicating that the procedures utilizing VATS are shorter in duration, the committee does not support expanding the range of procedures to which this E-code applies.
- The committee does not support this proposal.

23.8 M117 - Chest wall - pleura - Sternal fixation for trauma (PFAF 23-055)

Constituency Proposal

- The constituency proposed the deletion of M117 Sternal fixation for trauma, as it is a redundant code and should be replaced by M112 - sternal debridement and rewiring with or without special mechanical instrumentation – as sole procedure.

Committee Comments

- M112 was priced and rules written to act as a stand-alone code in the setting of sternal wound dehiscence post-surgery. This is very different than M117 which has different indications and is billed with other codes.
- The committee does not support this proposal.

23.9 M105 - Chest and Mediastinum - Chest wall tumour, resection of 2 or 3 ribs or cartilages (PFAF 23-116)

Constituency Proposal

- The constituency proposed a fee increase to M105, from $650.00 to $1,040.00 (60 per cent), and a descriptor revision as follows:

  Chest wall ~~tumour~~ resection, resection of ~~2 or 3~~ 1 - 3 ribs or cartilages.

  (Revisions underlined, deletions ~~strikethrough~~)

- The revision is to modify the number of ribs resected to 1-3, rather than 2 or 3, and thereby delete several other codes (see proposals for M111, E605, Z353, Z354, and Z337 below).

Committee Comments

- The committee does not support the descriptor change that removes the word “tumour” or the modification to “1-3” ribs.
- Rather, the committee supports expanding M105 to include wide resection of one rib for resection of malignant chest wall tumour, subject to schedule language approval.
- Final fee value will be subject to fitting and relativity.

23.10 M111 - Surgical collapse - Thoracoplasty - One stage (PFAF 23-056)

23.11 E605 - Surgical collapse - Thoracoplasty – for each additional rib (max 3 additional) (PFAF 32-056)

Constituency Proposal

- The constituency proposed the deletion of M111 and E605.
- M111 and E605 are rarely performed procedures, historically completed for tuberculosis involving the pleural space and lung. If a similar procedure is required, it can be billed under M105.

Committee Comments

- The committee supports this proposal.

23.12 Z353 - Chest and Mediastinum - Incision - Incisional biopsy of chest wall tumour (PFAF 23-057)

23.13 Z354 - Chest and Mediastinum - Incision - Excisional biopsy of rib for tumour (PFAF 23-057)

Constituency Proposal

- The constituency proposed the deletion of Z353 and Z354.

- Z353 and Z354 are rarely performed procedures, historically completed prior to the availability of image guided core biopsies. If a surgical biopsy of a rib is required, this can be billed under a revised M105 - rib resection (see below).

Committee Comments

- Given the committee's recommendation regarding M105, these codes need to remain in the Schedule of Benefits.
- The committee does not support this proposal.

23.14 Z337 - Rib resection for drainage (PFAF 23-106)

Constituency Proposal

- The constituency proposed the deletion of Z337.
- Z337 is a rarely performed procedure. If a rib resection for drainage is required then this can be billed either as M105 - chest wall resection, or as Z357 - thoracic window creation, depending on the indication.

Committee Comments

- The committee supports the deletion of Z337.
- Z354 is to be re-written as, "Z354 Excisional biopsy of rib, or rib resection for drainage."

23.15 Z332 - Aspiration with therapeutic drainage with or without diagnostic sample (PFAF 23-060)

23.16 Z331 - Aspiration for diagnostic sample (PFAF 23-059)

Constituency Proposal

- The constituency proposed a revision to Z332 as follows:

  Z332 Thoracentesis - Aspiration <u>for diagnosis or for therapeutic drainage</u> ~~with therapeutic drainage with or without diagnostic sample~~

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

- With this revision, the constituency also requested the deletion of Z331 - aspiration of diagnostic sample.
- Z331 will be combined as part of the revised Z332 to more accurately represent the risk of thoracentesis when performed for either indication.

Committee Comments

- The committee supports the proposal in principle, subject to fitting.

23.17 Z333 Endoscopy - with transbronchial biopsy under image intensification (including bronchoscopy) (PFAF 23-058)

Constituency Proposal

- The constituency proposed the deletion of Z333.

Committee Comments

- The committee supports this proposal.

23.18 Z352 - Intrapleural administration of thrombolytic or fibrinolytic agent via thoracostomy tube (chest tube) (PFAF 23-062)

23.19 Z349 - Intrapleural administration of chemotherapy or sclerosing agent - by any method (PFAF 23-061)

Constituency Proposal

- The constituency proposed a revision to Z352 as follows:

  Intrapleural administration of thrombolytic agent, fibrinolytic agent, chemotherapy or sclerosing agent via thoracostomy tube (chest tube).

  (Revisions underlined)

- With this revision, the constituency also requested the deletion of Z349 -intrapleural administration of chemotherapy or sclerosing agent - by any method.

Committee Comments

- As this is a new fee code, the committee recommends a moratorium on further changes until accurate utilization data becomes available. The proposal may be revisited during a future fee setting process.
- The committee does not support this proposal at this time.

23.20 Z338 - Biopsy of pleura or lung - with limited thoracotomy (PFAF 23-107)

Constituency Proposal

- The constituency proposed the deletion of Z338.
- Z338 is no longer performed with the ability to complete VATS surgery. When a pleural biopsy is required, this is completed VATS and can be billed more appropriately as Z335. If a lung biopsy is being completed, then this is usually M145 or a VATS wedge resection to reflect the lung resection.

Committee Comments

- The committee supports this proposal.

23.21 R940 - Mesenteric or celiac artery repair - Pulmonary thromboendarterectomy (PTE) – includes circulatory arrest with hypothermia (PFAF 23-097)

Constituency Proposal

- The constituency proposed a fee increase to R940 from $2,021.05 to $2,728.42, by 35.0 per cent.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

23.22 M106 - Chest wall reconstruction - Mediastinal tumour (PFAF 23-098)

Constituency Proposal

- The constituency proposed a revision to the payment rules for M106.
- The proposed payment rule addition is to allow the following E-codes to be billed with M106:
    - E615... Intrapericardial dissection
    - E611... resection of diaphragm and direct suture closure
    - E849... resection of diaphragm and reconstruction
    - E848... reconstruction of pericardium requiring repair with graft material
    - E618… decortication of remaining lobes
    - E620... with wedge bronchoplasty
    - E621... with diagnostic wedge resection
    - E608... each additional wedge resection
    - E607... reoperation more than 30 days

Committee Comments

- No evidence has been provided that that shows M106, as currently billed, is undervalued relative to other surgical codes used by this section.
- The committee does not support this proposal.

23.23 M106 - Chest wall reconstruction mediastinal tumour (PFAF 25-268)

Constituency Proposal

- The constituency proposed a fee value increase to the M106 fee code, from $1,004.00 to $1,255.00 (25.0%).
- The constituency stated as the population ages, there has been more complexity in the surgical management of mediastinal masses. The tendency for thymic neoplasms in particular toward invasion, increases complexity of resection, often requiring resection of lung, pericardium or vascular structures.

Committee Comments

- The committee supports an increase to this fee code, subject to fitting and relativity.

23.24 N284 - Chest wall reconstruction - Excision of first rib and/or cervical rib to include scalenotomy when required (PFAF 23-109)

Constituency Proposal

- The constituency proposed a fee increase to N284 from $408.00 to $714.00 (75 per cent) and a revision as follows:

    Excision of first rib and/or cervical rib to include scalenotomy, fibrolysis and neurolysis when required.

    (Revisions underlined)

Committee Comments

- The committee supports the proposed descriptor change.
- The committee supports this proposal, subject to fitting and relativity.

23.25 M155 - Lung transplant (one lung) (PFAF 23-112)

Constituency Proposal

- The constituency proposed a fee increase to M155 from $2,054.25 to $2,465.09 (20 per cent).
- When allocation became known, the constituency increased their proposed increase to $2670.55 (30 percent).

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

23.26 Z788 - Extracorporeal Membrane Oxygenator (ECMO) - includes cannulating and decannulating, by any method heart, vein and/or artery and repair of vessels if rendered (PFAF 23-113)

Constituency Proposal

- The constituency proposed to split the fee code based on two indications: (1) ECMO for respiratory indications (e.g., lung failure) and (2) ECMO for cardiac indications (e.g., heart failure).
- The constituency proposes a change in fee increase for respiratory indications, from $366.50 to $549.75 (50 per cent).

Committee Comments

- The committee does not support the proposal to split the fee code based on indication, as the section has not provided evidence that physician workload differs between the two indications on the day ECMO is initiated.
- The committee notes that the constituency's primary rationale for the value change was related to care of the patient receiving ongoing ECMO. That care could be compensated by existing assessment and procedure codes.
- The committee does not support this proposal.

23.27 E616 - Bilobectomy on right side, add (PFAF 23-134)

Constituency Proposal

- The constituency proposed a fee increase to E616 from $142.10 to $305.52 (115 per cent) and a revision as follows:

> bilobectomy on right side <u>or segmentectomy plus lobectomy (same side).</u>
>
> (Revisions <u>underlined</u>)

Committee Comments

- The committee supports the proposed descriptor change.
- The committee supports the proposed value change, subject to fitting and relativity.

23.28 E676A - Morbidly obese patient, surgeon, to procedural fee(s), add (PFAF 23-223)

Constituency Proposal

- The constituency proposed a revision to the payment rules for E676A as follows:

  b. The surgery is rendered under general anaesthesia using either an open or minimally invasive technique for the thorax.

  (Revisions underlined)

Committee Comments

- Committee data analysis fails to demonstrate an increase in time associated with an increased BMI for the procedures listed in this proposal. The committee does not support this proposal.

23.29 R352 - Pectus excavatum or carinatum repair (by reconstruction, not implant) (PFAF 25-045)

Constituency Proposal

- The constituency proposed an increase in value to the R352 fee code, from $832.30 to $1,331.68 (60.0%).
- The constituency stated the current value of R352 does not capture the additional complexity of the procedure as it has evolved over time.

Committee Comments

- The committee supports the proposed fee value change, subject to fitting and relativity.

23.30 Sxxx - Sequential cryotherapy for intercostal neuralgia (PFAF 25-048)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for the sequential application of cryotherapy to intercostal nerves for blockade during major thoracic surgery.
- The constituency proposed the new fee code be valued at $300.00 with the following descriptor:

  Sxxx – Sequential application of cryotherapy to intercostal nerves for blockade during major thoracic surgery, more than 4 nerves
- The constituency proposed the following payment rule:
  1. Minimum of 4 intercostal nerves need to be ablated.
- The constituency stated cryotherapy is a novel method of nerve blockade which allows for consistent, long-term analgesia that lasts weeks-months after application. Cryotherapy has recently been shown to improve post operative pain control, reduce length of stay, and reduce complications.

Committee Comments

- The committee notes the constituency's feedback that this has become standard of care for a set of procedures within this section.
- Given that, the section should increase the value of these procedures if they are out of relativity rather than creating an add-on code.
- The committee does not support this proposal.

23.31 Multiple fee codes - Payment rules revision to thoracic oesophagus codes (PFAF 25-049)

Constituency Proposal

- The constituency proposed a revision to the following fee codes' payment rules to allow for 'B' codes, with a 10-unit startup:
  - S090 - Total thoracic oesophageal resection.
  - S091 - abdominal or transthoracic approach with fundal plication.
  - S092 – recurrent.
  - S096 - Ruptured oesophagus, suture and drainage.
  - S098 - with stomach.
  - S099 - with colon or jejunum.
- For procedures on the oesophagus, the following basic units for assistants and anaesthesiologists will apply except if a basic fee is listed.
  - S073 - Cervical approach… from 6 to 7
  - S074 - Thoracic approach… from 10 to 13
  - S075 - Abdominal approach… from 7 to 8

- The constituency stated only procedures on the esophagus have a unique billing code for assistants and anaesthesiologists. This leads to problems with manual reviews and results in multiple OHIP rejections.

Committee Comments

- The committee proposes deleting reference to assistants for codes S073, S074 and S075.
- The committee proposes adding base assist units for esophageal surgery and continues to deliberate the appropriate number of units.

23.32 A643, A644, and A645 - Increase in value of general thoracic consultation and assessment fee codes (PFAF 25-127)

Constituency Proposal

- The constituency proposed a fee value increase to the following 3 fee codes:

Fee code	Description	Current Value	Proposed Value	% increase
A643	Specific assessment	44.40	55.30	20%
A644	Partial assessment	24.10	28.90	20%
A645	Consultation	98.55	118.25	20%

Committee Comments

- The committee supports the proposed value changes subject to fitting and relativity.

23.33 M135 - Major decortication of lung for empyema or tumour (PFAF 25-203)

Constituency Proposal

- The constituency proposed a fee value increase to the M135 fee code, from $848.80 to $1,103.45 (30.0%).

Committee Comments

- The committee notes that one rationale for increasing the value of this code was related to post-operative care. With surgical unbundling, this rationale no longer applies.
- Committee analysis indicates that this code is not out of relativity with other surgical codes within this section.
- The committee does not support this proposal.

23.34 S090 - Total thoracic oesophageal resection (PFAF 25-234)

Constituency Proposal

- The constituency proposed a fee value increase to the S090 fee code, from $1,912.30 to $2,199.15 (15.0%).
- The constituency stated there has been a fundamental shift in the management of these patients in the recent 1-2 years. Whereas previous neoadjuvant approach has been with radiation and a chemosensitizer, a recent practice-changing trial now recommends perioperative cytotoxic chemotherapy.

Committee Comments

- The committee notes that the section decreased the proposed value change to 10%.
- Committee analysis indicates that this code is not out of relativity with other surgical codes within this section.
- The committee does not support this proposal.

24 Genetics

24.1 Kxxx Genetic Clinical Analysis and Care Planning (PFAF 21-D17)

Constituency Proposal

- The constituency 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.

Committee Comments

- Introducing a time-based non-patient-facing fee code represents a change with system-wide implications. Such a change exceeds the scope of the PPC.
- The committee is of the opinion that the work may be better compensated through the ongoing Alternate Payment Program discussions.
- The committee does not support this proposal.

24.2 K044 Genetic Family Counselling (PFAF 21-D18)
24.3 K016 Genetic assessment, patient or family (PFAF 21-D19)
24.4 A221 Genetic minor assessment (PFAF 21-D20)
24.5 A/C325 Limited consultation (PFAF 21-D21)

Constituency Proposal

- The constituency requested that the following fee codes be delisted:
    - K044 - Genetic Family Counselling
    - K016 - Genetic assessment, patient or family
    - A221 - Genetic minor assessment
    - A/C325 - Limited consultation
    - K223 - Clinical Interpretation

Committee Comments

- The committee notes the constituency's decision to withdraw these proposals.
- The committee supports the deletion of K016.

24.6 A225, K222 & K223 - Limited consultation (PFAF 25-014)

Constituency Proposal

- The constituency proposed fee value increases to the following codes:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A225	Consultation	$167.90	$198.10	18%
K222	Genetic Care, patient or family, per unit	$79.30	$94.35	19%
K223	Clinical interpretation by a geneticist	$40.00	$42.80	7%

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

25 Geriatric Medicine

25.1 Multiple Fee Codes– Fee value changes (PFAF 25-104, 25-111, 25-113)

Constituency Proposal

- The constituency proposed value changes to the following fee codes:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A/C/W770	Geriatrics (07) - Extended comprehensive geriatric consultation	$401.30	$446.45	11.3%
A070	Geriatrics (07) - Consultation in association with special visit to a hospital-in-patient, long-term care in-patient or emergency department patient	$232.10	$266.90	15.0%
A075	Geriatrics (07) - Consultation	$202.55	$232.95	15.0%
C075	Geriatrics (07) - Consultation	$232.10	$266.90	15.0%
W075	Geriatrics (07) - Consultation	$232.10	$258.20	11.2%
A/C/W775	Geriatrics (07) - Comprehensive geriatric consultation	$310.45	$345.35	11.2%
A/C071	Geriatrics (07) - Complex medical specific re-assessment	$91.90	$109.35	19.0%
A/C073	Geriatrics (07) - Medical specific assessment	$90.45	$103.10	14.0%
A/C074	Geriatrics (07) - Medical specific re-assessment	$72.90	$83.10	14.0%
A078	Geriatrics (07) - Partial assessment	$45.30	$51.65	14.0%
C072	Geriatrics (07) - Subsequent visits - first five weeks, per visit	$34.10	$37.95	11.3%
K703	GP/FP (00) - Geriatric out-patient case conference, per unit	$32.45	$36.10	11.2%
A/C/W076	Geriatrics (07) - Repeat consultation	$105.25	$117.10	11.3%
C077	Geriatrics (07) - Subsequent visits - sixth to thirteenth week inclusive (maximum 3 per patient per week, per visit	$34.10	$37.95	11.3%
C078	Geriatrics (07) - Concurrent care, per visit	$34.10	$37.95	11.3%

A/C/W375	Geriatrics (07) - Limited consultation	$105.25	$117.10	11.3%
C079	Geriatrics (07) - Subsequent visits - after thirteenth week (maximum 6 per patient per month), per visit	$34.10	$37.95	11.3%
W073	Geriatrics (07) - Nursing home or home for the aged - first 2 subsequent visits per patient per month, per visit	$34.10	$37.95	11.3%
W272	Geriatrics (07) - Admission assessment - Type 1	$69.35	$77.15	11.2%
W072	Geriatrics (07) - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month, per visit	$34.10	$37.95	11.3%
B988	SVP - Geriatric Home Visit - excluding Nights (00:00 - 07:00) - First Person Seen	$82.50	$91.80	11.3%
B986	SVP - Geriatric Home Visit - Travel Premium	$36.40	$45.50	25.0%

Committee Comments

- The committee supports these fee value changes, subject to fitting and relativity; Except:
  - B988 – The committee notes that B998 needs to remain equal to this code.
  - B986 – The committee notes that travel premiums are billed by all sections and any change would require broad support. The committee does not support this change.

25.2 A/C07x – Multiple Assessment codes (PFAF 25-108)

Constituency Proposal

- The constituency proposed revisions of payment rule commentary for multiple assessments codes, specifically: A/C073, A/C074, A/C071, A/C078.
- The constituency proposed the addition of commentary similar to that used for geriatrics:

  A07x/C07x is eligible for payment when the purpose is for the assessment of dementia regardless of the patient's age.

Committee Comments

- The committee supports the proposal in principle and is drafting appropriate schedule language.
- The committee will reach out to the constituency, as required.

25.3 K077 – Geriatric Telephone Support (PFAF 25-110)

Constituency Proposal

- The constituency proposed a fee value change from $40.05 to $44.55 (by 11.2%) and the revision of payment rules 1 and 2:

Payment rules:

1. *A maximum of two (2) three (3) units of K077 are eligible for payment per patient per day.*
2. *A maximum of eight (8) twelve (12) K077 units are eligible for payment per patient per 12-month period.*

(revisions underlined, deletions strikethrough)

Committee Comments

- The committee supports the change in fee value, subject to fitting.
- The committee does not support increasing the maximum per day.
- The committee supports increasing the maximum per year to 12.

26 Haematology & Medical Oncology

26.1 E078 - Chronic Disease Assessment Premium (PFAF 23-ONC-1)

Constituency Proposal

- The constituency requested that Myeloproliferative Neoplasms (Polycythemia Rubra Vera, Essential Thrombocytosis and Myelofibrosis) be added to the list of E078 applicable diagnostic codes (full list can be found on GP26).

Committee Comments

- The committee notes that in the section's response, it is not clear that this would address an intra-sectional relativity issue.
- The committee does not support this proposal.

26.2 G388 - Management of special oral chemotherapy, for malignant disease (PFAF 23-ONC-4)

Constituency Proposal

- The constituency requested the following changes to G388:

  a. increase the fee value from $25.75 to $60.00, by 133 per cent; and
  b. amending payment rule 2 to remove the 12-month limit, as follows:

  "G388 is only eligible for payment once every twenty-one (21) days ~~to a maximum of six (6) services per patient per 12 month period.~~"

  (Deletions ~~strikethrough~~)

- The constituency notes that the original decision to limit oral chemotherapy billing to 6 times per year does not reflect current practice of oral chemotherapy administration, which is most frequently continuous.
- The proposed fee value would bring the service into relativity with other IV chemotherapy administration/management.

Committee Comments

- The committee supports changing the payment rule to allow for monthly billing.
- The committee supports a value change, subject to fitting and relativity.

26.3 G389 - Infusion of gamma globulin, initiated by physician, including preparation per patient, per day (PFAF 23-ONC-2)

Constituency Proposal

- The constituency requested the following changes to G389:
    a. Increase the fee value from $13.90 to $20.00, by 43.9 per cent;
    b. changing the descriptor to,

    "Outpatient infusion of blood products – red cells, platelets, gamma globulin, clotting factors and intravenous iron"

    c. Introduce the following new payment rules:
        - Maximum one unit per patient per day, outpatient only.
        - This code is not to be used for transfusion in the setting of Congenital Anemias. The code utilized for these patients should be G098.
- The constituency states that the proposal to expand the billing code G389 to cover various blood products and iron infusions in the outpatient setting is a logical step towards addressing disparities in physician reimbursement for treating patients with classical hematological conditions. This expansion recognizes the landscape of hematological care.

Committee Comments

- The section states that the physician work associated with the administration of blood products and iron consists of obtaining and documenting consent and being in a position to manage all side effects. The committee believes this work is currently bundled with assessments (See items F. & G. on page GP15). The committee does not support unbundling that work.
- G389 is only eligible for payment if the IVIg infusion is initiated and prepared personally by the physician which does not occur when iron or other blood products are given.
- The committee does not support this proposal.

26.4 G390 - Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy) (PFAF 23-ONC-5)

Constituency Proposal

- The constituency requested a descriptor change to G390 as follows,
    G390 Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy) and/or Supervision of biologic agent(s) such as CAR-T infusion (maximum of 1 per infusion) and/or Supervision of bispecific antibody infusion, during initial dosing phase, where there is a high risk of cytokine release syndrome (maximum of 3 per initial dosing phase)

(Revisions underlined)

- Given the intensive monitoring, the Hematology Oncology section is requesting addition of the first bispecific antibody therapy and CART infusion under the G390 code.
- Subsequent bispecific antibody infusion should be billed under the code G359 because of severe immunosuppression and other associated side effects.

Committee Comments

- The committee has drafted schedule language addressing this proposal and notes the constituency's agreement.

26.5 Z403 - Bone marrow aspiration and/or core biopsy (PFAF 23-ONC-3)

26.6 Z403 - Bone marrow aspiration (see Schedule for additional details) (PFAF 25-086)

Constituency Proposal

- The constituency requested a fee value change from $101.25 to $130.00, by 28 per cent.
- During the last allocation process, the Section's proposal intended for the existing code Z403 to replace both Z403 ($42.20 bone marrow aspiration) and Z408 (bone marrow biopsy, billed at $79.20). The decision to combine these two procedures into a single code was prompted by the common practice of billing only under Z403, even when both aspiration and biopsy procedures were carried out.
- Historically, some physicians have managed to secure reimbursement for both procedures by means of manual review requests submitted to the Ministry of Health (MOH, yielding a total reimbursement of $121). However, with the introduction of the current revised billing code for bone marrow testing at $101.25, it becomes evident that a code fee reduction has occurred.
- This updated fee will accurately reflect the comprehensive nature of both bone marrow aspiration and biopsy procedures, taking into account inflation and ensuring fair compensation for these vital medical services.
- The constituency modified their 2023 proposal and now proposes a fee value change to Z403 - Bone marrow aspiration from $101.25 to $133.55 (by 31.9%).

Committee Comments

- The committee supports this proposal, subject to fitting.

26.7 Gxxx - Systemic Therapy Planning (PFAF 21-D22)

Constituency Proposal

- The constituency requested the creation of a new systemic therapy planning fee code valued at $125.00.
- The planning of each subsequent line of chemotherapy is the standard of care for patients being treated for cancer, where the principles of management include using sequential lines of different systemic therapies to prolong life and maintain quality of life. Code would be billable for the initial and each new subsequent line of therapy.

Committee Comments

- All of the services the section has described are currently bundled with consults and assessments. The committee does not support unbundling these services.
- The committee does not support this proposal.

26.8 A/Cxxx – Comprehensive hematology consultation (PFAF 25-088)

Constituency Proposal

- The constituency proposed the creation of a comprehensive hematology consultation payable at $319.80.
- This service is a consultation rendered by a specialist in hematology 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.
- Proposed payment rules:
    1. Start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
    2. The service must satisfy all the elements of a consultation.
    3. The calculation of the 75-minute minimum time excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

26.9 A/Cxxx – Comprehensive medical oncology consultation (PFAF 25-103)

Constituency Proposal

- The constituency proposed the creation of a comprehensive medical oncology consultation payable at $319.80.
- This service is a consultation rendered by a specialist in medical oncology 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.
- Proposed payment rules:
    1. Start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
    2. The service must satisfy all the elements of a consultation.
    3. The calculation of the 75-minute minimum time excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

26.10 A/Cxxx – Comprehensive care review for transition treatment (PFAF 25-089)

Constituency Proposal

- The constituency proposed the creation of a comprehensive care review for transition treatment payable at $125.00.
- This service is a comprehensive review rendered by a specialist in hematology/oncology who provides all the appropriate elements of complex medical specific re-assessment in patients with a malignancy or complex non-hematological blood disorder who require a distinct new treatment or distinct change in treatment, or transition to palliative care alone, including the transition to palliative care alone.
- Proposed payment rules:
    1. Billable for the initial and each new subsequent line of therapy.
    2. Cannot be billed with A615 or complex consultation.
    3. Maximum of 3 services per year.
    4. Billable by a specialist in haematology (61) or medical oncology (44).

Committee Comments

- The committee notes that this work is currently compensated through existing assessment and management fees.
- If existing assessment and management fees are out of relativity with other services, the section may propose increasing the value of those fee codes.
- The committee does not support this proposal.

26.11 A/Cxxx – Comprehensive care review for transition treatment (PFAF 25-105)

Constituency Proposal

- The constituency proposed the creation of a comprehensive care review for transition treatment payable at $125.00.
- This is a new follow-up code to be billed for follow-ups by oncologists where a new distinct anti-cancer treatment plant is discussed, or transition of palliative care is discussed.
- Proposed payment rule:
    1. Maximum of 3 per patient per physician per 12-month period. Any amount in excess of that will be adjusted to a lesser assessment fee.

Committee Comments

- The committee notes that this work is currently compensated through existing assessment and management fees.
- If existing assessment and management fees are out of relativity with other services, the section may propose increasing the value of those fee codes.
- The committee does not support this proposal.

26.12 Preamble – Chemotherapy (PFAF 25-109)

Constituency Proposal

- The constituency proposed a revision to the Chemotherapy Preamble (page J58):

    Chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) - with administration supervised by a physician for intravenous infusion for treatment of malignant or autoimmune disease. The physician must be available to intervene in a timely fashion at the

initiation and for the duration of the prescribed therapy to manage immediate and delayed toxicities. The physician may be available in person or remotely.

(revisions underlined)

- The constituency would like to clarify the language to make it abundantly clear that the physician may supervise and bill remotely or in person.

Committee Comments

- This proposal speaks to the need for a broader reassessment of management and supervision fees associated with the delivery of chemotherapy.
- The committee will explore a process to achieve that broader reassessment with input from all stakeholders.

26.13 Geriatric age-based premium (PFAF 25-092, 25-179)

Constituency Proposal

- The constituency proposed the addition of consultation and visit codes rendered by a physician registered with OHIP specialty medical oncology (44) or haematology (61) to be eligible for the geriatric age-based premium listed on page GP64.
- This would apply to the following fee codes: A445, A443, A441, A444, A448, A615, A613, A611, A614, A618.

Committee Comments

- The proposed change has broad implications across the Schedule of Benefits and require consultation with all affected sections.
- The committee does not support the proposal.

26.14 E078 – Chronic Disease Premium (PFAF 25-090, 25-098, 25-106)

Constituency Proposal

- The constituency proposed the addition of the following diagnostic codes to the E078 Chronic Disease Premium on page GP25/26 when the service is rendered by a physician registered with OHIP specialty medical oncology (44) or haematology (61).
- Non-malignant haematological diagnosis:
    - 283 – Chronic acquired hemolytic anemia
    - 285 – Anemia NYD
    - 288 – Neutropenia
- Malignant hematological diagnosis:
    - 202 – Lymphoma
    - 203 – Multiple myeloma/immunoproliferative neoplasms
    - 204 – Lymphoid leukemia
    - 205 – Myeloid leukemia
- All diagnostic codes for malignant diseases (examples: colon cancer, prostate cancer, breast cancer, etc.): 140 to 165, 170 to 175, 179 to 199

Committee Comments

- With the inclusion of these diagnosis codes, most of the patients seen by this constituency would qualify for this premium.
- Therefore, this proposal does not address intrasectional relativity.
- The committee does not support this proposal.

26.15 G381 - Chemotherapy - Standard chemotherapy - agents with minor toxicity that require physician monitoring

26.16 G281 - Chemotherapy - each additional standard chemotherapy agent, other than initial agent (PFAF 25-197)

Constituency Proposal

- The constituency proposed the amalgamation of G381 and G281 into a single fee code on a cost-neutral basis.
- This would be done by revising G381 - Chemotherapy - Standard chemotherapy - agents with minor toxicity that require physician monitoring, including any additional standard chemotherapy other than the initial agent.

Committee Comments

- The committee supports this proposal.

26.17 Multiple Fee Codes– Fee value changes (PFAF 25-091, 25-204)

Constituency Proposal

- The constituency proposed value changes to the following fee codes to better reflect the time and complexity of the service provided:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A613	Haematology - Medical specific assessment	$85.80	$95.25	11.0%
A614	Haematology - Medical specific re-assessment	$65.85	$73.10	11.0%
A611	Haematology - Complex medical specific re-assessment	$76.20	$84.60	11.0%
A618	Haematology - Partial assessment	$38.05	$42.25	11.0%
A443	Medical Oncology - Medical specific assessment	$79.85	$88.65	11.0%
A444	Medical Oncology - Medical specific re-assessment	$61.25	$68.00	11.0%

A441	Medical Oncology - Complex medical specific re-assessment	$70.90	$78.70	11.0%
A448	Medical Oncology - Partial assessment	$38.05	$42.25	11.0%

Committee Comments

- The committee supports these proposals, subject to fitting and relativity.
- The committee notes that C and W versions of these codes would also increase.

26.18 A615 – Haematology (61) – Consultation (PFAF 25-095)

26.19 A445 – Medical Oncology (44) – Consultation (PFAF 25-176)

Constituency Proposal

- The constituency proposed value changes to the following fee codes to better reflect the time and complexity of the service provided:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A615	Haematology (61) - Consultation	$172.00	$206.50	20.1%
A445	Medical Oncology (44) - Consultation	$166.50	$206.50	24.0%

Committee Comments

- The committee supports these proposals, subject to fitting and relativity.
- The committee notes that C and W versions of these codes would also increase.

26.20 G382 - Chemotherapy - Monthly telephone supervision (PFAF 25-097, 25-112)

Constituency Proposal

- The constituency proposed a value change to G382 Chemotherapy - Monthly telephone supervision - Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, from $13.95 to $30.00 (by 115.1%).

Committee Comments

- The committee supports a value change, subject to fitting and relativity.

26.21 G359 - Chemotherapy - Special single agent or multi-agent therapy

26.22 G345 - Chemotherapy - Complex single agent or multi-agent therapy (PFAF 25-087, 25-107)

Constituency Proposal

- The constituency proposed amalgamating G359 and G345 by revising the fee codes and changing the fee value, such that Haematology & Medical Oncology would no longer bill G345.
- G359 - Special single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician, currently paid at $105.15.
- G345 - Complex single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) that can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicities that may require immediate intervention by the physician, paid at $75.00.
- Under this proposal, both G359 and G345 would pay $97.90.
- Revised descriptor for G359:

  Complex or special single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) for a malignant diagnosis that can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicities, and/or with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician in person or virtually.
- Proposed payment rules:

  1. Diagnostic codes restricted to malignant hematology/oncology diagnostic codes.
  2. G359 would then be billable only for administration of systemic therapy for malignant disease.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

27 Hospital Medicine

27.1 Cxxx - Inpatient transfer of care (PFAF 21-D23)

27.2 Admission Assessment – General Requirements - Payment Rule 3 amendment (PFAF 21-D24)

27.3 Cxxx - Day of discharge, medically complex patient (PFAF 21-D25)

27.4 Wxx2 - MRP day of discharge, medically complex patient, long term care or chronic care facility (PFAF 21-D26)

Constituency Proposal

- The constituency requested:
  - 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.
  - Amend the Admission Assessment – General Requirements - Payment Rule 3 (GP40), such that (1) general or specific assessments or reassessment are eligible for payment per physician per admission when care is transferred from one physician to another physician, (2) Such assessments related to transfer of care should be limited to once a week (Monday-Sunday), and (3) E083 or E084 should apply to these codes to reflect the MRP (Most Responsible Physician) providing the service.
  - Create a new medically complex patient - day of discharge fee of $106.85 with the same service elements as C124, or a fee increase to C124 from $61.15 to $106.85.

- Create new MRP day of discharge fees for inpatients in chronic care settings, similar to MRP discharge fees for hospital inpatients; Wxx1 MRP day of discharge (equal to C124 at $61.15) and Wxx2 MRP day of discharge, medically complex patient (equal to Cxx at $106.85)

Committee Comments

- The committee notes that the constituency submitted updated requests pertaining to 21-D23 and 21-D25, please see the following 2025 proposals for more detail:
  - Discharge Medically Complex Patient (PFAF 25-144)
  - Inpatient transfer of care (PFAF 25-139)

27.5 Cxxx – Inpatient transfer of care (PFAF 25-139)

Constituency Proposal

- The constituency proposed a new code for inpatient transfer of care at $31.35, eligible for payment to the MRP provider who is transferring care of medically complex patients to an oncoming MRP.
- Payment is eligible when there is a minimum of 10 minutes work to provide a safe and effective handover as per CMPA/CPSO policies. The 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).

Committee Comments

- The committee notes that there is a provision within the 2021 Physician Services Agreement to establish a hospitalist APP.
- This proposal involves a significant change which affects many physician groups aside from hospitalists and would require consultation with those groups.
- The committee does not support this proposal.

27.6 Cxxx – Discharge Medically Complex Patient (PFAF 25-144)

Constituency Proposal

- The constituency proposed a new code for discharge of complex patients from acute care facility, day of discharge payable at $95.10.
- Discharging a medically complex patient from acute care or health-care institution with 3 or more chronic diseases which requires significant time commitment to complete, total of 45 minutes direct and indirect time.
- 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.
- This fee code 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.

Committee Comments

- The committee supports the creation of this code and continues to deliberate appropriate payment rules.
- The committee awaits feedback from the constituency to aid in its deliberations.

27.7 Wxxx – Discharge patient from LTC or Complex Continuing Care facility (PFAF 25-146)

Constituency Proposal

- The constituency proposed a new code for discharge of patients from LTC or complex continuing care facility payable at $61.15.
- Definition/Required elements of service: Subsequent visit by the MRP – day of discharge is payable to the physician identified as the MRP for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any. The discharge summary must include as a minimum the following information:
    a. reason for admission;
    b. procedures performed during the hospitalization;
    c. discharge diagnosis;
    d. medications on discharge; and
    e. follow-up required

Committee Comments

- The committee supports this proposal, with the addition that schedule language would make it clear that the patient is being discharged to another facility and provider for ongoing care.

27.8 Kxxx – Interprofessional rounds (PFAF 25-147)

Constituency Proposal

- The constituency proposed a new code for inter-professional rounds payable at $31.35 per 10-minutes.
- Definition and Required Elements of Service: Interdisciplinary Care Conference (ICC) is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers, and/or regulated health professionals, conducted for the purpose of discussing and directing the management and disposition planning of one or more hospital, chronic care, or long-term care patients where the physician is in attendance either in person
- Proposed payment rules:
    1. Kxxx is only eligible for payment in circumstances where the ICC is pre-scheduled.

2. Kxxx is eligible for payment for each patient discussed where the total time of discussion for all patients meets at least 10 minutes, where the number of patients for Kxxx is payable is adjusted to correspond to the overall time of discussion.
3. Kxxx are only eligible for payment if the physician is actively participating in the case conference, and their participation is documented in the record.
4. Kxxx is limited to a maximum of 3 services per patient per day.
5. Kxxx is limited to a maximum of 9 services per physician, per day and 28 units per physician per week.
6. Any other insured service rendered during an ICC is not eligible for payment.
7. Kxxx is only eligible for payment to the Most Responsible Physician
8. Kxxx is only eligible for payment to physicians from General and Family Practice (00) or Internal Medicine (13).
9. Kxxx is eligible for payment in conjunction with any hospital assessment or subsequent visit (e.g.: C002 / C007 / C009 / C132 / C137 / C139 / C122 / C123 / C124 / C933 / C135 / C121 / C882 / W882 / C982 / W002 / W001 / W132 / W121).

- Proposed medical record requirements:
  1. identification of the patient;
  2. identification of eligible participants;
  3. total time of discussion for all patients discussed; and
  4. the outcome or decision of the case conference related to each of the patients discussed.

Committee Comments

- The committee notes that there is a provision within the 2021 Physician Services Agreement to establish a hospitalist APP.
- This proposal involves a significant change which affects many physician groups aside from hospitalists and would require consultation with those groups.
- The committee does not support this proposal.

27.9 Multiple Fee Codes – Fee value changes (PFAF 25-149, 25-142)

Constituency Proposal

- The constituency proposed value changes to the following fee codes to better reflect the time and complexity of the service provided:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
C002	GP/FP - Non-emergency hospital in-patient services - Subsequent visits - Up to five weeks - Per visit	$34.10	$42.45	24.5%
C132	Internal Medicine - Non-emergency hospital in-patient services - Subsequent visits - First five weeks - Per visit	$34.10	$42.45	24.5%
C007	GP/FP - Non-emergency hospital in-patient services - Subsequent visits - 6th-13th wks. incl. (max. of 3/per patient/wk.)	$34.10	$42.45	24.5%

C137	Internal Medicine - Non-emergency hospital in-patient services - Subsequent visits - 6th-13th wks inclusive (max. of 3 per patient/wk.) - Per visit	$34.10	$42.45	24.5%
C009	GP/FP - Non-emergency hospital in-patient services - Subsequent visits - After 13th week (max. of 6/per patient/mth)	$34.10	$42.45	24.5%
C139	Internal Medicine - Non-emergency hospital in-patient services - Subsequent visits - After 13th week (max. of 6/patient/mth)	$34.10	$42.45	24.5%
C121	Subsequent visits by the MRP following transfer from an Intensive Care Area - Additional visits due to intercurrent illness	$34.10	$42.45	24.5%
C122	All specialties - Subsequent visits by the MRP - Day following hospital admission assessment	$61.15	$71.35	16.7%
C123	All specialties - Subsequent visits - MRP - Second day following hospital assessment	$61.15	$71.35	16.7%
C142	First subsequent visit by the MRP following transfer from an intensive care area	$61.15	$71.35	16.7%
C143	Second subsequent visit by the MRP following transfer from an Intensive Care Area	$61.15	$71.35	16.7%

Committee Comments

- The committee supports a proposed increase to the fee codes listed, subject to fitting and relativity.

27.10 Multiple Fee Codes – Hospital Inpatient Subsequent Visits (PFAF 25-142)

Constituency Proposal

- The constituency proposed revisions and fee value changes to the Hospital inpatient subsequent visits (C002/C132, C007/C137, C009/C139 and C121):
    - The constituency proposed removing limits from rounding codes when required for non-alternate level of care (ALC) patients.
    - Current limits can remain for ALC patients.
    - The constituency proposed raising the fee value from $34.10 to $42.45 (by 24.5%).

- The constituency subsequently proposed two approaches for the PPC to consider as modifications to their proposal:
    1. Remove or revise weekly and monthly limits on C007, C137, C009, C139
    2. Alternate proposal: Allow E083/E084 MRP premium with C121
- The constituency notes that providers should not be paid less than the usual subsequent visit code to provide care during an intercurrent illness.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

28 Hyperbaric Medicine

28.1 Axxx - Consultation in Hyperbaric Medicine (PFAF 23-140)

Constituency Proposal

- The constituency requested a new fee code Axxx Consultation in Hyperbaric Medicine, paid at $188.80.
- Proposed payment rules: As meeting all of the requirements for a consultation as defined in the Schedule of Benefits (GP16) for an approved indication for hyperbaric medicine as listed in the Schedule of Benefits (J37).
- This proposal seeks to designate a ubiquitous fee code to be used across all specialties when performing a consultation in hyperbaric medicine for an approved indication.

Committee Comments

- Consultation codes are reserved for specialties recognized by the Royal College of Physicians and Surgeons and who have a unique section designation from the Ministry of Health.
- Designating a new specialty falls outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.

28.2 Gxx1 – Pre-emptive Comorbidity Management - single fee

28.3 Gxx2 - Evolving Comorbidity Management fee - per 15 minutes (PFAF 25-275)

Constituency Proposal

- The constituency proposed new fee codes for the hyperbaric medicine specific management of certain comorbidities of chronic diseases:

Gxx1 - Pre-emptive Comorbidity Management - single fee paid at $12.51

  - In many instances hyperbaric physicians provide pre-emptive management of cases which could easily evolve into a need for more aggressive resuscitation. The interventions required include psychological counseling, educational intervention, high index of suspicion for narcotic dependency, and patient pre-treatment glycemic management. Intravenous line management as well as catheters and drains is a common requirement. Those with mobility challenges and morbid obesity require additional care and monitoring as well as careful transfer on and off of stretchers and in and out of the chamber, often requiring the use of lifting devices. Bowel & bladder incontinence must be managed as well. Reversible airways disease status and management optimization on a daily basis may be needed. Implementing a host of Eustachian tube function optimization options is the most common pre-emptive care provided.
  - The constituency proposes that this service be applicable only to treatment of patients with specific diagnoses (250, 381, 401,412, 428, 477, 493, 977) as well as incontinence of bowel or bladder as well as presence of intravenous lines, catheters, and drains.

Gxx2 - Evolving Comorbidity Management fee – per 15 minutes of hyperbaric treatment paid at $7.25

- Problems develop requiring urgent management while the patient is undergoing treatment:
    - The obligatory vasoconstriction imposed by hyperbaric oxygen therapy may precipitate angina in a previously stable patient.
    - Those with cerebral edema or known seizure disorder may deteriorate over the course of treatment necessitating monitoring by a physician at intervals requiring treatment modification.
    - Denovo deterioration into congestive failure/pulmonary edema and management may require changes to hyperbaric treatment and titration of treatment intensity against an individual's unique tolerance of increased peripheral vascular resistance. This typically requires aftercare medications / dialysis modification coordination as well.
- The constituency proposes that this service be applicable only to treatment of patients with specific diagnoses (300, 412, 428, 998).

Committee Comments

- The committee does not believe the proposed changes address intra-sectional relativity.
- The committee notes that existing consultation, assessment, and counselling fees, as well as other procedural fees, compensate for much of the work described in this proposal.
- The committee does not support this proposal.

28.4 HBOT – Hyperbaric Oxygen Therapy (PFAF 25-337)

Constituency Proposal

- The constituency proposed an addendum to the HBOT services on the Schedule of Benefits pages J35 and J36:
    - Added description: "HBOT is to be provided in Health Canada approved multi-patient chambers or single patient mono-chambers."
    - The constituency adding the following note/ indication (page J36):

      "HBOT is only eligible for payment for AVN of bone when the following conditions are met:
      Diagnostic imaging confirmation of symptomatic early to mid-stage AVN, e.g. Ficat stage I, II, or III or equivalent. "

Committee Comments

- The committee supports this proposal.

28.5 Multiple Fee Codes – Fee value changes (PFAF 25-348)

Constituency Proposal

- The constituency proposed fee value increases to G804 and G805 of 9.0%.
    - G804 - HBOT - Physician in hyperbaric unit but not in chamber(s) with patient(s), per session per patient - first ¼ hour; from $71.85 to $78.32.
    - G805 - HBOT - Physician in hyperbaric unit but not in chamber(s) with patient(s), per session per patient - after first ¼ hour (per ¼ hour or major part thereof); from $35.90 to $39.13.

Committee Comments

- The committee does not believe the proposed changes address intra-sectional relativity.

- The committee does not support the proposal.

29 Infectious Diseases

29.1 Relativity fee value changes to various consult and assessment codes (PFAF 23-252)

Constituency Proposal

- The constituency requested various fee values changes of around 3 per cent, subject to allocation:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A/C/W465	Infectious Diseases - Consultation	$181.65	$187.10	$5.45	3.00%
A/C463	Infectious Disease - Medical specific assessment	$94.40	$97.23	$2.83	3.00%
A/C464	Infectious Disease - Medical specific re-assessment	$72.45	$74.62	$2.17	3.00%
A468	Infectious Disease - Partial assessment	$45.00	$46.35	$1.35	3.00%
A/C461	Infectious Disease - Complex medical specific re-assessment	$83.85	$86.37	$2.52	3.00%
C462	Infectious Disease - Non-emergency hospital in-patient services - Subsequent visits - First five weeks - Per visit	$34.10	$35.12	$1.02	3.00%
A/C/W466	Infectious Disease - Repeat consultation	$109.40	$112.68	$3.28	3.00%
A/C/W460	Infectious Disease - Comprehensive infectious disease consultation	$310.45	$319.76	$9.31	3.00%

Committee Comments

- The committee notes the constituency's decision to withdraw this proposal when it submitted PFAF 25-043.

29.2 Gxxx - Supervision of Outpatient Antimicrobial Therapy (PFAF 21-D27)

Constituency Proposal

- The constituency requested a new code for the Supervision of Outpatient Antimicrobial Therapy at $25.00 per week with the following payment rules:
    - 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.
    - Providers would also need to be most responsible physician for any biochemical or other monitoring needed for therapy.
    - Clinicians can bill weekly while the patient is actively on therapy.
    - This service would be restricted to Infectious Disease specialists given that it is a specialized service.

Committee Comments

- Supervision of microbial therapy is not specific to Infectious Disease. Monitoring the condition of the patient and intervening, until the next insured service is included as an element of the preceding assessment fee (SOB GP15).
- The committee does not support this proposal.

29.3 Axxx - Management of Fecal Microbiota Transplant (FMT) (PFAF 21-D28)

Constituency Proposal

- The constituency requested a new code for the 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.

Committee Comments

- The committee acknowledges the constituency's decision to withdraw this proposal from consideration for the current allocation.

29.4 A/Cxxx – Complex infectious diseases assessment (PFAF 25-044)

Constituency Proposal

- The constituency proposed a new fee code for complex infectious diseases assessment, paid at $95.75.
- This service is an assessment for the ongoing management of the following infectious diseases where the complexity of the condition requires the continuing management by an infectious diseases specialist (46):

  a. active pulmonary or extrapulmonary disease due to mycobacterial tuberculosis complex (latent tuberculosis infection is excluded); or
  b. active pulmonary or extrapulmonary non-tuberculous mycobacterial disease (airway or tissue colonization without disease is excluded)
  c. Deep seeded fungal infection (aspergilloma is excluded) - e.g.: dimorphic fungi, candida auris infections
  d. Patient with an infection with a multi drug resistant organism (such as MDR pseudomonas, ESBL, AmpC, CPE, MRSA, VRE) who are currently requiring IV antibiotic (or PO linezolid) outside of hospital supervised by the billing physician. Note it does not include any patient on IV antibiotics but only those with multi drug resistance.
- The constituency proposed a rule to limit to 6 per patient per 12-month period.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

29.5 Multiple Fee Codes – Fee value changes (PFAF 25-043)

Constituency Proposal

- The constituency proposed value changes of 14.2% to the following fee codes.

- One exception is A468 with a value change of 40.6% to bring it back into relativity and compensate for complexity and time.

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A/C465	Infectious Disease (46) - Consultation	$181.65	$207.45	14.2%
A/C463	Infectious Disease (46) - Medical specific assessment	$94.40	$107.80	14.2%
A/C461	Infectious Disease (46) - Complex medical specific re-assessment	$83.85	$95.75	14.2%
A/C464	Infectious Disease (46) - Medical specific re-assessment	$72.45	$82.75	14.2%
A/C/W460	Infectious Disease (46) - Comprehensive infectious disease consultation	$310.45	$354.55	14.2%
A468	Infectious Disease (46) - Partial assessment	$45.00	$63.25	40.6%
A/C466	Infectious Disease (46) - Repeat consultation	$109.40	$124.95	14.2%
C462	Infectious Disease (46) - Subsequent visits - first five weeks, per visit	$34.10	$38.95	14.2%
C468	Infectious Disease (46) - Concurrent care, per visit	$34.10	$38.95	14.2%
C467	Infectious Disease (46) - Subsequent visits - sixth to thirteenth week inclusive (maximum 3 per patient per week, per visit	$34.10	$38.95	14.2%
A/C/W275	Infectious Disease (46) - Limited consultation	$105.25	$120.20	14.2%
C469	Infectious Disease (46) - Subsequent visits - after thirteenth week (maximum 6 per patient per month), per visit	$34.10	$38.95	14.2%
W462	Infectious Disease (46) - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month, per visit	$34.10	$38.95	14.2%

Committee Comments

- The committee supports increasing the value of these fee codes, subject to fitting and relativity.

29.6 Major Initiative - Compensation Model for SAP & EAP Forms (MI 25-02)

Constituency Proposal

- The constituency requested a compensation model for forms which physicians need to fill out for SAP and EAP.
- The constituency stated that organizing evidence therapeutics which are guideline-based, such as Fidaxomicin, is a time-consuming process which requires frequent correspondence.
- The constituency proposed that the compensation model should cover phone calls, paperwork or electronic applications required—including the correspondence for the urgent and often lifesaving medications they prescribe via EAP and SAP.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

30 Laboratory Medicine

30.1 Deletion of fee codes (PFAFs 23-066 to 23-075, 23-076 to 23-082, 23-088)

Constituency Proposal

- The constituency proposed the deletion of the following fees:

Fee code	Descriptor	Fee value
L801	Anatomic Pathology - Surgical Pathology - Metabolic bone studies	$95.30
L833	Anatomic Pathology - Surgical Pathology - Nerve teasing	$140.75
L807	Cytogenetics - Smear for sex chromatin (Barr Body) or Neutrophil drumsticks	$4.95
L811	Cytogenetics - Y chromosome	$6.05
L803	Cytogenetics - Karyotype	$73.95
L832	Special Procedures and Interpretation - Histology or Cytology - X-ray diffraction analysis and interpretation	$23.70
L831	Special Procedures and Interpretation - Histology or Cytology - analytical electron microscopy, elemental detection or mapping, electron diffraction, per case, add	$49.35
L847	Special Procedures and Interpretation - Histology or Cytology - Caffeine - halothane contracture test and other confirmatory tests for malignant hyperthermia	$65.15
L828	Biochemistry and Immunology - Interpretation of hormone receptors for carcinoma to include estrogen and/or progesterone assays	$7.95
L830	Haematopathology - Terminal transferase by immunofluorescence	$11.85
L838	Haematopathology - Leukocyte phenotyping by monoclonal antibody technique	$19.80
L827	Biochemistry and Immunology - Interpretation of carcinoembryonic antigen (CEA)	$5.30
L849	Special Procedures and Interpretation - Histology or Cytology - Interpretation and handling of decalcified tissue	$15.60

Fee code	Descriptor	Fee value
L834	Special Procedures and Interpretation - Histology or Cytology - Histochemistry of muscle - 1 to 3 enzymes	$15.60
L835	Special Procedures and Interpretation - Histology or Cytology - each additional enzyme, add	$15.60
L825	Anatomic Pathology - Cytopathology - Compensated polarized light microscopy for synovial fluid crystals	$25.20
L843	Special Procedures and Interpretation - Histology or Cytology - Special microscopy of tissues including polarization, interference phase contrast, dark field, autofluorescence or other microscopy and interpretation	$24.05

Committee Comments

- The committee supports the proposal to delete or simplify the codes listed.

30.2 Fee code revisions (PFAFs 23-083 to 23-087, 23-089, 23-170)

Constituency Proposal

- The constituency proposed revisions to L848, L819, L823, L822, L812, L837, and L844 as follows:

Fee Code	Proposed descriptor
L848	Seminal fluid analysis - quantitative kinetic studies~~, including velocity linearity and lateral head amplitude~~
L819	Basic seminal fluid analysis for infertility, including count, motility and morphology
L823	-each subsequent frozen section or direct smear ~~and/or selection of tissue for biochemical assay e.g. estrogen receptors, add~~
L822	Operative consultation, with or without frozen section or direct smear
L812	Cervical vaginal sample, HPV testing and/or cytology ~~specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation~~
L844	Special microscopy including polarization, phase-contrast, differential interference contrast, dark field, autofluorescence or other microscopy and interpretation ~~of fluids (polarization, interference, phase contrast, dark field, autofluorescence or other microscopy and interpretation)~~
L837	Immunohistochemistry, direct immunofluorescence, in situ hybridization, immunobead or other method and interpretation - per marker

Committee Comments

- For L812, the committee does not support the proposal to modify the fee as HPV testing is provided through the Ontario Cancer Screening Program (OCSP).
- For L848 and L819, the committee supports the proposed descriptor changes with the addition of a reference to WHO standards.
- For L822 and L823, the committee supports the proposal, in principle.
- For L841, the committee acknowledges the section's request to withdraw this proposal (PFAF 84).
- For L837 and L844, the committee supports the descriptor changes, subject to fitting.

30.3 Fee code Increases (PFAFs 23-090, 23-092, 23-111)

Constituency Proposal

- The constituency proposed the following fee increases:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
L800	Haematopathology - Blood film interpretation (Romanowsky stain)	$22.70	$24.95	$2.25	9.9%
L810	Anatomic Pathology - Cytopathology - Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	$25.00	$27.50	$2.50	10.0%
L846	Flow cell cytometry and interpretation - per marker	$12.60	$13.85	$1.25	9.9%

Committee Comments

- The committee notes the constituency's decision to withdraw this proposal with the submission of PFAF 25-017.

30.4 A/C586 - Repeat Consultation (PFAF 23-093, 23-110)

Constituency Proposal

- The constituency proposed fee increases for A/C586 from $71.20 to $108.95 (53%).

Committee Comments

- The committee supports the proposed fee value changes subject to fitting and relativity.

30.5 L812 – Laboratory Medicine - Anatomic Pathology - Cytopathology - Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation (PFAF 25-016)

Constituency Proposal

- The constituency proposed the deletion of L812 - Laboratory Medicine - Anatomic Pathology - Cytopathology - Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation.
- In subsequent correspondence, the constituency proposed a fee value increase.

Committee Comments

- The committee notes the correspondence with the section there remains clinical indications for this test outside of cervical screening. Additionally, L812 remains eligible in the context of reflex cytology for cervical cancer screening.
- No evidence was provided to justify an increase to the fee value.
- The committee does not support the deletion of the fee code nor the proposed value change.

30.6 A/Cxxx – Comprehensive laboratory medicine consultation (PFAF 25-018)

Constituency Proposal

- The constituency proposed a new fee code for comprehensive laboratory medicine consultation, paid at $310.45.
- This service is a consultation rendered by a specialist in laboratory 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 committee supports this proposal subject to fitting and relativity.

30.7 Kxxx – MCC Laboratory Medicine Participant, per patient (PFAF 25-019)

Constituency Proposal

- The constituency proposed a new fee code for MCC Laboratory Medicine Participant, per patient, paid at $32.45.
- Multidisciplinary cancer conference (MCC) is a service conducted for the purpose of discussing and directing the management of one or more cancer patients where the physician is in attendance either in person, by telephone or videoconference as a participant or chairperson in accordance with the defined roles and minimum standards established by Ontario Health.
- Payment rules are similar to those for K710, with a few exceptions (e.g.: Kxxx is only eligible for payment to physicians from Laboratory Medicine (28).

Committee Comments

- The section indicated in correspondence with the PPC that this proposal was to address hospital-based salary or contracted pathologists. Those physicians are already compensated for this work through their salaries or contracts.
- The committee does not support the proposal.

30.8 Lxx1 – Single Gene Analysis (PFAF 25-020)

30.9 Lxx2 – Small Gene Panel (PFAF 25-021)

30.10 Lxx3 – Large Gene Panel (PFAF 25-022)

Constituency Proposal

- Lxx1 - Reporting molecular pathology for single gene analysis including PCR, NGS, ddPCR, SNP-array, methylation analysis or other single gene assay, for solid organ or hematolymphoid neoplasm, interrogation for sequence variants, insertions/deletions, copy number variants, rearrangements, and other alterations, paid at $102.10.
- Lxx2 - solid organ or hematolymphoid neoplasm or disorder, 2 - 50 genes, NGS, PCR, microarray or other multi-gene analysis or other genomic analysis, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression, mRNA expression levels or other genetic findings, paid at $123.10.
- Lxx3 - solid organ or hematolymphoid neoplasm or disorder, >50 genes, WGS, WES, NGS, microarray, Nanostring, methylation array or other genomic analysis, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression, mRNA expression levels or other genetic findings, paid at $321.35.
- These services will only be provided in hospitals and subject to consultation (A585) billing rules.

Committee Comments

- The committee notes that this work is covered either by salary or contract remuneration or is bundled in existing consult and assessment fees.
- The committee does not support this proposal.

30.11 Multiple Fee Codes – Fee value changes (PFAF 25-017)

Constituency Proposal

- The constituency proposed value changes to the following fee codes to better reflect the time and complexity of the service provided.
- With the proposed value changes, the Section on Laboratory Medicine will have achieved internal relativity for consult and visit codes, and for diagnostic and therapeutic procedure codes, respectively.

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A585	Laboratory medicine - Diagnostic consultation	$73.30	$105.60	44.07%
C585	Laboratory Medicine - Non-emergency hospital in-patient services - Diagnostic consultation	$73.30	$105.60	44.07%
L800	Laboratory Medicine - Haematopathology - Blood film interpretation (Romanowsky stain)	$22.70	$29.20	28.63%
L810	Laboratory Medicine - Anatomic Pathology - Cytopathology - Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	$25.00	$36.35	45.40%
L846	Laboratory Medicine - Special Procedures and Interpretation - Flow cell cytometry and interpretation - Per marker	$12.60	$15.55	23.41%

Committee Comments

- The committee supports the proposed fee value increases, subject to fitting and relativity.

31 Long Term Care & Care of the Elderly

31.1 Nursing Home or Home for the Aged Fees (PFAF 23-173 to 23-175)

Constituency Proposal

- The constituency requested fee increases to the following codes:

Fee Code	Descriptor	Current Fee	Proposed Fee	$ Increase	% Increase
W010	Monthly management of a Nursing Home or Home for the Aged Patient - Monthly management fee (per patient per month)	$115.25	$205.80	$90.55	78.6%
W003	Nursing home or home for the aged - first 2 subsequent visits per patient per month, per visit	$34.10	$55.25	$21.15	62.0%
W008	Nursing home or home for the aged - subsequent visits per month (maximum of 3 per patient per month), per visit	$34.10	$55.25	$21.15	62.0%

Committee Comments

- The committee does not support this proposal as it would take these codes out of relativity with other family practice codes.
- These codes may be increased in a manner that keeps them in relativity to other General and Family Practice fee codes.

31.2 Wxxx - LTC telephone support (PFAF 23-176)

Constituency Proposal

- The constituency requested a new fee code Wxxx LTC telephone support, paid at $40.05 per unit of 10 minutes with the following descriptor and payment rules:

  Wxxx LTC telephone support initiated by a physician where a physician provides telephone support to a caregiver(s) for a patient residing in LTC.

  Payment rules:

  3. A maximum of two (2) units of Wxxx are eligible for payment per patient per day.
  4. A maximum of eight (8) Wxxx units are eligible for payment per patient per 12-month period.
  5. Wxxx is only eligible for payment where:
     a. there is a minimum of 10 minutes of patient-related discussion; and
     b. the physician is the LTC MRP or acting in the capacity of MRP

Committee Comments

- The committee is of the opinion that this work is part of the management fee or an element of assessment codes. If those codes are undervalued, then the value of those codes should be increased.
- The committee does not support this proposal.

31.3 Kxxx – LTC telephone support for Emergent Advance Care Planning / Goals of Care Discussion (PFAF 25-162)

Constituency Proposal

- The constituency proposed a new fee code for LTC telephone support for Emergent Advance Care Planning / Goals of Care Discussion per unit of 10 minutes, paid at $35.05.
- This is a service initiated by an LTC physician where goals of care are discussed by telephone with a patients POA in a situation of acute decompensation.
- The constituency proposed the following payment rules:
    1. A maximum of four (4) units of Kxxx are eligible for payment per patient per day.
    2. A maximum of eight (8) Kxxx units are eligible for payment per patient per 12-month period.
    3. Kxxx is only eligible for payment where:
        a. there is a minimum of 10 minutes of patient-related discussion; and
        b. the physician is the LTC MRP or acting in the capacity of MRP

Committee Comments

- The committee notes that it is standard of care that advance care planning and goals of care discussion occur at admission or shortly thereafter. The situation being addressed by this proposal should therefore be uncommon.
- The committee does not support this proposal.

31.4 K042 - Extended specific neurocognitive assessment (PFAF 23-178)

Constituency Proposal

- The constituency requested a revision to the eligibility requirements for K042 to include physicians with the COE (Care of the Elderly) designation or has an exemption to access bonus impact in Care of the Elderly from the MOH; K042 is only eligible for payment to specialists in Geriatrics (07), Neurology (18) and Psychiatry (19).

Committee Comments

- In consultation with all relevant sections, the tests required to bill the current code appear to be provided by physicians who have the specialty designations listed.
- The committee does not support this proposal.

31.5 A075 & A775 - Consultations (PFAFs 23-180, 23-181)

Constituency Proposal

- The constituency requested adding the following payment rules to A075 (consultation) and A775 (comprehensive geriatric consultation):

  The physician:
    i. is a specialist in Geriatrics (07); or
    ii. has a certificate of special competence in Geriatrics; or
    iii. has an exemption to access bonus impact in Care of the Elderly from the MOH.

- The Section noted that A075/A775 is only eligible for payment to specialists Geriatrics (07).

Committee Comments

- The committee does not support this proposal as specialist consultation codes are limited to physicians with the associated Royal College designation.

31.6 A/C/W771 – Certification of death (PFAF 25-163)

Constituency Proposal

- The constituency proposed fee value changes to A/C/W771 – Certification of death from $20.60 to $40.00 (94.2% increase).

Committee Comments

- The committee supports a value change, subject to fitting and relativity.
- The committee notes that A777 and A772 will need to be increased to maintain relativity.

32 Nephrology

32.1 Exxx - Complex Chronic Kidney Disease Assessment Premium (PFAF 23-063)

Constituency Proposal

- The constituency requested the creation of a new complex chronic kidney disease premium valued at 50%.
- The premium would be applicable to nephrology assessment codes when providing CKD care.
- The proposed payment rules are as follows:

1. The assessment is a:
    a) medical specific assessment (A163);
    b) medical specific re-assessment (A164);
    c) complex medical specific re-assessment (A161); or
    d) partial assessment (A168);
2. The service is rendered by a physician with a specialty designation in (16) Nephrology;
3. The assessment is not eligible for payment when rendered in an emergency department or emergency department equivalent or to a hospital inpatient;
4. The purpose of the assessment is advanced CKD care; and
5. The patient has advanced CKD defined as
    a) 2 Year Kidney Risk Failure Equation (KFRE2) ≥ 10%
    b) eGFR <15mL/min/1.73m2

Committee Comments

- The committee was unable to determine the proposed code's impact on intra-sectional relativity.
- As a result, the committee does not support this proposal.

32.2 E060 - Post Renal Transplant Assessment Premium (PFAF 23-064)

Constituency Proposal

- The constituency requested an increase in the post renal transplant assessment premium from 25% to 50%.

- The Section commented that this change would help improve intra-sectional relativity between various Nephrology specific premium assessments. The premium would be on par with E078.

Committee Comments

- The committee notes the constituency's choice to withdraw this proposal, and to replace with PFAF 25-068.

32.3 Gxxx – Hospital haemodiafiltration (PFAF 25-058)

Constituency Proposal

- The constituency proposed a new weekly team fee code for hospital haemodiafiltration, paid at $135.15.
- This is to help modernize the Schedule, as this service is currently billed as G860 – hospital haemodialysis, even if it is technically haemofiltration. The fee value and criteria should be identical to the current dialysis weekly team fees (e.g.: G860, G861).

Committee Comments

- The committee proposes that the descriptors for haemodialysis be modified to include haemodiafiltration rather than the creation of a new code.

32.4 Gxxx – Nephrological pre-operative management of renal transplantation recipient (PFAF 25-060)

Constituency Proposal

- The constituency proposed a new code for Nephrological pre-operative management of renal transplantation recipient, paid at $192.10
- This code is to compensate nephrologists for the relevant work done in assessing the subtility of a particular donor-recipient pair for transplantation. The time and intensity of this service is identical to the existing G411 fee code.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

32.5 G324 – Subclavian or external jugular catheter for haemodialysis – insertion (PFAF 25-055)

Constituency Proposal

- The constituency proposed a revision to the description header for G324 as follows:

  Subclavian or ~~external~~ internal jugular catheter for haemodialysis

  (revision underline, deletions ~~strikethrough~~)

- This revision would also affect G336 and G312.

- The constituency noted that the revised description is reflective of normal medical practice.

Committee Comments

- The committee supports deleting the word 'external' from the descriptor of G312, G324, and G366.

32.6 Multiple Consult & Visit Fee Codes – Fee value changes (PFAF 25-054, 25-063)

Constituency Proposal

- The constituency proposed value changes to the following consult & visit fee codes to better reflect the time and complexity of the service provided.

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
Nephrology - Consultation & Visit fees (PFAF 25-054)				
A165	Nephrology – Consultation	$162.90	$179.19	10.0%
C165	Nephrology - Non-emergency hospital in-patient services - Consultation	$162.90	$179.19	10.0%
A865	Nephrology - Limited consultation	$105.25	$115.78	10.0%
C865	Nephrology - Non-emergency hospital in-patient services - Limited consultation	$105.25	$115.78	10.0%
A166	Nephrology - Repeat consultation	$105.25	$115.78	10.0%
C166	Nephrology - Non-emergency hospital in-patient services - Repeat consultation	$105.25	$115.78	10.0%
A163	Nephrology - Medical specific assessment	$80.95	$89.05	10.0%
C163	Nephrology - Non-emergency hospital in-patient services - Medical specific assessment	$80.95	$89.05	10.0%
A164	Nephrology - Medical specific re-assessment	$62.10	$68.31	10.0%
C164	Nephrology - Non-emergency hospital in-patient services - Medical specific re-assessment	$62.10	$68.31	10.0%

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A161	Nephrology - Complex medical specific re-assessment	$71.85	$79.04	10.0%
C161	Nephrology - Non-emergency hospital in-patient services - Complex medical specific re-assessment	$71.85	$79.04	10.0%
A168	Nephrology - Partial assessment	$38.55	$42.41	10.0%
C168	Nephrology - Non-emergency hospital in-patient services - Concurrent care - Per visit	$34.10	$37.51	10.0%
A765	Medical Specialist (13, 15, 16, 34, 41, 44, 46, 47, 48, 60, 61, 62) - Consultation, patient 16 years of age and under	$165.50	$182.05	10.0%
C765	Medical Specialist (13, 15, 16, 34, 41, 44, 46, 47, 48, 60, 61, 62) - Consultation, patient 16 years of age and under	$165.50	$182.05	10.0%
Nephrology - Comprehensive Consults (PFAF 25-063)				
A/C/W160	Nephrology - Comprehensive nephrology consultation	$310.45	$357.02	15.0%

Committee Comments

- The committee supports an increase to these fee codes, subject to fitting and relativity.

32.7 Multiple Dialysis Codes – Fee value changes (PFAF 25-056)

Constituency Proposal

- The constituency proposed value changes to the following dialysis codes to better reflect the time and complexity of the service provided.

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
G325	Dialysis - Haemodialysis - Medical component alone	$354.20	$367.48	3.8%
G323	Dialysis - Haemodialysis - Acute, repeat - for the first 3 services	$177.10	$183.74	3.8%
G083	Dialysis- Haemodialysis - Continuous venovenous haemodialysis - Initial and acute (for the first 3 services)	$380.75	$395.03	3.8%

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
G085	Dialysis- Haemodialysis - Continuous venovenous haemofiltration - Initial and acute (for the first 3 services)	$369.65	$383.51	3.8%
G082	Dialysis- Continuous haemodiafiltration - Continuous venovenous haemodiafiltration - Initial and acute (for the first 3 services)	$380.75	$395.03	3.8%
G094	Dialysis- Continuous haemodiafiltration - Chronic, continuous haemodiafiltration	$67.00	$69.51	3.8%
G090	Dialysis- Slow continuous ultrafiltration - Venovenous slow continuous ultrafiltration - Initial and acute (for the first 3 services)	$317.25	$329.15	3.8%
G096	Dialysis- Slow continuous ultrafiltration - Chronic, slow continuous ultrafiltration	$67.00	$69.51	3.8%
G330	Dialysis - Peritoneal dialysis - Acute (up to 48 hours) includes stylette cannula insertion (temporary)	$237.40	$246.30	3.8%
G331	Dialysis - Peritoneal dialysis - Repeat acute (up to 48 hours) - for the first 3 services	$213.70	$221.71	3.8%
G860	Dialysis - Chronic dialysis weekly team fee - Hospital haemodialysis	$130.15	$135.03	3.8%
G861	Dialysis - Chronic dialysis weekly team fee - Hospital peritoneal dialysis	$130.15	$135.03	3.8%
G862	Dialysis - Chronic dialysis weekly team fee - Hospital self- Care haemodialysis or satellite haemodialysis	$130.15	$135.03	3.8%
G863	Dialysis - Chronic dialysis weekly team fee - Independent health facility haemodialysis	$130.15	$135.03	3.8%
G864	Dialysis - Chronic dialysis weekly team fee - Home peritoneal dialysis	$130.15	$135.03	3.8%
G865	Dialysis - Chronic dialysis weekly team fee - Home haemodialysis	$130.15	$135.03	3.8%
G866	Dialysis - Chronic dialysis weekly team fee - Intermittent haemodialysis - At an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above)	$70.40	$73.04	3.8%

Committee Comments

- The committee supports an increase to these fee codes, subject to fitting and relativity.

32.8 Multiple Per Diem Codes – Fee value changes (PFAF 25-069)

Constituency Proposal

- The constituency proposed value changes to the following Nephrological component of renal transplantation per diem codes to better reflect the time and complexity of the service provided.

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
G412	Nephrological component of renal Transplantation - 1st day following Transplantation	$311.90	$358.69	15.0%
G408	Nephrological component of renal Transplantation - 2nd to 10th day, inclusive, per diem	$155.90	$179.29	15.0%
G409	Nephrological component of renal Transplantation - 11th to 21st day, inclusive, per diem	$77.95	$89.64	15.0%

Committee Comments

- The committee supports an increase to these fee codes, subject to fitting and relativity.

32.9 E060 – Post renal transplant assessment premium (PFAF 25-068)

Constituency Proposal

- The constituency proposed a value change to E060 - Post renal transplant assessment premium add-on code from 25% to 50%.
- This is a targeted increase to further address intra-sectional relativity and bring it on par with the chronic disease premium E078.

Committee Comments

- The committee supports this proposal, subject to fitting.

32.10 Z457 – Venipuncture - Surgical removal or Repair of implanted central venous catheter (PFAF 25-073)

Constituency Proposal

- The constituency proposed a value change to Z457 – Venipuncture - Surgical removal or Repair of implanted central venous catheter from $48.90 to $61.13 (by 25.0%).
- This is to better reflect the time and complexity of the service provided.

Committee Comments

- The committee supports this proposal, subject to fitting.
- To improve clarity, the committee proposes that the word 'implanted' be replaced with 'tunnelled' in the descriptor.

33 Neurodevelopmental Disorders

33.1 K133 - Periodic health visit for adults with Intellectual and Developmental Disabilities (IDD) (PFAF 25-249)

Constituency Proposal

- The constituency proposed revision to an existing fee code (K133) (descriptor, payment rules, with or without fee value change), valued at $160.
- The constituency stated that the criteria for the use of K133 code includes a limit of one use per patient over a 12-month period, it does not require a special practice designation to bill, the visit must be 50 minutes in length, and one or more of the following diagnostic codes must be used:
    - intellectual disability, unspecified 319
    - mid 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
    - spinner bifida 741
- The constituency requested that the K133 code is modified to an out of basket code for FHO and FHT physicians

Committee Comments

- Changing the status of in basket codes is out of scope for the PPC.
- Given the recent introduction of this fee code, the PPC is not considering modifications during the current fee setting process.
- The committee does not support this proposal.

33.2 Kxxx - Intellectual and Developmental Disability primary care (PFAF 25-318)

Constituency Proposal

- The constituency proposed a new time based K code to provide assessment and counseling services for adults with intellectual and developmental disabilities in family practice, valued at $70.10.
- The constituency stated Intellectual and Developmental Disability primary care encompassing any combination or form of assessment and treatment by a family physician for complex,

atypical and/or undifferentiated symptom presentations where there is consideration of the patient's biological and psychosocial functioning.

- The constituency proposed the following payment rules and/or medical record keeping requirements:
    - Kxxx is a time-based service with time calculated based on units. Unit means ½ hour or major part therefore- see General Preamble GP7, GP55 for definitions and time keeping requirements.
    - No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as Kxxx to the same patient by the same physician.
    - Kxxx is only payable when the patient has Intellectual and Developmental Disability associated with one of the following conditions (listed with ministry diagnostic codes):
        - Autism spectrum disorder 299
        - intellectual disability or fetal alcohol syndrome 319
        - cerebral palsy 343
        - spina bifida with or without hydrocephalus, meningocele, meningomyelocele 741
        - Chromosomal anomalies such as Down's syndrome, fragile X syndrome other Autosomal anomalies 758

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

34 Neurology

34.1 G874 - Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral) (PFAF 23-127)

Constituency Proposal

- The constituency requested a change in fee value from $50.00 to $120.00 (140 per cent increase) and a modification to G874 descriptor as follows:

    "Botulinum toxin injection(s) for ~~sialorrhea~~ parasympathetic gland hyperfunction (e.g., sialorrhea, epiphora), (unilateral or bilateral)"

    (Revisions underlined, deletions ~~strikethrough~~)

- The section notes that by combining botulinum toxin injections for sialorrhea and epiphora into a single G874 code (for parasympathetic gland hyperfunction) valued at $120, this would be on par with the other comparator botulinum toxin injection codes.

Committee Comments

- The committee supports the proposal of changing the description of G874 to:

    Botulinum toxin injection(s) for sialorrhea **or** epiphora, (unilateral or bilateral).

    (Revisions underlined, deletions ~~strikethrough~~)

- The committee supports the proposed fee value change, subject to fitting and relativity.

34.2 Kxxx - Neurologist to allied health professional outpatient consultation (PFAF 23-144)

Constituency Proposal

- The constituency requested a new fee code be created for neurologist consultation to an allied health professional in an outpatient setting, valued at $35.00.
- This is the service where the neurologist participates in a consultation with one or more of the following allied professionals: a. a physiotherapist who is a member of the College of Physiotherapists of Ontario; b. an occupational therapist who is a member of the College of Occupational Therapists of Ontario; or c. a social worker who is a member of the Ontario College of Social Workers and Social Service Workers; or d. a speech-language pathologist who is a member of the Ontario Audiologists and Speech-Language Pathologists.

Committee Comments

- Communications with a single allied health provider is currently bundled with consults and assessments. Unbundling the service would have broad implications in the Schedule and is therefore not supported by the committee.
- The committee does not support this proposal.

34.3 Axxx - Complex headache assessment (PFAF 23-145)

Constituency Proposal

- The constituency requested the creation of a new assessment code for complex headache valued at $134.00 per unit with the following payment rules:
    - Must be claimed by an adult or paediatric neurologist;
    - maximum 4 times annually, per patient, per physician;
    - patient must be booked for at least a 20-minute appointment;
    - start/stop times documented; limited to chronic headache disorders;
    - cannot be combined with A183/A181/A184.
- The section notes that the introduction of this code would help to bring chronic headache assessments in line with the value of physician's time in other parts of the Schedule of Benefits.

Committee Comments

- The committee notes the constituency's support for adding the elements of this proposal to A113, rather than creating a new code. Appropriate schedule language is under development and the PPC will reach out to the constituency as required.
- The committee notes the constituency's desire that with this addition, the value of A113 would remain the same or increase. The committee proposes that this fee increase in value to maintain relativity with other consultations and assessments, which are being increased in this allocation.

34.4 E150 - CritiCall review of complex neurosurgical imaging, to K733 (PFAF 23-146)

Constituency Proposal

- The constituency requested revisions to the descriptor and payment rule 6 of E150 as follows:

CritiCall review of complex neuroimaging ~~neurosurgical imaging~~, to K733

Payment rules:

6. E150 is only eligible for payment
    a. to specialists in Neurosurgery (04) or Neurology;
    b. for review of all complex ~~neurosurgical imaging~~ neuroimaging provided by the referring physician/nurse practitioner which is defined as at least one brain and/or spinal CT, MRI or angiography; and,
    c. when the analysis of the complex ~~neurosurgical imaging~~ neuroimaging provided by the physician claiming E150 is documented in the patient permanent medical record.

(Revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- The committee supports the proposal, subject to fitting.

34.5 Kxxx - Neurology Assessment Extension (PFAF 23-194)

Constituency Proposal

- The constituency requested a new fee code Kxxx Neurology Assessment Extension, paid at $134.00 per unit with the following payment rules:
    - This service is eligible for payment to an adult neurologist or paediatric neurologist for an extension to the assessment codes listed below when the physician is required to spend an additional period of consecutive or non-consecutive time on the same day with the patient and/or patient's relative(s), patient's representative or other caregivers. The time unit measured excludes time spent on separately billable interventions. Start and stop time of the assessment must be charted.
    - Eligible assessment codes include: A183/C183, A181/C181, A184/C184, A188/C188 KXXX is a time-based service/premium. Time is calculated based on units – one unit means an hour or major part thereof – see General Preamble GP7 for definitions and time-keeping requirements.
    - KXXX is limited to a maximum of three units per patient per physician per day. The start time of the first extension is after 20 minutes have elapsed rendering the eligible assessment.
    - KXXX is payable in accordance with the following rules: 1 unit: minimum time 20 minutes (i.e., applies after 40+ minutes) 2 units: minimum time 46 minutes 3 units: 76 minutes.

Committee Comments

- The committee notes the similarities between this proposal and the existing K001. The committee does not support creating a detention code for assessments which is unique to a section.
- The committee does not support this proposal.

34.6 Exxx - Chronic CNS disorders premium (PFAF 23-198)

Constituency Proposal

- The constituency requested the creation of a premium for Chronic CNS disorders valued at 50%.
- Under the proposal, 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 CNS disorder 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. Eligible chronic neurologic conditions (OHIP codes), in order of priority: 346 - Chronic migraine, 306 - Psychosomatic disturbances (functional neurological disorder), 335 - Motor neuron disease, 358 - Myasthenia gravis, 436 – Stroke, 191 - Malignant neoplasms (brain), 350 - Trigeminal neuralgia, 349 - Huntington's chorea, 432 - Intracranial haemorrhage.

Committee Comments

- The committee notes the section's support for adding the elements of this proposal to A113, rather than creating a new code.
- The committee notes the section's desire that with this addition, the value of A113 would remain the same or increase. The committee proposes that this fee increase in value to maintain relativity with other consultations and assessments, which are being increased in this allocation.

34.7 Axxx - Complex neuro-oncology assessment (PFAF 23-242)

Constituency Proposal

- The constituency requested a new fee code for a complex neuro-oncological assessment valued at $120.00
- The proposed complex neuro-oncology assessment is an assessment for the ongoing management of the following diseases of the central nervous system where the complexity of the neuro-oncological condition requires the continuing management by a neurologist:
    a) a. primary tumor of the central nervous system;
    b) b. central nervous system metastasis;
    c) c. neurological complications of cancer therapy;
    d) d. paraneoplastic neurological syndromes.

    With the following payment rules:

1. A complex neuro-oncology 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 neuro-oncology assessments are limited to 12 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 this code

- The Section notes that monitoring of chemotherapy side effects, palliation of symptoms, and lengthy discussions about goals of care are routinely required during follow-ups for these patients.

Committee Comments

- The committee notes the constituency's support for adding the elements of this proposal to A113, rather than creating a new code.
- The committee notes the constituency's desire that with this addition, the value of A113 would remain the same or increase. The committee proposes that this fee increase in value to maintain relativity with other consultations and assessments, which are being increased in this allocation.

34.8 G419 - Tensilon test (PFAF 23-243)

Constituency Proposal

- The constituency requested that G419 be deleted, as there are now safer ways to diagnose myasthenia gravis and this code is obsolete.

Committee Comments

- The committee supports the proposal to delete G419.

34.9 Exxx - After Hours Acute Stroke Premium (50%) (PFAF 21-D37)

34.10 Exxx - After Hours Acute Stroke Premium (75%) (PFAF 21-D38)

Constituency Proposal

- The constituency requested the creation of 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)

Committee Comments

- The committee notes that Special Visit Premiums are currently applicable to A384 and that other similar services, such as resuscitation care (G521, G523, G522, G395 and G391) are not eligible for after-hours premiums.
- The committee does not support these proposals.

34.11 Kxx1 - Epilepsy Surgery Multidisciplinary Rounds (PFAF 21-D39)

34.12 Kxx2 - Epilepsy Surgery Rounds Planning and Preparation (PFAF 21-D40)

Constituency Proposal

- The constituency requested two new codes related to Epilepsy Surgery Multidisciplinary Rounds:
    - Kxx1 - Epilepsy Surgery Multidisciplinary Rounds at $31.35 per 10 minutes.
    - Kxx2 - Epilepsy Surgery Rounds Planning and Preparation at $150 per hour.

Committee Comments

- The committee supports PFAF D39 and proposes the fee value be set equal to K121.
- The committee notes that for other multidisciplinary rounds, planning and preparation is bundled in the multidisciplinary rounds fee.
- The committee does not support PFAF D40.

34.13 G456 - Needle Electromyography and Nerve Conduction Studies - professional component (PFAF 21-D41)

Constituency Proposal

- The constituency requested an increase to G456 from $99.90 to $120.00.

Committee Comments

- The committee supports the proposed increase, subject to fitting.
- The committee notes the relevant constituencies' support of an increase to G457, in order to maintain relativity.

34.14 Gxxx - Neuromuscular Ultrasound (PFAF 21-D42)

Constituency Proposal

- The constituency requested a new code Gxxx - Neuromuscular Ultrasound: per muscle or nerve at $50.00.

Committee Comments

- The committee finds insufficient evidence to support the creation of a unique code in terms of the time, intensity, and work effort associated with the service.
- The committee does not support this proposal.
- The committee notes that this proposal has been replaced by PFAF 25-005.

34.15 Jxxx – Neuromuscular Ultrasound nerve imaging (PFAF 25-005)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for a neuromuscular ultrasound nerve imaging procedure, valued at $61.00.
- The procedure includes real-time imaging; image documentation and Interpretation performed in conjunction with neurophysiological assessment.

- The Proposed Descriptor is:
  "Ultrasound examination of a nerve or nerves throughout their entire anatomic course, per extremity"

  The proposed payment rules are:
  1. The procedure must involve real-time ultrasound imaging of nerve(s), with appropriate image documentation maintained in the patient's medical record.
  2. A written interpretation must be included within, or as an addendum to, the neurophysiology report.
  3. This procedure code may only be billed as an adjunct to existing neurophysiology codes G456, G457, and G473.

Committee Comments

- The committee supports the proposal with the following edits:
  1. Provided the service is personally provided by the physician.
  2. The medical record documents that nerve conduction studies have been performed and are unable to localize the pathology (this would replace proposed payment rule #3).

34.16 Gxx1 - Transcranial Doppler Ultrasound – Complete Study (60 minutes) (PFAF 21-D43)

34.17 Gxx3 - Transcranial Doppler Ultrasound – Limited Study (30 minutes) (PFAF 21-D44)

Constituency Proposal

- The constituency requested new fees for the professional component of Transcranial Doppler Ultrasounds as follows:
  - Transcranial Doppler Ultrasound – Complete Study (60 minutes) – professional component, proposed at $150.00.
  - New fee code for Transcranial Doppler Ultrasound – Limited Study (30 minutes) – professional component, proposed at $100.00.

Committee Comments

- The committee finds insufficient evidence to support the creation of a unique code in terms of the time, intensity, and work effort associated with the service.
- The committee does not support these proposals.

34.18 G545 - Prolonged EEG monitoring (PFAF 21-D45)

Constituency Proposal

- The constituency requested an increase to the maximum number of units for G545 - Prolonged EEG monitoring from 12 to 18 units.

Committee Comments

- The committee supports the proposal, with a rule clarification that this may be the only EEG code billed on the service date, may be billed only 14 times per patient admission, and is not eligible for payment when used for monitoring the depth of sedation.
- The committee notes that the increase of units will not apply to G540, since technical fees are outside of the PPC's mandate.

34.19 Gxxx – Initial clinical programming of subcutaneous foslevodopa/foscarbidopa (PFAF 25-001)

Constituency Proposal

- The constituency proposed an introduction of a new code for foslevodopa/foscarbidopa clinical programming of the external infusion pump.
- The constituency stated foslevodopa/foscarbidopa is a solution of levodopa and carbidopa for continuous infusion for the treatment of advanced Parkinson's disease in patients who lack control of their motor symptoms, moderate to server disease with dyskinsias and sudden OFF periods.
- The constituency also stated the initial programming visit occurs over two hours and dose conversion calculations and pump programming are performed by a Neurologist familiar with the management of advanced Parkinson's disease.
- The constituency proposed the new fee code to be valued at $500.00.
- The constituency proposed the following descriptor and payment rules accompany the new fee code:

  Proposed Descriptor:
  "Clinical programming of External infusion pump"

  Proposed Payment Rules:
  1. Payable to physician who provides the service in direct patient contact.
  2. Restricted to neurologists with experience or training in management of Parkinson's disease or related disorders.
  3. One service per patient per day.
  4. Maximum of 5 services per year.

Committee Comments

- The committee notes the section's support for the creation of a time-based fee code for this service. The committee continues to deliberate on appropriate schedule language and will reach out to the constituency, as required.

34.20 G458 – Single Fiber Electromyography (PFAF 25-002)

Constituency Proposal

- The constituency proposed an increase in the G458 fee code value, from $191.70 to $275.00 (43.5%).
- The constituency stated the professional fee for G458 has not been revised since its inception and has fallen out of relativity.

Committee Comments

- The committee supports this proposal, subject to fitting.

34.21 G473 – Complex neuromuscular electrodiagnostic testing (PFAF 25-003)

Constituency Proposal

- The constituency proposed a revision to the G473 fee code descriptor and payment rules to modernize and reflect the current clinical practices.
- The constituency proposed the following revisions to the G473 fee code descriptor:

  ~~*Complete procedure for*~~ *complex neuromuscular* ~~*disorders*~~ *electrodiagnostic testing.*

  (deletions ~~strikethrough~~, revisions underlined)

- The constituency proposed new payment rules:
  1. Requires a minimum of 60 minutes to perform the procedure that includes any combination of:
     - i) Nerve conduction studies.
     - ii) Late motor responses.
     - iii) Needle EMG of distinct muscles.
     - iv) Repetitive stimulation of muscle nerve pairs.

       Or
     - v) Autonomic studies that total to 10.

Committee Comments

- The committee proposes editing proposed payment rule (v) to state "10 or more autonomic studies." The committee notes the section's support.
- The committee proposes schedule language to ensure the physician spends a minimum of 60 minutes personally providing this service, to the exclusion of all other billable services.

34.22 Gxxx – Ice pack test (PFAF 25-004)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for an ice pack diagnostic test of ocular myasthenia gravis.
- The constituency stated single-fiber EMG of the orbicularis oculi is considered the most sensitive test for OMG but it is often not readily or widely available, alternatively the ice pack test is a quick and simple test reported to have high sensitivity for the diagnosis of myasthenic ptosis.
- The constituency stated this proposal should be revenue neutral or revenue negative as several patients will now undergo an ice pack diagnostic test instead of a SF-EMG diagnostic test which creates additional consultations.
- The constituency proposed the new fee code be valued at $50.00. It was also proposed that the new fee code would have the following descriptor and payment rules:

  Proposed Descriptor:
  "Ice pack test for diagnosis of Ocular Myasthenia Gravis"

Proposed Payment Rules:

1. Performed by the clinician.
2. Measurement of pre and post margin reflex.
3. Distance is recorded in the permanent medical record.

Committee Comments

- The committee believes this diagnostic test should be part of the physical examination and therefore included in the applicable consultation or assessment fee.
- The committee does not support this proposal.

34.23 Kxxx – Neurologic outpatient case conference (PFAF 25-025)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for a neurologic out-patient case conference. This is a neurologic care out-patient case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers, and/or regulated health professionals regarding a neurologic care out-patient.
- The constituency stated the new fee code is the same as the K121 fee code (hospital in-patient case conference) but modified for outpatient settings. The constituency also stated that this new fee code is the same as K700 (palliative out-patient case conference) except that it only applies to neurologists.
- The constituency proposed the new fee code should be valued at $42.00 per unit. It was also proposed that the new fee code would have the following payment rules:

  Proposed Payment Rules:

  1. No other case conference telephone consultation service is eligible for payment with Kxxx for the same patient on the same day.
  2. Kxxx is limited to a maximum of 4 services per patient, per physician, per 12-month period.
  3. A maximum of 8 units of Kxxx are payable per physician, per patient, per day.
  4. Kxxx is only eligible for payment to:
     i) Physicians within the neurology (18) specialty.

Committee Comments

- The committee notes that the constituency indicated this would be a rarely billed code.
- The committee does not support the proposal as this would provide a limited benefit to members.

34.24 Kxxx – Individual neurodevelopmental counselling

34.25 Kyyy – Family neurodevelopmental counselling (PFAF 25-026)

Constituency Proposal

- The constituency proposed the introduction two new fee codes for neurodevelopment counselling, one for individuals and the other for families.

- The constituency stated that the proposed neurodevelopmental counselling codes align perfectly with existing OHIP codes such as K122 and K123, which provide remuneration for developmental and behavioural care by paediatricians.
- The constituency proposed the value of these new fee codes should be equivalent to the K122 and K123 fee codes. The proposed values, descriptors, and payment rules can be seen below:

  Proposed Descriptors and Values:

  Kxxx - Individual neurodevelopmental counselling. per unit $89.70
  Kyyy - Family neurodevelopmental counselling. per unit $101.75

  Proposed Payment Rules (for both Kxxx and Kyyy):

  These services are only payable to neurologists who satisfy one of the following criteria:

  1. 35% or more of the dollar value of the annual fee-for-service claims in any 12-month period consist of Kxxx and/or Kyyy.
  2. 35% or more of the dollar value of the annual fee-for-service claims in any 12-month period consist of any combination of K005, K007, K019, K020, K012, K024, K025, K010, K004, K006, or K008, or Kxxx/Kyyy.
  3. Specialty training (residency/fellowship) in neurology (18) or subspecialty training in developmental disorders. Residency or fellowship training includes completion of a recognized paediatric neurology residency training program or a post-residency fellowship or other equivalent training in neurodevelopmental disorders. Documentation of additional residency or fellowship training must be provided if requested by the ministry.

  Neurologists who do not meet the criteria listed above but believe they have appropriate training and/or experience to permit them to provide neurodevelopmental counselling may contact the ministry to determine whether their training and/or experience constitute an equivalent residency, training, or program. Services rendered by physicians who do not meet these requirements are still insured but eligible for payment under another fee schedule code (e.g., primary mental health care (K005), counselling (K013/K033), or group counselling (K040/K041)).

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

34.26 Multiple fee codes - Increase to various Neurology and AVCS consultation fee codes (PFAF 25-165)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following Neurology consultation fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Neurology & AVCS Consultation fee codes (PFAF 25-165)					
A185	Neurology - Consultation	$184.40	$225.00	$40.60	22.0%
C185	Neurology - Non-emergency hospital in-patient services - Consultation	$184.40	$225.00	$40.60	22.0%
A180	Neurology - Special neurology consultation	$310.45	$350.00	$39.55	12.7%
C180	Neurology - Non-emergency hospital in-patient services - Special neurology consultation	$310.45	$350.00	$39.55	12.7%
A682	Extended special neurological consultation	$401.30	$415.00	$13.70	3.4%
C682	Extended special neurological consultation	$401.30	$415.00	$13.70	3.4%
A186	Neurology - Repeat consultation	$87.70	$125.00	$37.30	42.5%
C186	Neurology - Non-emergency hospital in-patient services - Repeat consultation	$87.70	$125.00	$37.30	42.5%
A385	Neurology - Limited consultation	$87.70	$125.00	$37.30	42.5%

C385	Neurology - Non-emergency hospital in-patient services - Limited consultation	$87.70	$125.00	$37.30	42.5%
A384	Consultation and Management for Acute Cerebral Vascular Syndrome (ACVS)	$200.00	$275.00	$75.00	37.5%
C384	Consultation and Management for Acute Cerebral Vascular Syndrome (ACVS)	$200.00	$275.00	$75.00	37.5%

- The constituency stated in neurology, the fees paid for consults have not increased proportionally with the fees paid for other services including follow-ups and extended consultations. The proposed value increases to neurology consult fee codes was made to reduce the fee disparity with other services in neurology.

Committee Comments

- The committee supports increases in these fee codes, subject to fitting and relativity.
- The committee notes that increases to other consultation and assessment fee codes will be considered in order to maintain relativity.

34.27 A384 - Consultation and management for acute cerebral vascular syndrome (ACVS) (PFAF 25-190)

Constituency Proposal

- The constituency proposed a revision to the A/C384 fee code payment rules.
- The constituency proposed the following payment rule revisions:

1. *A384 and K181 are only eligible for payment for patients seen within the timeframe for eligibility for intravenous thrombolysis therapy <u>and/or endovascular thrombectomy</u> as defined by the Canadian Stroke Best Practices.*
2. *A384 and K181 must be rendered in a hospital with CT or MRI facilities onsite.*
3. *A384 and K181 are only eligible for payment to a specialist in Neurology (18).*
4. *A384 and K181 are only eligible for payment if the physician remains in constant attendance with the patient <u>or is providing a consultation by video.</u>*
5. *G521, G522, G523, or G391 are not eligible for payment with A384 or K181.*
6. *K181 is only eligible for payment for patients treated with intravenous thrombolysis therapy as defined by the Canadian Stroke Best Practices.*
7. *K181 is limited to a maximum of 6 units per patient per day*

(revisions <u>underlined</u>)

- The constituency stated the proposed revision to payment rule #1 was made because acute stroke assessments require neurologists to assess for eligibility for both acute thrombectomy as well as thrombolysis.
- The constituency stated the proposed revision to payment rule #4 was made because as in many parts of medicine, virtual care is becoming an essential tool for stroke neurology.

Committee Comments

- The committee notes that the intention of the code was to compensate the physician directly providing the care, in person.
- The committee notes that the window for thrombectomy is significantly longer than the window for thrombolysis. Physicians who provide thrombectomy have a menu of consult, assessment, and procedural fees which compensate for this care.
- The committee does not support this proposal.

35 Neuroradiology

35.1 Cxxx – Non-emergency hospital in-patient services for radiologists, including daily visits and assessments following imaging-guided procedures requiring patient admission (PFAF 25-024)

Constituency Proposal

- The constituency proposed a new fee code where complex endovascular procedures requiring hospital admission, radiologists visit and assess their patients daily to monitor clinical status, check vital signs, inspect surgical incisions, prescribe medications, and provide compassionate support to families. This critical component of post-operative care can range from 20 to 120 minutes per visit and is essential for patient safety and recovery.
- The fee value was proposed to align with other fees on page A11-A12.
- The constituency stated that currently there is no directly comparable fee code claimed by radiologists.

Committee Comments

- The committee notes that members of this constituency can bill existing in-patient assessment codes according to the bundling rules associated with procedures. It is therefore unclear why this new code would need to be created.
- The committee does not support this proposal.

35.2 Nxxx – Endovascular intervention for ischemic stroke secondary to occlusion (EVT) (PFAF 25- 247)

35.3 Exxx – Endovascular intervention for ischemic stroke secondary to occlusion (EVT) – intracranial stent, add (PFAF 25-247)

35.4 Exxx – Endovascular intervention for ischemic stroke secondary to occlusion (EVT) – extracranial stent, add (PFAF 25-247)

Constituency Proposal

- The constituency proposed a new fee code for a procedure valued at $2500 and said that currently this procedure does not have a dedicated billing code also they don't have any means to track the number of cases being completed.
- The constituency proposed that given the various new technical nuances, E codes are proposed to account for additional interventions that may be required for optimal patient care.
- The following fee values are proposed:
    - Base value: 2500$
    - Additional E code for intracranial stent - $600
    - Additional E code for extracranial stent - $450
- The constituency proposes that no addition of any J or X codes be allowed.
- The constituency stated after surveying the various groups in the province and has been relayed in previous requests during this process to establish a designated fee code for this procedure, it is generally accepted that N107 (endovascular approach to include balloon catheter or embolization techniques for arteriovenous malformation - $1456.95) is the most utilized fee for this procedure.

Committee Comments

- The committee notes that PFAF 25-247 replaces a duplicate proposal for EVT (PFAF 25-023).
- The committee supports creating an all inclusive cerebral EVT code with the value of the code set at the current R990 rate (equivalent to N107), subject to fitting and relativity.
- The committee supports the proposed E-codes at the proposed value, subject to fitting.

35.5 Nxxx – Endovascular approach to include stenting of the carotid/vertebrobasilar arteries, with or without a proximal/distal embolic protection device (PFAF 25-260)

Constituency Proposal

- The constituency proposed a new fee code related to Carotid and Vertebral Arterial Stenting, valued at $1400.00
- The constituency stated currently this procedure does not have a dedicated billing code. Consequently, they have no means by which to track the number of cases being completed.

Committee Comments

- The committee supports creating the proposed fee code with the specification this is for Extracranial Carotid Artery Stenting and Vertebrobasilar Artery Stenting.
- The committee continues to deliberate on the proposed fee value.

35.6 N122 - intracranial endovascular surgery - Intracranial aneurysm repair - Endovascular approaches - Carotid circulation, per vessel (PFAF 25-261)

35.7 N125 - intracranial endovascular surgery - Intracranial aneurysm repair - Endovascular approaches - Carotid circulation, per vessel (PFAF 25-261)

Constituency Proposal

- The constituency proposed the following descriptor changes as well as additional E code add-ons:

- The constituency proposed a revision to an existing fee code where the current fee is $2140.15, and the proposed fee is $2354.15 (10% increase) as the endovascular treatment of intracranial aneurysms has become more complex and delicate.
- The constituency proposed changing the descriptor of N122 and N125:
    - N122 - Anterior Circulation
    - N125 - Posterior circulation, including vein of Galen
- New devices are now available for the treatment of these lesions requiring expert skills and technique. The section proposed the following be billable with N122 and N125:
    - E894- aneurysm greater than 2.5 cm, to N122 or N125 $229.55
    - Additional E Code – balloon-assistance or balloon-standby - $300
    - Additional E Code – stent-assistance - $400
    - Additional E Code – flow-diverter or intra-saccular device deployment (max twice if more than one device used) - $700
    - Stipulation: N122 and N125 cannot be billed with any other N Code or J Code

Committee Comments

- The committee supports the proposed increase in the value of the codes subject to fitting, and relativity and appropriate schedule language.
- The committee supports the proposed E codes subject to fitting, and relativity and appropriate schedule language.

35.8 E875 - with magnetic resonance spectroscopy, to X421 add (PFAF 25262)

35.9 E876 - with magnetic resonance spectroscopy, to X425 add (PFAF 25262)

Constituency Proposal

- The constituency proposed to add MRI perfusion and MRI fiber tracking to the description of the E875 & E876 fee codes.
- Specifically, the constituency proposed the following descriptor revisions:

    E875 - with magnetic resonance spectroscopy and/or MRI perfusion and/or MRI fiber tracking, to X421 add 19.40
    E876- with magnetic resonance spectroscopy and/or MRI perfusion and/or Fiber Tracking, to X425 9.70
    (revisions underlined)

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

36 Neurosurgery

36.1 Nxxx - Endovascular mechanical thrombectomy for embolic stroke (PFAF 23-124)

Constituency Proposal

- The constituency proposed a new fee for endovascular mechanical thrombectomy for embolic stroke, valued at $2,500.00.

Committee Comments

- Please see the committee's response to PFAF 25- 247 from Neuroradiology.

36.2 Exxx - BMI premium (PFAF 23-126)

Constituency Proposal

- The constituency proposed a new premium to be applied to patients with a BMI greater than 35, valued at 20%.

Committee Comments

- The committee acknowledges the constituency's change in their proposal to a BMI cut-off of 40 and is now requesting revisions to E676 eligibility criteria.
- A surgical time analysis performed by the committee failed to demonstrate a significant increase in surgical time associated with BMI > 40.
- The committee does not support this proposal.
- The committee notes that this proposal is similar to PFAF 25-138.

36.3 Nxxx - Endovascular approach to include stenting of the carotid/vertebrobasilar arteries, with or without a proximal/distal embolic protection device (PFAF 25-129)

Constituency Proposal

- The constituency proposed a new code Endovascular approach to include stenting of the carotid/vertebrobasilar arteries, with or without a proximal/distal embolic protection device, paid at $1,400.00.

Committee Comments

- Please see the committee's response to PFAF 25-247 from Neuroradiology.

36.4 Nxxx - Endovascular intervention to ischemic stroke secondary to occlusion (PFAF 25-131)

Constituency Proposal

- The constituency proposed a new code Endovascular intervention to ischemic stroke secondary to occlusion, paid at $2,500.00.

Committee Comments

- Please see the committee's response to PFAF 25-247 from Neuroradiology.

36.5 E372 – Posterior Interbody Implant/Graft/Nuclear Replacement - one disc level, to N511, N512 or N513 (PFAF 25-133)

Constituency Proposal

- The constituency proposed an addendum to the fee code commentary/payment rules as follows:
- The described procedure includes any interbody implant designed to achieve interbody fusion across a disc level, i.e. synthetic implants (e.g. cages, rods, struts, screws, cement etc.), bone graft or graft substitutes (e.g. corticocancellous chips, calcium graft extenders, etc.), strut grafts
- The proposed change is meant to eliminate any ambiguity in interpretation when billing E372.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

36.6 R469 – Pelvis and Hip, Arthrodesis - Sacro-iliac joint (PFAF 25-137)

Constituency Proposal

- The constituency proposed a revision to R469 as follows:

  Sacro-iliac joint (standalone) or sacro-iliac joint (part of lumbopelvic construct) or extension of lumbar fusion to ilium

  (revisions underlined)

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

36.7 E676 – Morbidly obese patient premium (PFAF 25-138)

Constituency Proposal

- The constituency proposed the addition of prone-position major spinal surgical codes to the eligibility for E676A. Added fee codes would be:
  - N509, 510, N520, N511, N512, N524, N574, N575, N576, N572, N560, N561, N519, N532, N515, N582, N570, N583.

Committee Comments

- Committee data analysis fails to demonstrate an increase in time associated with an increased BMI for the procedures listed in this proposal.
- The committee does not support this proposal.

36.8 Multiple Fee Codes – Fee value changes (PFAF 25-006, 25-126)

Constituency Proposal

- The constituency proposed value changes to the following fee codes:

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
A043	Neurosurgery (04) - Specific assessment	$58.25	$67.00	15.0%
A044	Neurosurgery (04) - Partial assessment	$30.00	$34.50	15.0%
A045	Neurosurgery (04) - Consultation	$130.75	$150.35	15.0%
C042	Neurosurgery (04) - Subsequent visits - first five weeks, per visit	$31.00	$35.65	15.0%

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
C047	Neurosurgery (04) - Subsequent visits - sixth to thirteenth week inclusive (maximum 3 per patient per week, per visit	$31.00	$37.20	20.0%
E150	CritiCall review of complex neurosurgical imaging, to K733	$44.00	$55.90	27.0%
E361	Posterior Spinal Decompression - Cervical/Thoracic/Lumbar - each additional level decompressed including disc excision - unilateral or bilateral, to N509, N510, N511, N512, N524 or N562, add	$255.00	$262.65	3.0%
E365	Anterior Spinal Arthrodesis Following Decompression - Cervical - with instrumentation including cages - one disc level, to N500, N501, N572, N560 or N561, add	$765.00	$893.00	16.7%
E370	Posterior Spinal Arthrodesis Following Decompression or Osteotomy - Cervical … with instrumentation - by same surgeon - one disc level - below C2, to N509, N510, N572, N574, N575, N576, N560 or N561, add	$867.00	$884.35	2.0%
E901	Cranial - with operating microscope, to N152, N153, N105 or N154, N106 or N155, N129, N266 or N267, N211 or N213, add	$234.65	$258.10	10.0%
N102	Meningioma and other tumourous lesions, including pituitary tumours - supratentorial	$1,862.85	$2,049.15	10.0%
N103	Craniotomy plus excision - Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour - supratentorial	$1,686.05	$1,938.95	15.0%
N104	SPONTANEOUS INTRACEREBRAL HAEMORRHAGE - Craniotomy plus removal - supratentorial	$1,230.00	$1,476.00	20.0%
N105	Neurosurgery - Open Surgical Approach - Intracranial aneurysm repair - Craniotomy approaches - Carotid circulation - per vessel	$2,477.45	$2,725.20	10.0%
N106	Neurosurgery - Open Surgical Approach - Cerebral vascular malformation - Craniotomy - supratentorial	$2,006.05	$2,407.25	20.0%

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
N110	INTRACRANIAL ABSCESS - Lobectomy and/or excision of cortical scar for epilepsy	$2,184.20	$2,511.85	15.0%
N111	Skull Base Surgery – Resection Of Lesion(S) - Endonasal Approach - Pituitary lesion(s) - Transsphenoidal microscopic resection of lesion(s) originating in the sella turcica requiring simple closure, repair and/or reconstruction of surgical defect(s)	$1,879.00	$2,066.90	10.0%
N117	INTRACRANIAL ABSCESS - Craniotomy	$1,416.50	$1,699.80	20.0%
N119	INTRACRANIAL ABSCESS - Functional stereotaxy - Intracranial implantation of chronic surface electrodes	$1,185.30	$1,422.35	20.0%
N122	INTRACRANIAL ENDOVASCULAR SURGERY - Intracranial aneurysm repair - Endovascular approaches - Carotid circulation - per vessel	$2,140.15	$2,354.15	10.0%
N123	INTRACRANIAL ABSCESS - Stereotaxis - intracranial (to include ventriculography)	$559.60	$643.55	15.0%
N124	INTRACRANIAL ABSCESS - Functional stereotaxy	$2,040.15	$2,244.15	10.0%
N125	INTRACRANIAL ENDOVASCULAR SURGERY - Intracranial aneurysm repair - Endovascular approaches - Vertebrobasilar circulation, including aneurysm of vein of Galen	$2,140.15	$2,354.15	10.0%
N129	INTRACRANIAL ABSCESS - Posterior fossa decompression for Arnold Chiari malformation	$1,284.95	$1,670.45	30.0%
N140	Cranial - Reduction of skull fracture - compound	$895.00	$1,163.50	30.0%
N148	Cranial - Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	$1,204.65	$1,385.35	15.0%
N151	Craniotomy plus excision - Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour - infratentorial	$1,862.85	$2,049.15	10.0%

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
N152	Craniotomy plus excision - Craniotomy plus lobectomy	$1,575.80	$1,812.15	15.0%
N153	Meningioma and other tumourous lesions, including pituitary tumours - infratentorial or basal	$2,529.80	$2,909.25	15.0%
N154	Neurosurgery - Open Surgical Approach - Intracranial aneurysm repair - Craniotomy approaches - Vertebrobasilar circulation, including aneurysm of vein of Galen	$2,477.45	$2,849.05	15.0%
N155	Neurosurgery - Open Surgical Approach - Cerebral vascular malformation - Craniotomy - infratentorial	$2,015.00	$2,317.25	15.0%
N157	SPONTANEOUS INTRACEREBRAL HAEMORRHAGE - Craniotomy plus removal - infratentorial	$1,388.40	$1,804.90	30.0%
N161	Cranial - Repair of skull defect - Acrylic or metal cranioplasty	$600.85	$691.00	15.0%
N200	Cranial - Decompressive craniectomy (frontal, sub-temporal)	$738.60	$1,107.90	50.0%
N230	Cranial - CSF shunting procedures - all types	$1,027.40	$1,130.15	10.0%
N245	Cranial - Revision of CSF shunt - operative - all types	$585.90	$703.10	20.0%
N500	Anterior Spinal Decompression - Cervical - Disc excision (one level)	$918.00	$1,155.40	25.9%
N501	Anterior Spinal Decompression - Cervical - Vertebrectomy (removal of vertebral body and excision of adjacent discs)	$1,100.40	$1,320.50	20.0%
N510	Posterior Spinal Decompression - Cervical / Thoracic - One level - bilateral	$1,208.70	$1,390.00	15.0%
N512	Posterior Spinal Decompression - Lumbar - One level - bilateral	$1,004.70	$1,155.40	15.0%
N524	Posterior Spinal Decompression - Lumbar - One level - bilateral canal enlargement - unilateral approach	$1,208.70	$1,329.55	10.0%
N540	Deformities of the Spine - Posterior scoliosis correction - up to six levels	$2,805.00	$3,366.00	20.0%

Fee Code	Descriptor	Fee Value	Proposed Fee Value	% Increase
	(includes approach, disc excision and instrumentation)			
N560	Intradural extramedullary spinal tumour(s) - partial or total removal	$2,132.80	$2,666.00	25.0%
N561	Intradural intramedullary spinaltumour(s) - partial or total removal	$2,461.45	$3,076.80	25.0%
N572	Fractures of the Spine - Open reduction, any single level, spine fracture/dislocation, anterior/posterior	$1,020.00	$1,122.00	10.0%
Z820	INTRACRANIAL ABSCESS - Ventriculoscopy - Insertion of intracranial pressure monitor and/or external ventricular drainage	$367.95	$404.75	10.0%
Z823	Neurological Surgical Procedures - Cranial/Peripheral Nerves - Functional stereotaxy - Implantation or revision of stimulation pack or leads (peripheralnerve, brain)	$404.30	$444.75	10.0%

Committee Comments:

- The committee supports a fee value change for the listed codes, and continues to deliberate what that fee value change should be, based on fitting and relativity; except for:
    - E150. The committee notes this is code was created with the most recent allocation. The committee does not support changes to recently created codes. Therefore, the committee does not support a change to the value of E150 with this allocation.

37 Nuclear Medicine

37.1 J809 - Myocardial Perfusion Scintigraphy - application of SPECT (maximum two per examination), to J808 (PFAF 23-095)

Constituency Proposal

- The constituency proposed a revision to J809 as follows:

    - Application of SPECT (maximum ~~2~~3 per examination), to J807 or J808.

    (Revisions underlined, deletions ~~strikethrough~~)

- J866 is used for both cardiac and non-cardiac SPECT, while J809 is also used for cardiac SPECT. Separating the codes so J809 is used only for cardiac SPECT and J866 only for non-cardiac SPECT is proposed. As J809 and J866 currently pay the same amount this change will be cost-neutral.

Committee Comments

- The committee supports the proposal, subject to appropriate schedule language.

37.2 J866 - Application of (SPECT), maximum one per examination, to J807 (PFAF 23-096)

Constituency Proposal

- The constituency proposed a revision to J866.
- J866 has 2 separate listings in the SOB:
    - Page B3: Myocardial Perfusion Scintigraphy -application of SPECT (maximum 1 per examination), to J807
    - Page B10: Application of Tomography (SPECT), other than to J808 or J852 -maximum one per Nuclear Medicine examination
- Proposed descriptor:
    - Page B3: Delete this listing entirely.
    - Page B10: Application of Tomography (SPECT), other than to <u>J807,</u> J808, or J852 - maximum one per Nuclear Medicine examination

    (Revisions <u>underlined</u>, deletions ~~strikethrough~~)
- J866 is used for both cardiac and non-cardiac SPECT, while J809 is also used for cardiac SPECT. Separating the codes so J809 is used only for cardiac SPECT and J866 only for non-cardiac SPECT is proposed. As J809 and J866 currently pay the same amount this change will be cost-neutral.

Committee Comments

- The committee supports the proposal, subject to appropriate schedule language.

37.3 A735 - Diagnostic Consultation (PFAF 23-104)

Constituency Proposal

- The constituency proposed adding and additional condition to A735 descriptor as follows:

    c. when the diagnostic consultation is done for a PET scan, add 50%
- PET scans are significantly more complicated and time-consuming to interpret compared to other Nuclear Medicine studies, creating an intra-sectional relativity issue. This would result in an increase from $67.40 to $101.10 for PET scans.

Committee Comments

- Analysis has demonstrated that the impact of this change is of limited benefit.
- The committee does not support this proposal.

37.4 Cardiac codes - J807, J808, J809, J900, J901, J811, J812, J813, J814 (PFAF 23-244)

Constituency Proposal

- The constituency proposed a fee reduction to the following codes, valued at 10%:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
J807	Myocardial Perfusion Scintigraphy - resting, immediate post stress	$38.10	$34.29	-$3.81	-10.0%
J808	Myocardial Perfusion Scintigraphy - delayed	$20.90	$18.81	-$2.09	-10.0%
J809[1]	Myocardial Perfusion Scintigraphy - application of SPECT (maximum 2 per examination), to J808	$23.65	$21.29	-$2.36	-10.0%
J900	application of Rubidium PET for cardiac perfusion (maximum 1 per examination)	$23.65	$21.29	-$2.36	-10.0%
J901	application of Rubidium PET for cardiac perfusion (maximum 1 per examination), to J808	$23.65	$21.29	-$2.36	-10.0%
J811[2]	Myocardial wall motion - studies	$43.25	$38.93	-$4.32	-10.0%
J812[2]	Myocardial wall motion - repeat same day (to a maximum of three repeats)	$20.90	$18.81	-$2.09	-10.0%
J813[2]	Myocardial wall motion - studies with ejection fraction	$62.50	$56.25	-$6.25	-10.0%
J814[2]	Myocardial wall motion - repeat same day (to a maximum of three repeats)	$33.00	$29.70	-$3.30	-10.0%

- Cardiac SPECT procedures currently billed as J866 will be moved to J809 if the separate J809 proposal is approved, and the value of these SPECT procedures would also be reduced.
- The constituency previously proposed creating equivalent codes to J811, J812, J813, and J814 when these procedures are done as part of myocardial perfusion studies instead of standalone exams. These new codes would also be reduced by 10% to reflect their lesser time and workload compared to the standalone exams. The standalone codes J811, J812, J813, and J814 would not change their values.
- The funding freed up by reducing these codes will be used to pay for the proposed SPECT/CT and second SPECT codes.

Committee Comments

- The committee supports the value changes proposed.
- The committee does not support the proposal to create equivalent codes for procedures done as part of myocardial profusion studies.

37.5 Jxxx - Brain scintigraphy - cerebral perfusion (PFAF 23-245)

Constituency Proposal

- The constituency proposed a new fee code be created to split J858 into two separate codes for perfusion and non-perfusion studies, valued at $49.80.
- Studies done for perfusion are more complex than other types of brain scintigraphy.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

37.6 Jxxx1, Jxx2, Jxx4 - hybrid tomographic (SPECT/CT) imaging and multiple tomographic sequences (PFAF 23-246)

Constituency Proposal

- The constituency previously proposed new codes for hybrid tomographic (SPECT/CT) imaging and multiple tomographic sequences (deferred items Jxx1, Jxx2, Jxx3, and Jxx4). An amendment to these codes is proposed to increase the value for the hybrid codes (Jxx1, Jxx2, and Jxx4) compared to the underlying non-hybrid base codes J866 and J819, with an approximate value of $10-$20 above J866.
- The use of a modifier was proposed as an alternative: e.g., bill Y866 instead of J866 when hybrid imaging is performed, with an add-on to J866.

Committee Comments

- The committee supports the creation of a single add-on code.
- The committee continues to deliberate an appropriate fee value based on fitting and relativity.

37.7 Cost neutral modernization of the OHIP Schedule: application of SPECT and hybrid SPECT/CT, cardiac nuclear medicine studies and miscellaneous nuclear medicine studies (PFAF 21-D52, 21-D53, 21-D65 to D72)

Constituency Proposal

- The constituency proposed modernization of the OHIP Schedule on a cost neutral basis relating to:

    - Cardiac Nuclear Medicine studies on page B4
    - Descriptor revisions of the following fee codes to reflect modern day practice: J820, J857, J858, J860, J865, J869, J830 and J878

Committee Comments

- The committee supports the proposals related to modernization, but continue to deliberate the proposals related to Cardiac Nuclear Medicine studies and will reach out to the section as required.

37.8 Modernization of the OHIP Schedule, PET and PET/CT studies (PFAF 21-D54 to 21-D57)

Constituency Proposal

- The constituency proposed modernization of the OHIP Schedule on a cost neutral basis relating to:

    - PET - Oncology
    - PET - Cardiology
    - PET - Neurology

- PET - Other

Committee Comments

- The committee supports modernization of the PET codes, using the following breakdown: PET-Oncologic, PET – Cardiology, PET – Neurology, subject to schedule language.

37.9 Jxxx - Quantification of coronary artery calcification using a non-contrast CT scan performed on a hybrid (SPECT/CT or PET/CT) system, either as part of a myocardial perfusion study or as a standalone test, when specifically and separately requested by an ordering practitioner (PFAF 25-266)

Constituency Proposal

- The constituency proposed a new code where quantification of coronary artery calcification non-contrast CT scans performed using the CT component of a hybrid (SPECT/CT or PET/CT) imaging system, valued at $64.95 with the following payment rules:

    1. When performed in conjunction with a myocardial perfusion study, coronary calcium scoring must be specifically and separately requested by the ordering practitioner.
    2. This service is limited to one per day.

- The constituency stated that Coronary calcium scoring (CCS) is a common and valuable tool in assessing atherosclerotic disease and risk, included in many professional guidelines. It requires dedicated software and careful analysis to validate measured values.
- The constituency stated CCS is already an insured service when done on a standalone diagnostic CT scanner. Many hybrid Nuclear Medicine imaging (i.e. SPECT/CT or PET/CT) systems can perform CCS using the CT portion of a hybrid study without requiring a separate CT examination. Due to existing payment rules, however, CCS can only be billed when performed on a standalone CT scanner. As a result, patients requiring both a Nuclear Medicine study and CCS must be sent for two separate tests, resulting in additional radiation to the patient and unnecessary utilization of CT scanner time. They would like a new code for CCS performed on Nuclear Medicine hybrid imaging systems.

Committee Comments

- Research conducted by the committee failed to demonstrate that this is currently standard of care.
- Therefore, the committee does not support this proposal at this time.

38 Obstetrics & Gynaecology

38.1 Pxxx - Management of labour (PFAF 23-139)

Constituency Proposal

- The constituency proposed a new fee code for management of labour, valued at $687.43 with the following payment rules:

- Requires completion of written record. Payable only after at least one hour of attendance at bedside. Payable once per obstetrician but can be billed by any obstetrician managing more than one hour of complex labour.
- Includes monitoring of labour with or without delivery. Performed only by a specialist obstetrician (OHIP specialty #20).
- Can be billed by any obstetrician managing complex labour for more than one hour.

Payable only for the following conditions:

- Fetal conditions:
  (a) Abnormal FH tracing,
  (b) Prematurity <37 completed weeks gestation,
  (c) Severe IUGR (< 2500 g),
  (d) Multiple gestation,
  (e) Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g.: open neural tube defect, body wall defect such as omphalocele, or gastroschisis, congenital; fetal arrhythmia, hydrocephalus),
  (f) Hydrops fetalis,
  (g) Iso-immunization.

- Placental or amniotic fluid conditions:
  (a) Placental abruption,
  (b) Severe oligohydramnios (AFI<6),
  (c) Severe polyhydramnios (AFI>25).

- Maternal Conditions:
  (a) Cardiovascular disease where the management or labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrhythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilatation.
  (b) Renal disease (e.g.: renal failure. renal transplant),
  (c) Pulmonary disease (e.g.: pulmonary fibrosis. severe asthma, cystic fibrosis),
  (d) Endocrine disease (e.g.: Addison's disease. clinical hyperthyroidism, Type 1 Diabetes Mellitus),
  (e) Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia),
  (f) Infectious disease (AIDS. severe pneumonia, systemic sepsis),
  (g) Severe pre-eclampsia (attempt made to deliver vaginally),
  (h) Maternal obesity - BMI >40,
  (i) Any labour requiring oxytocin augmentation.

Committee Comments

- Committee analysis indicates that allocation of new funds to obstetrical care will likely worsen intrasectional relativity.

- The committee could only proceed with this proposal if it could be costed very accurately. The committee does not see any method by which such an estimate could be achieved and guaranteed.
- The committee does not support this proposal.

38.2 S760 - Abdominal approach to vaginal vault prolapse - vaginal sacropexy (PFAF 23-197)

38.3 S813 - Abdominal approach to vaginal vault prolapse - repeat - vaginal sacropexy (PFAF 23-201)

Constituency Proposal

- The constituency proposed the following fee increases and descriptor revisions:

Fee code	Descriptor	Current value	Proposed value	$ Increase	% Increase
S760	Abdominal approach to vaginal ~~vault~~ apical prolapse - vaginal sacropexy	$432.45	$800.00	$367.55	85.0%
S813	Abdominal approach to vaginal ~~vault~~ apical prolapse - repeat - vaginal sacropexy	$515.05	$1200.00	$684.95	133.0%

(Revisions underlined, deletions ~~strikethrough~~)

- Proposed payment rules:
  - Can be billed concurrently with S757, S816, S758, S759.
  - Can be billed along with # E862 if done laparoscopically.

Committee Comments

- The committee supports the modification to the descriptors.
- The committee believes the remainder of the proposed changes within these PFAFs are more effectively addressed by the time-based gynaecological surgery billing proposal.

38.4 Exxx - female genital procedures - vagina - repair - anterior or posterior repair - when implant is used (PFAF 23-209)

Constituency Proposal

- The constituency requested a new add on premium for anterior or posterior repair when an implant is used valued at $130 per compartment applicable to: S716, S717, S718, S719, S723, S720, S721, S722, S812.
- Implant, permanent synthetic or biologic must be attached to the arcus tendineus fascia pelvic for the anterior compartment; and to the sacrospinous ligament for a posterior compartment implant.
- This can only be billed by someone with advanced training (e.g. FPMRS)

Committee Comments

- The committee believes the change proposed by this PFAF is more effectively addressed by the time-based gynaecological surgery billing proposal.

- The committee does not support this proposal.

38.5 Sxxx - Pelvic mesh excision (PFAF 23-210)

Constituency Proposal

- The constituency proposed a new fee for pelvic mesh excision, valued at $557.95.
- Proposed payment rules: description of dissection into the retropubic space by either abdominal or vaginal approach. Documentation of prior vaginal or pelvic mesh procedure.

Committee Comments

- The committee believes the remainder of the proposed changes within this PFAF is more effectively addressed by the time-based gynaecological surgery billing proposal.

38.6 S725 - Colpocleisis (PFAF 23-212)

Constituency Proposal

- The constituency proposed a fee increase to S725, from $300.35 to $515.05, and a revision as follows:

  Colpocleisis or vaginectomy

  (Revisions underlined)

- Proposed payment rule: Involves closure of the vaginal vault.

Committee Comments

- The committee supports rewording S725 to be “colpectomy, colpocleisis, or vaginectomy for indications other than gender affirming surgery.” For gender affirming surgery, see appendix D.
- The committee proposes deletion of S742.
- The committee believes the value change proposed by this PFAF is more effectively addressed by the time-based gynaecological surgery billing proposal.

38.7 S727 - Ovarian debulking, for ovarian carcinoma of stage 2C, 3B, 3C, or 4 and may include hysterectomy, omentectomy, bowel resection, one or more biopsies and/or resection of pelvic peritoneum

38.8 Sxx1 - Stripping bladder peritoneum with cancer

38.9 Sxx2 - Stripping large/ small bowel mesentery with cancer

38.10 Sxx3 - Resection of diaphragmatic disease from cancer

38.11 Sxx4 - Resection of omental cake from cancer (PFAF 23-215)

Constituency Proposal

- The constituency proposed the unbundling and deletion of S727 and the introduction of 4 separate new fee codes as a replacement:
  - Sxx1 Stripping bladder peritoneum with cancer, valued at $300.00

- Sxx2 Stripping large/ small bowel mesentery with cancer, valued at $300.00
- Sxx3 Resection of diaphragmatic disease from cancer, valued at $ $450.00
- Sxx4 Resection of omental cake from cancer, valued at $450.00.

Committee Comments

- The committee believes the changes proposed by these PFAFs are more effectively addressed by the time-based gynaecological surgery billing proposal.

38.12 Zxxx - Transvaginal injection into pelvic floor muscle trigger point for chronic pain (PFAF 23-220)

38.13 Exxx - Each additional injections to a maximum of 6 additional (PFAF 23-220)

Constituency Proposal

- The constituency proposed two new fees for:
  - Transvaginal injection into pelvic floor muscle trigger point for chronic pain, valued at $55.00.
  - Each additional injection to a maximum of 6, valued at $19.90.
- E542 (when performed outside hospital) would be eligible for payment in addition to the new transvaginal injection fee.

Committee Comments

- Topics related to this proposal are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

38.14 S745 Oophorectomy - and/or oophorocystectomy (PFAF 23-219, 23-222)

Constituency Proposal

- The constituency proposed two revisions to S745:
  - The addition of laparoscopic ovarian tissue harvesting for the purpose of ovarian tissue cryopreservation to the list of indications for laparoscopic oophorectomy/ ovarian biopsy.
  - The revision of the code for ovarian surgery to perform ovarian tissue transplantation, which requires similar training and skills to perform other ovarian/ pelvic surgeries.

Committee Comments

- Such a change exceeds the scope of the PPC. The committee recommends that the constituency direct the request to the Ontario Fertility Program.

38.15 P020 - Operative delivery, i.e. mid-cavity extraction or assisted breech delivery (PFAF 23-239)

Constituency Proposal

- The constituency proposed a revision to P020 as follows:

  Operative delivery, i.e. ~~mid-cavity extraction or assisted breech delivery~~ forceps or vacuum-assisted delivery, breech delivery, shoulder dystocia using advanced manoeuvres or greater than 1 minute in duration and/or urgent referral to the obstetrician on call for assistance.

  (Revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- The committee supports the following language:

  "Operative delivery, defined as any of: i) forceps or vacuum-assisted delivery, or ii) breech delivery, or iii) shoulder dystocia using advanced manoeuvres"

38.16 Zxxx - Insertion of hormonal implant or rod for contraception, menstrual cycle control or menopausal hormone therapy (PFAF 23-240)

Constituency Proposal

- The constituency proposed a new fee for insertion of hormonal implant or rod for contraception, menstrual cycle control or menopausal hormone therapy, valued at $42.00.
- Risk factors include potential translocation of the pellet, possible intravascular injection, infection. This code requires a tray fee.

Committee Comments

- The committee supports this proposal in principle and has drafted schedule language that has been shared with the appropriate constituencies.
- The committee notes with creation of this code, G342 will be deleted.

38.17 Z463 Removal of Norplant (PFAF 23-241)

Constituency Proposal

- The constituency proposed a fee increase for Z463 from $65.30 to $95.00 (45.5 per cent) and a revision as follows:

  Removal of ~~Norplant~~ contraceptive or hormonal rod or pellet requiring skin incision & dissection.

  (Revisions underlined, deletions ~~strikethrough~~)

- The fee has mostly been unused for over 20 years. A generic code will be used more frequently with the reintroduction of implantable contraceptives.

Committee Comments

- Given the fee code for the insertion of Norplant was removed from the Schedule of Benefits in 2007, the PPC recommends the deletion of Z463, as it is not eligible for payment for any other type of removal.
- Z114 is the appropriate code for a simple removal and Z115 is the appropriate code for a complex removal under general anaesthetic.

- Note that Z114 includes a tray fee when performed out of hospital.
- The committee does not support this proposal.

38.18 E090 Oophorectomy - removal of contralateral ovary with moderate or severe endometriosis, to S745, add (PFAF 23-262)

Constituency Proposal

- The constituency proposed a revision to E090 as follows:

  Removal of contralateral ovary ~~with moderate or severe endometriosis~~, to S745, add.

  (Deletions ~~strikethrough~~)

- Removal of contralateral ovary always involves more time. It is unfair for bilateral procedures to be paid the same as unilateral procedures.

Committee Comments

- The committee believes the change proposed by this PFAF is more effectively addressed by the time-based gynaecological surgery billing proposal.

38.19 Various fee increases (PFAF 23-260, 23-264 to 23-267, 23-270, 23-284, 23-294, 23-296, 23-297)

Constituency Proposal

- The constituency proposed the following fee increases:

Fee Code	Descriptor	Current Value	Proposed Value	% Increase
S784	Ectopic pregnancy – management by any surgical technique	$382.10	$458.60	20.0%
S738	Salpingectomy or Salpingoophorectomy (Uni- or bilateral)	$366.20	$458.60	25.2%
S745	Oophorectomy and/or oophorocystectomy	$366.20	$458.60	25.2%
Z552	Laparoscopy without biopsy	$149.65	$160.00	6.9%
Z553	Laparoscopy with biopsy and/or lysis or adhesions &/or removal of foreign body &/or cautery of endometrial implants	$196.65	$225.00	14.4%
S759	Hysterectomy - with or without adnexa (unless otherwise specified) - with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	$655.05	$700.00	6.9%

Fee Code	Descriptor	Current Value	Proposed Value	% Increase
Z715	Abscess of vulva, Bartholin or Skene's gland - general anaesthetic	$56.70	$100.00	76.4%
Z716	Abscess of vulva, Bartholin or Skene's gland - Marsupialization of Bartholin's cyst or abscess	$89.80	$110.00	22.5%
Z475	Biopsy(ies) - when sole procedure - general anaesthetic	$56.70	$100.00	76.4%
S707	Hymenectomy (with or without perineotomy) or hymenotomy	$97.20	$120.00	23.5%
S706	Cyst of Bartholin's gland	$129.85	$160.00	23.2%
Z737	Laparoscopy - Laser treatment of extensive pelvic disease	$215.80	$260.00	20.5%

Committee Comments

- For codes S738, S745, S759, Z737, and Z553, the committee believes the changes proposed by these PFAFs are more effectively addressed by the time-based gynaecological surgery billing proposal.
- For the remaining codes, the committee supports the fee value changes, subject to fitting and relativity.

38.20 Pxxx - Monitoring of patient on oxytocin in labour (PFAF 25-067)

Constituency Proposal

- The constituency proposed a new code where obstetricians are responsible for monitoring patients who are on oxytocin (as they require cEFM), valued at $18/15min with the following payment rules:
    - In addition to fee for initiating oxytocin, there should be a fee for ongoing fetal monitoring during oxytocin infusion which is time-based.
    - Requires documentation of amount of oxytocin and categorization of and FHR/contraction pattern every two hours.
- The constituency stated physicians need to frequently access FHR and contraction pattern to determine if it is safe to continue oxytocin and if the amount needs to be increased / decreased. Obstetricians monitoring patients on oxytocin are usually in-house (so on for the labour floor).

Committee Comments

- Committee analysis indicates that allocation of new funds to obstetrical care will likely worsen intrasectional relativity.
- The committee could only proceed with this proposal if it could be costed very accurately. The committee does not see any method by which such an estimate could be achieved and guaranteed.
- The committee does not support this proposal.

39 Ophthalmology / Eye Physicians and Surgeons of Ontario

39.1 Various fee value changes to consult and assessment fee codes (PFAF 23-147, 23-148, 23-171, 23-172)

Constituency Proposal

- The constituency requested the following fee value changes to consult and assessment fee codes:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A235	Ophthalmology - Consultation	$82.40	$88.80	$6.40	7.8%
A233	Ophthalmology - Specific assessment	$57.70	$62.30	$4.60	8.0%
A253	Ophthalmology - Optometrist - Requested Assessment (ORA)	$82.40	$88.80	$6.40	7.8%
A234	Ophthalmology - Partial assessment	$30.50	$32.90	$2.40	7.9%

- These fee value changes are to address inflationary burden, promote office-based care, and further facilitate intra-sectional relativity.

Committee Comments

- The committee supports the proposed value changes, subject to fitting and relativity.

39.2 Axxx - Optometrist-Requested Assessment for Uveitis and Ocular Inflammatory Diseases (PFAF 23-261)

Constituency Proposal

- The constituency requested a new fee code Axxx Optometrist-Requested Assessment for Uveitis and Ocular Inflammatory Diseases, paid at $150.00 with the same payment rules as A930.
- The A930 Uveitis and ocular inflammatory diseases consultation is not paid if the patient is referred by an optometrist. A code identical to A930, but permitted with a referral from an optometrist, is needed to cover the complete spectrum of diagnosis, therapy and care provided to patients with ocular inflammatory disease.
- The referral source does not change the complexity of the patient's presentation, or the complexity of care provided, such as the diagnosis, investigations, referrals made, or the volume/length of communications sent to coordinate care for the patient.

Committee Comments

- The committee supports the creation of the proposed fee code modelled on the equivalent consult from a physician.

39.3 Axxx - Optometrist-Requested Assessment for Neuro-ophthalmic Disorders (PFAF 23-263)

Constituency Proposal

- The constituency requested a new fee code Axxx Optometrist-Requested Assessment for Neuro-ophthalmic Disorders, paid at $148.50 with the same payment rules as A231.
- The A231 Neuro-ophthalmology consultation is not paid if the patient is referred by an optometrist. A code identical to A231, but permitted with a referral from an optometrist, is needed to cover the complete spectrum of diagnosis, therapy and care provided to patients presenting with a neuro-ophthalmic disorder.
- The referral source (optometrist or physician) does not change the complexity of the patient's presentation, or the complexity of care provided, such as the detailed clinical assessment (see payment rules,) diagnosis or investigations interpreted.

Committee Comments

- The committee supports the creation of the proposed fee code modelled on the equivalent consult from a physician.

39.4 E877 - Strabismus procedures - repeat strabismus procedure(s), to E185, E184, E183, or E182 (PFAF 23-004)

Constituency Proposal

- The constituency requested a revision to E877 as follows:

  Repeat strabismus procedures. additive to E185, E184, E183, E182, or to strabismus procedure performed for patients with post traumatic strabismus, Thyroid eye disease, post placement of a retinal buckle, or external ophthalmoplegia.

  (Revisions underlined)

- Strabismus surgery when performed on patients with post traumatic strabismus, Thyroid eye disease or external ophthalmoplegia is extremely complex due to the disruption of normal anatomy, and extreme restriction of eye movements. Therefore, there should be an additional premium applied to compensate for this complexity.

Committee Comments

- Preliminary data regarding E877 indicates that cases for which it is billed do not take longer than for cases for which it is not billed.
- The committee does not support this proposal to expand indications.

39.5 Exxx - Laser retinopexy for retinoblastoma (PFAF 23-007)

Constituency Proposal

- The constituency requested a new fee code Exxx Laser retinopexy for retinoblastoma, paid at $750.00 with the following payment rules:

  - Payable per individual eye treated (if second eye is treated in the same session payable at 85%).
  - Detailed record required of precise tumor location, number of laser applications and visual response to treatment.

- The procedure is only performed in major centers with fellowship trained paediatric ophthalmologists with expertise in oncology and retinoblastoma. The service takes between 20-60 minutes per eye for actual treatment, with additional 20-60 minutes for examination and documentation.
- This service has been billed under the E154 code, which does not recognize the time risk and expertise required to perform this service.
- This service is most similar to the E125 procedure (laser retinopexy for retinopathy of prematurity). No increase in the numbers of procedures is expected in the future.

Committee Comments

- The committee proposes that fee codes E125 (currently Laser retinopexy for Retinopathy of Prematurity – one eye) and E126 (both eyes) be modified to include Laser retinopexy for retinoblastoma.

39.6 Exxx - Cryopexy for retinoblastoma (PFAF 23-008)

Constituency Proposal

- The constituency requested a new fee code Exxx Cryopexy for retinoblastoma, paid at $375.00 per individual eye treated (if second eye is treated in the same session payable at 85%).
- A detailed record would be required of precise tumor location, number of cryotherapy applications and visual response to treatment
- This service has been billed under the E155 code, which does not recognize the time risk and expertise required to perform this service.
- This service is most similar to the E125 procedure (laser retinopexy for retinopathy of prematurity), but takes less physician time to perform, but similar expertise. The fee has been adjusted for time and expertise relative to the E125.

Committee Comments

- The committee notes this code would be billed very infrequently and the existing code currently billed is close in terms of value.
- The committee does not support this proposal.

39.7 Exx1 - Pediatric cataract extraction age 0 to 7 years (PFAF 23-012)

39.8 Exx2 - Pediatric cataract extraction age years (PFAF 23-013)

Constituency Proposal

- The constituency requested two new fee codes:

    - Exx1 Paediatric cataract extraction age 0 to 7 years, paid at $1,225.00
    - Exx2 Paediatric cataract extraction age 8 to 16 years, paid at $750.00.

- Proposed payment rule: Rule: payment per cataract, with permanent detailed record of the procedure to be kept.
- Cataract surgery in infants, young children, youngsters and teenagers is significantly more complex, requires more time, is of increased stress level and poses more risk, along with lifelong

risk for vision. This procedure is significantly different from cataract surgery in adults to warrant is own code.

Committee Comments

- Based on an analysis service time and taking into account the age premium that already applies, and the section's lack of available allocation, the committee does not support this proposal.

39.9 G428 - Hess screen examination - professional component (PFAF 23-002)

Constituency Proposal

- The constituency requested a fee value change from $6.85 to $25.00.
- This evaluation is similar to A230 Orthoptics examinations, paid at $25.00.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.10 G436 - Visual fields - kinetic (with permanent record) - professional component (PFAF 23-003)

Constituency Proposal

- The constituency requested a fee value change from $14.50 to $26.95.
- Similar time to assess and expertise required as G432 Visual Fields static, paid at $26.95.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.11 G432 - Ophthalmology - Visual fields - Static - professional component (PFAF 23-214)

Constituency Proposal

- The constituency requested a fee value change for G432 Ophthalmology - Visual fields - Static - professional component, from $26.95 to $60.00.
- The current fee does not sufficiently cover for the time spent.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.12 G453 - Contact lens fitting - Electro-oculogram - interpretation fee (PFAF 23-005)

Constituency Proposal

- The constituency requested a value change from $41.60 to $75.00.
- Similar time and expertise required as G524 Electro-retinography, paid at $75.00.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.13 G150 - Visual evoked response - threshold - professional component (PFAF 23-006)

Constituency Proposal

- The constituency requested a fee value change from $19.20 to $75.00.
- Similar time and expertise required as G524 Electro-retinography, paid at $75.00.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.14 G147 - Visual evoked response - simple - professional component (PFAF 23-009)

Constituency Proposal

- The constituency requested a fee value change from $12.30 to $75.00.
- Similar time and expertise required as G439 Full field electro-retinography, paid at $75.00.
- G147 requires similar time and expertise to read and document as electroretinogram and should be paid a similar amount.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.15 G438 - Colour vision detailed assessment - professional component (PFAF 23-010)

Constituency Proposal

- The constituency requested a various fee value change for G438 Colour vision detailed assessment – professional component, from $22.15 to $35.00.
- Comparable service is G852 electroretinogram with report takes similar time, but less expertise is required.

Committee Comments

- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.16 G870 - Botulinum toxin injection(s) of extraocular muscle(s), (unilateral) (PFAF 23-011)

Constituency Proposal

- The constituency requested a various fee value change for G870 Botulinum toxin injection(s) of extraocular muscle(s), (unilateral), from $120.00 to $200.00.
- This procedure is complex and poses significant risk for penetration of the globe and loss of vision, retro-orbital haemorrhage with need for urgent surgical intervention to relieve pressure or loss of vision, inaccurate placement of injection leading to inadvertent effects on other muscles and worsening diplopia, along with additional less significant risks.

Committee Comments

- Given the amount of time required for direct physician involvement in the service, the committee is of the opinion that the current fee value is appropriate.
- The committee does not support this proposal.

39.17 E140 - Cataract - all types of, by any procedure, includes insertion of intraocular lens (PFAF 23-204)

Constituency Proposal

- The constituency requested a fee value change for E140 Cataract - all types of, by any procedure, includes insertion of intraocular lens, from $397.75 to $429.00, by 7.9 per cent.
- This is to keep up with the inflationary burden.

Committee Comments

- The rationale in the PFAF is not unique to this code. If the section wishes to continue to pursue this, please provide rationale based on intra-sectional relativity with respect to time and intensity of the procedure.
- The committee does not support this proposal.

39.18 Various fee value changes to oculoplastics fee codes (PFAF 23-118 to 23-120)

Constituency Proposal

- The constituency requested a various fee value changes to the following fee codes:

Type	Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
Lacrimal	E218	Dacryocystorhinostomy	$542.00	$993.00	$451.00	83.2%
Lacrimal	E216	Lacerated canaliculus - immediate repair	$350.00	$600.00	$250.00	71.4%
Lacrimal	E217	Lacerated canaliculus - delayed repair	$411.20	$750.00	$338.80	82.4%
Lacrimal	E954	Dacryocystorhinostomy - with lacrimal bypass procedure (e.g. Lester Jones) or canalicular reconstruction, add	$80.90	$250.00	$169.10	209.0%
Eyelid	E190	Tarsorrhaphy	$150.00	$300.00	$150.00	100.0%
Eyelid	E191	Double adhesion	$161.75	$400.00	$238.25	147.3%
Eyelid	E192	Ptosis	$313.15	$750.00	$436.85	139.5%
Eyelid	E193	Ptosis - repeat or second repair	$393.00	$850.00	$457.00	116.3%
Eyelid	E198	Laceration, full thickness - including lid margin	$300.00	$750.00	$450.00	150.0%
Eyelid	E199	Laceration, full thickness	$225.00	$600.00	$375.00	166.7%

Type	Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
Eyelid	E221	Laceration of eyelid including levator palpebrae superioris with ptosis	$329.30	$850.00	$520.70	158.1%
Eyelid	E937	Ocular and Aural Surgical Procedures - with autogenous conjunctival Transplant, add	$100.00	$250.00	$150.00	150.0%
Orbit	E169	Decompression – two walls	$542.00	$1,749.25	$1207.25	222.7%
Orbit	E170	Decompression – three walls	$575.85	$1,749.25	$1173.40	203.8%
Orbit	E167	Tumour or foreign body - posterior exposure	$640.00	$1,421.00	$781.00	122.0%
Orbit	E166	Tumour or foreign body - anterior route	$450.00	$994.85	$544.85	121.1%
Orbit	E165	Tumour or foreign body - Lateral orbitotomy (Kronlein)	$590.00	$1,691.50	$1,101.50	186.7%
Orbit	E164	Drainage of abscess	$350.00	$796.00	$446.00	127.4%
Orbit	E109	Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles.	$677.50	$894.95	$217.45	32.1%
Orbit	E103	Evisceration, with or without primary implant	$542.00	$795.50	$253.50	46.8%
Orbit	E102	Enucleation, with or without primary implant	$542.00	$795.50	$253.50	46.8%

- Significantly undercompensated, given how complex these procedures are and the high levels of knowledge and judgement involved, as well as increased risk, high stress, and several years of subspecialty training.

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity.

39.19 Z901 - Irrigation of nasolacrimal system - unilateral or bilateral (PFAF 23-118 attachment)

Constituency Proposal

- The constituency requested a revision to Z901 descriptor as follows:

  Irrigation of nasolacrimal system - <u>per eye</u> ~~unilateral or bilateral~~

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

Committee Comments

- The committee supports the proposed rule change, subject to fitting and relativity.

39.20 E194 - Distichiasis – unilateral (PFAF 23-119)

39.21 E195 - Trichiasis, repair by tarsal transplantation (PFAF 23-119)

Constituency Proposal

- The constituency requested a fee value change of E194 Distichiasis – unilateral, from $289.00 to $675.00.
- With the value change, the constituency also proposed the deletion of E195 and to combine it with E194, instead.

Committee Comments

- The committee supports the proposed combination of E194 and E195 at a prorated value, subject to fitting and relativity.

39.22 Z857 - Epilation -by hyfrecator, electrolysis (PFAF 23-119)

39.23 Z858 - Epilation -by cryopexy (PFAF 23-119)

Constituency Proposal

- The constituency requested a fee value change for Z857 from $26.60 to $175.00, by 557.9 per cent.
- With the value change, the constituency also proposed the deletion of Z858 and to combine it with Z857, instead.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

39.24 E196 - Entropion, other than Zeigler puncture

39.25 E197 - Ectropion, other than Zeigler puncture

39.26 E945 - Repeat by second surgeon, add (PFAF 23-119)

Constituency Proposal

- The constituency requested a revision and fee value change for E196, E197 and E945 as follows:

    - E196 Entropion~~, other than Zeigler puncture~~, from $290.00 to $500.00, by 72.4 per cent.
    - E197 Ectropion~~, other than Zeigler puncture~~, from $310.00 to $500.00 by 61.3 per cent.
    - E945 Repeat ~~by second surgeon~~, from $52.40 to $100.00 by 90.8 per cent

    (deletions ~~strikethrough~~)

- Fee descriptor for E196 and E197 should exclude “other than Zeigler puncture”, as this is rarely done.
- Fee descriptor for E945 should say “repeat” (delete “by second surgeon”).

- Also, E196 and E197 should be allowed to be billed with E930 when done in conjunction with another procedure.

Committee Comments

- Given that the Zeigler puncture is still performed, the PPC does not support the proposal to change the descriptor in this way.
- The committee supports the proposal to revise E945 by deleting, "by second surgeon."
- The committee supports the proposed fee value changes, subject to fitting and relativity.

39.27 E948 - Ocular and Aural Surgical Procedures - with mucous membrane graft, add (PFAF 23-119)

Constituency Proposal

- The constituency requested a fee value change for E948 - with mucous membrane graft, from $113.20 to $200.00, by 76.7 per cent and the following descriptor revision:

  with mucous membrane graft <u>or amniotic membrane or spacer graft</u>.

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

Committee Comments

- The constituency did not provide adequate justification in support of the proposal.
- The committee does not support the proposed change in language.
- The committee supports a fee value change, subject to fitting and relativity.

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39.28 E210 - Excision of conjunctival lesion (PFAF 23-119)

Constituency Proposal

- The constituency requested the E210 fee value be increased from $100.00 to $750.00 (650 per cent) and the following descriptor revision:

  Excision of conjunctival lesion <u>presumed malignant</u>

  (Revisions <u>underlined</u>)

Committee Comments

- The committee notes the constituency has withdrawn their request to change the descriptor.
- The committee supports a fee value change, subject to fitting and relativity.

39.29 E169 - Decompression - two walls (PFAF 23-120)

39.30 E170 - Decompression - three walls (PFAF 23-120)

Constituency Proposal

- The constituency requested the E169 fee be increased from $542.00 to $1,749.25 (222.7 per cent) and the following descriptor revision:

Decompression – two or more walls

(Revisions underlined, deletions ~~strikethrough~~)

- With this proposal, the Section requests deleting E170 Decompression -three walls, and combine it with E169.

Committee Comments

- The committee supports the proposed descriptor change, and deletion of E170.
- The committee supports a fee value change, subject to fitting and relativity for E169.

39.31 E157 - Placement and suturing of iris prosthetic device with or without suturing of iris/pupillary defect (PFAF 23-150)

Constituency Proposal

- The constituency requested a revision to E157 as follows:

  Placement and/or suturing of iris prosthetic device with or without suturing of iris/pupillary defect.

  (Revisions underlined)

- Proposed revision reflects current practice as techniques have evolved.

Committee Comments

- The committee supports this proposal.

39.32 E138 - Fixation of intraocular lens and/or capsular tension device by suturing (PFAF 23-151)

Constituency Proposal

- The constituency requested a revision to E138 as follows:

  Fixation of intraocular lens and/or capsular tension device by suturing and/or direct fixation

  (Revisions underlined)

- Proposed revision reflects current practice as techniques have evolved.

Committee Comments

- The committee supports this proposal in principle, subject to appropriate Schedule of Benefits language.

39.33 Exxx - Pneumatic Retinopexy (PFAF 23-152)

Constituency Proposal

- The constituency requested a new fee code Exxx Pneumatic Retinopexy, paid at $160.00.
- Proposed payment rule: E148, E142, E149, E147, E175, Z851 not eligible for payment with this code on the same day.
- It has been compensated routinely by MoH under IC when supporting documentation is submitted. It has been paid at $160, which is the equivalent of the two procedures, Z851 and E149, that are involved. It is more involved, time consuming and intense than E149/Z851, however, the section is proposing a cost-neutral solution, at this point in time, and looking to eliminate the requirement of IC by creating a new fee code.

Committee Comments

- The committee supports this proposal in principle, subject to appropriate Schedule of Benefits language.

39.34 E151 - Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure (PFAF 23-153)

Constituency Proposal

- The constituency requested a revision to E151 as follows:

  ~~Re-attachment of retina and choroid by diathermy,~~ Retinal laser photocoagulation or cryopexy for treatment of retinal tear or retinal detachment ~~as an initial procedure~~.

  (Revisions underlined, deletions ~~strikethrough~~)

- The current descriptor is not specific. Proposed revision reflects current practice as techniques have evolved.

Committee Comments

- The constituency did not provide feedback which the committee required to properly assess this proposal.
- The committee does not support the proposed change in language.

39.35 E154 - Photocoagulation (xenon, argon laser, etc.) - one eye (PFAF 23-154)

Constituency Proposal

- The constituency requested a revision to E154 as follows:

  Retinal laser photocoagulation of retinal lesion or for panretinal photocoagulation or for focal macular treatment ~~(xenon, argon laser, etc.) - one eye.~~

  (Revisions underlined, deletions ~~strikethrough~~)

- The current descriptor is not specific. Proposed revision reflects current practice as techniques have evolved.

Committee Comments

- The constituency did not provide feedback which the committee required to properly assess this proposal.
- The committee does not support the proposed change in language.

39.36 E940 - Anterior vitrectomy - when done in conjunction with another intraocular procedure, add (PFAF 23-159)

Constituency Proposal

- The constituency requested a revision to E940 as follows:

  Anterior vitrectomy - by corneal or pars plana approach ~~when done~~ in conjunction with another intraocular procedure, add.

  (Revisions underlined, deletions ~~strikethrough~~)

- The revision will add additional clarity to the code, as. anterior vitrectomy is a partial vitrectomy. It can be done by corneal or pars plana approach. Anterior vitrectomy can be billed with E140, E139, E141, E141/E950, E143, E138, E144, E145, E146, E130, and other Iris and Ciliary Body surgical codes.

Committee Comments

- The committee drafted schedule language which addressed the portions of these proposals with which we had adequate information to deliberate.
- This draft schedule language has been shared with the constituency for their feedback.
- The committee has received no edits or objections to the drafted schedule language changes from the constituency.
- The committee did not have adequate information to deliberate on portions of these proposals and these portions were therefore not supported by the committee.

39.37 E148 - Anterior vitrectomy - Vitrectomy by infusion suction cutter technique (PFAF 23-157)

39.38 E936 - Vitreous exchange - to vitrectomy (PFAF 23-157)

Constituency Proposal

- The constituency requested E148 fee be increased from $720.00 to $810.00 (12.5 per cent) and the following description revision:

  Vitrectomy, complete and by posterior approach, with vitreous exchange (air, gas, or artificial vitreous substance) ~~by infusionsuction cutter technique~~

  (Revisions underlined, deletions ~~strikethrough~~)

- The increased fee value and revised descriptor would include the combination of E936 into E148.
- This is a cost-neutral proposal. All vitrectomies involve a vitreous exchange (air, gas, or artificial vitreous substance) billed as E936. The intention is to streamline billing and make it easier by combining these codes that are always billed together.

Committee Comments

- The committee drafted schedule language which addressed the portions of these proposals with which we had adequate information to deliberate.
- This draft schedule language has been shared with the constituency for their feedback.
- The committee has received no edits or objections to the drafted schedule language changes from the constituency.
- The committee did not have adequate information to deliberate on portions of these proposals and these portions were therefore not supported by the committee.

39.39 Various proposals to the Ocular and Aural Surgical Procedures – Vitreous – Anterior vitrectomy section in the Schedule (PFAF 23-157, 23-158, 23-160 to 23-167)

Constituency Proposal

- The constituency requested new fee codes listed in the table below, based on revisions proposed in PFAF 157.
- Currently almost all retina surgeries performed go to a manual review. These proposals are cost-neutral that will reduce the administrative burden for MoH doing manual reviews and for surgeons submitting claims.

PFAF #	Type	Fee Code	Proposed Descriptor	Proposed Value	Notes
157	Revision	New E148	Vitrectomy, complete and by posterior approach, with vitreous exchange (air, gas, or artificial vitreous substance)	$810.00	Combined E148 + E936
158	New fee code	Exx1	Vitrectomy, complete and by posterior approach, with cataract extraction, by phacoemulsification including insertion of intraocular lens	$1,148.09	New E148 + E140
160	Deletion	E142	Anterior vitrectomy - Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation	$0.00	Combined E142 + E936
161	New fee code	Exx2	Vitrectomy, complete and by posterior approach, with preretinal membrane peeling or segmentation, and vitreous exchange (air, gas, or artificial vitreous substance)	$920.00	Combined E142 + E936
162	New fee code	Exx3	Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, without intraocular lens insertion patient left aphakic	$1,239.63	New E148 + E141
163	New fee code	Exx4	Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, with intraocular lens insertion	$1,318.26	New E148 + E141 + E950

PFAF #	Type	Fee Code	Proposed Descriptor	Proposed Value	Notes
164	New fee code	Exx5	Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, and with insertion and fixation of IOL by suturing, trans-scleral haptic fixation, or iris fixation	$1,622.13	New E148 + E141 + E138
165	New fee code	Exx6	Vitrectomy, complete and by posterior approach, removal of IOL, and with insertion and fixation of IOL by suturing, trans-scleral haptic fixation, or iris fixation	$1,575.00	New E148 + E144 + E138
166	New fee code	Exx7	Vitrectomy, complete and by posterior approach, with membrane peeling, photocoagulation, and cataract extraction, by phacoemulsification including insertion of intraocular lens	$1,258.09	New E142 + E140
167	New fee code	Exx8	Vitrectomy for repair of retinal detachment, including photocoagulation, and cataract, by phacoemulsification including insertion of intraocular lens	$1,388.34	New E148 + E151 + E140

Committee Comments

- The committee drafted schedule language which addressed the portions of these proposals with which we had adequate information to deliberate.
- This draft schedule language has been shared with the constituency for their feedback.
- The committee has received no edits or objections to the drafted schedule language changes from the constituency.
- The committee did not have adequate information to deliberate on portions of these proposals and these portions were therefore not supported by the committee.

39.40 Gxxx - Pattern electroretinogram (PFAF 23-014)

Constituency Proposal

- The constituency requested a new fee code Gxxx Pattern electroretinogram, paid at $75.00.
- Proposed payment rule: payment per procedure, with permanent detailed record of the procedure to be kept.
- Children with significant abnormalities in vision where diagnosis and potential treatment require more detailed information on macular and optic nerve function.
- Similar time and expertise required as G524 Electro-retinography, paid at $75.00.

Committee Comments

- Given the low volume of these tests being performed and that all providers are funded through AFPs, the committee does not support this proposal.

39.41 Gxxx - Colour vision screening with permanent record (PFAF 23-015)

Constituency Proposal

- The constituency requested a new fee code Gxxx Colour vision screening with permanent record, paid at $25.00.
- Proposed payment rule: 1 service per year, require performance of 2 tests HRR and D15, or Mollon-Reffin minimalists test with permanent record.
- Comparable procedure is G438 colour vision detailed assessment. This procedure is a screening procedure that takes less time than the detailed assessment but remains critical in assessment and surveillance of appropriate patients with progressive retinal and optic nerve conditions or colour deficiencies.

Committee Comments

- Given the low volume of these tests being performed and that all providers are funded through AFPs, the committee does not support this proposal.

39.42 Gxxx - Full field stimulus threshold testing (FST) (PFAF 23-016)

Constituency Proposal

- The constituency requested a new fee code Gxxx Full field stimulus threshold testing (FST), paid at $75.00.
- Proposed payment rule: Payment per procedure, with permanent detailed record of the procedure to be kept.
- Comparable procedure is G439 Full field electro-retinography, paid at $75.00.

Committee Comments

- Given the low volume of these tests being performed and that all providers are funded through AFPs, the committee does not support this proposal.

39.43 Gxxx - Visual Evoked Response pattern reversal (PFAF 23-017)

Constituency Proposal

- The constituency requested a new fee code Gxxx Visual Evoked Response pattern reversal, paid at $75.00.
- Proposed payment rule: Payment per procedure, 1 procedure per year with permanent detailed record of the procedure to be kept.
- G150 Visual evoked potential threshold is often inaccurately used to bill for this procedure. It requires its own billing code and descriptor to more accurately track this procedure.

Committee Comments

- Given the low volume of these tests being performed and that all providers are funded through AFPs, the committee does not support this proposal.

39.44 Gxxx - Pupillometry (PFAF 23-018)

Constituency Proposal

- The constituency requested a new fee code Gxxx Pupillometry, paid at $75.00.

- Proposed payment rule: Payment per procedure, maximum 1 per year with permanent detailed record of the procedure to be kept.
- Similar time and expertise required as G524 Electro-retinography, paid at $75.00.

Committee Comments

- Given the low volume of these tests being performed and that all providers are funded through AFPs, the committee does not support this proposal.

39.45 G820 - OCT unilateral or bilateral - glaucoma, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure (PFAF 23-217)

Constituency Proposal

- The constituency requested a revision for G820 OCT unilateral or bilateral - glaucoma, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure.
- Proposed revisions to payment rules:

> 2. G822 is only eligible for payment when the limit of any combination of G818, ~~G820~~ or G821 is reached.
>
> 6. G820 is limited to a maximum of ~~two~~ four services per patient per 12-month period.
>
> (Revisions underlined, deletions ~~strikethrough~~)

- Classifying and monitoring a patient with advanced glaucoma would require up to 4 assessments per year, including OCT as an assessment method of the optic nerve. Therefore, a maximum of 4 G820 services per year is a proposed payment rule.
- The OCT from one facility is not available to a physician in another facility, and so the "services per patient" and combination of G818/820/821 need to be removed (meaning payment rules 6 and 7.).

Committee Comments

- The proposal partially seeks to address an administrative problem related to facilities sharing data and reports. This falls outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.
- Insufficient evidence was provided to support a clinical need for increasing the number of OCTs performed annually.
- The committee does not support this proposal.

39.46 G822 - OCT unilateral or bilateral - active management with laser or intravitreal injections for neovascularization (PFAF 23-224)

Constituency Proposal

- The constituency requested G822 fee be increased from $25.00 to $35.00, by 40 per cent and deletion of payment rule #2 "G822 is only eligible for payment when the limit of any

combination of G818, G820 or G821is reached" or exclude G820 (glaucoma) from payment rules.

- Performing the test, interpreting the test and the costs and time involved for the patient, the technician and physician supervising does not change over time, therefore, the payment should remain the same, and not decrease from 35 to 25 dollars. The service time and skill does not decrease and therefore the payment should remain the same.

Committee Comments

- The committee's analysis determined that this proposal does not address an intrasectional relativity issue.
- The committee does not support this proposal.

39.47 G813 - Corneal pachymetry, professional component (PFAF 23-232)

Constituency Proposal

- The constituency requested G813 fee be increased from $5.10 to $15.00 (194.1 per cent), and its payment rule as follows:

> This service is limited to one per patient per year ~~lifetime~~. Services in excess of this limit or rendered for any purpose other than identifying patients at risk for glaucoma, are not insured services.
>
> (Revisions underlined, deletions ~~strikethrough~~)

- Changes in central corneal thickness occur over a patient's lifetime and the measurement should be repeated when a change is anticipated.

Committee Comments

- The committee supports changing the descriptor to, "the service is limited to one per patient per five years."
- The committee notes that the constituency has prioritized other items.
- The constituency has inadequate allocation for this proposal to proceed.

39.48 E132 - Glaucoma filtering procedures (PFAF 23-225)

Constituency Proposal

- The constituency requested a revision to E132 as follows:

> Glaucoma ~~filtering~~ surgical procedures to include both angle and subconjunctival based surgery
>
> (Revisions underlined, deletions ~~strikethrough~~)

- Modernization of fee Schedule. Glaucoma surgery has evolved beyond traditional procedures. This language will now allow all current and future procedures to be covered.

Committee Comments

- Preliminary review of the literature indicates that minimally invasive glaucoma procedures take less time than traditional glaucoma filtering procedures.
- The committee supports in principle the proposal of E132 being changed according to proposed descriptor, adding “except for minimally invasive approaches.”
- The committee proposes a new code be created for minimally invasive glaucoma procedures. The new code would be set at a value less than the value of E132.
- Draft schedule language has been shared with the constituency for their feedback.

39.49 E983 - Glaucoma filtering procedures - following previous glaucoma filtering procedure, to E132, add (PFAF 23-235)

Constituency Proposal

- The constituency requested a revision to E983 as follows:

  > Glaucoma filtering procedures - following previous glaucoma filtering procedure or previous retinal scleral buckling procedures, to E132, add 25%.
  >
  > (Revisions underlined, deletions ~~strikethrough~~)

- Retinal scleral buckling procedures should be included, as these can make dissection/surgery difficult, as for prior a previous glaucoma filtering procedure.

Committee Comments

- The committee reviewed surgical time for E132 when the patient has a E152 (Scleral resection or buckling procedure) previously and notes no change. Thus, the committee is of the opinion that the E983 25% premium should not apply to previous retinal scleral buckling procedures.
- The committee does not support this proposal.

39.50 E214 - Glaucoma filtering procedure and cataract extraction (same eye) (PFAF 23-229)

Constituency Proposal

- The constituency requested a revision to E214 as follows:

  > Glaucoma ~~filtering~~ surgical procedure to include both angle and subconjunctival based surgery and cataract extraction (same eye).
  >
  > (Revisions underlined, deletions ~~strikethrough~~)

- Modernization of fee Schedule. Please see explanation for E132.

Committee Comments

- The committee reviewed surgical time for E132 when the patient has a previous E152 and notes no change.
- The committee does not support this proposal.

39.51 E984 - Glaucoma filtering procedure and cataract extraction (same eye) - following previous glaucoma filtering procedure, to E214, add (PFAF 23-237)

Constituency Proposal

- The constituency requested a revision to E984 as follows:

> Glaucoma filtering procedure and cataract extraction (same eye) - following previous glaucoma filtering procedure or previous retinal scleral buckling procedures, to E214, add.
>
> (Revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- Based on the analysis performed for items 33.49 and 33.50 (PFAFs 229 and 235), and in the absence of additional time data provided by the section, the committee does not support this proposal.

39.52 Exxx - Retinal imaging including peripheral retinal imaging by ultra-widefield or widefield fundus cameras (PFAF 23-238)

Constituency Proposal

- The constituency requested a new fee code Exxx Retinal imaging including peripheral retinal imaging by ultra-widefield or widefield fundus cameras, paid at $46.50.
- Proposed payment rule: Photography of one or both eyes of a patient. Maximum one per patient per year.
- There is a fee code for a similar procedure, G425 ($44.40) that involves injection of dye into a vein with retinal photography. This fee is too low.

Committee Comments

- The committee does not support the proposed unbundling of retinal photography from consults and assessments.
- The committee does not support this proposal.

39.53 E202 - Corneal cross-linking (PFAF 23-257)

Constituency Proposal

- The constituency requested a fee value change to E202 Corneal cross-linking from $200.00 to $400 (100% increase).
- Prior to this code being created unilaterally from the Ministry, the Section had expressed that the fee was too low to justify the procedure being performed.

Committee Comments

- The committee notes that this is a new code introduced during the last allocation. Given the recent introduction of this fee code, the PPC is not considering modifications during the current fee setting process.

39.54 E123 - Division of iris to cornea (PFAF 23-227)

Constituency Proposal

- The constituency requested a revision to E123 as follows:

  Division of iris to cornea and/or angle

  (Revisions underlined, deletions ~~strikethrough~~)

- Modernization of fee Schedule. New language allows for existing procedure (goniosynechialysis) to be included in the Schedule of Benefits.

Committee Comments

- The committee supports the proposed descriptor change and adds that this code could not be billed with any other code that involved treatment of glaucoma or insertion of prosthesis to the iris.

39.55 Extraction cataract all types of, by any procedure, bilateral and simultaneous, includes insertion of intraocular lens (PFAF 21-D74)

Constituency Proposal

- The constituency requested 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.

Committee comments

- 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).
- Sufficient rationale was not provided explaining why the payment discount rule should not apply to cataract surgery in terms of time, intensity and intra-sectional fee relativity principles.
- The committee does not support this proposal.

39.56 Exxx - cyclo-photocoagulation/ablation/destruction (laser to the ciliary body) - either trans-scleral or endoscopic (PFAF 21-D75)

Constituency Proposal

- The constituency requested a new fee for cyclo-photocoagulation/ablation/destruction (laser to the ciliary body) - either trans-scleral or endoscopic at $400.

Committee comments

- The committee proposes that E134 be expanded to include this procedure.
- The committee notes the constituency's support for expanding E134 to include this procedure.

39.57 U235 - Initial e-assessment (PFAF 21-D76)

39.58 U236 - Follow-up e-assessment (PFAF 21-D77)

Constituency Proposal

- The constituency requested a payment rule revision for U235 Initial e-assessment ($45.85) and U236 Follow-up e-assessment ($28.95) to allow referrals from optometrists.

Committee Comments

- The committee notes that the clinical scenarios provided by the section focused on triage of consultations which is not the purpose of e-assessments.
- The committee does not support this proposal.

40 Orthopedic Surgery

40.1 Flatfoot Correction (PFAF 21-D78)

40.2 Cavovarus Foot Reconstruction (PFAF 21-D79)

40.3 Multi ligament knee reconstruction– Acute (PFAF 21-D80)

Constituency Proposal

- The constituency proposed the creation of the following fees:

Fee Code	Descriptor	Proposed value
Rxx1	Flatfoot Correction	$1,000.00
Rxx2	Cavovarus Foot Reconstruction	$1,000.00
Rxx11	Multi ligament knee reconstruction– Acute	$1,500.00

Committee comments

- Committee acknowledges the constituency's request to withdraw proposals related to flatfoot correction and Cavovarus foot reconstruction.
- With respect to PFAF D80, for multi ligament knee reconstruction, the committee continues to deliberate and will reach out to the constituency as required.

40.4 Exxx - Obesity add-on code - total knee replacement (PFAF 23-001)

Constituency Proposal

- The constituency proposed a new obesity add-on fee for total knee replacement, valued at $120.00.
- The proposed E-code is similar to one that is added on for total hip replacements (E676).

Committee Comments

- The committee finds insufficient evidence to support the creation of the proposed code in terms of the physician's time and work effort.
- The committee does not support this proposal.
- The committee notes the constituency's choice to withdraw this proposal, as this proposal is replaced by PFAF 25-140.

40.5 Rxxx - Distal biceps tendon repair

40.6 Exxx - Distal biceps tendon reconstruction modifier (PFAF 25-007)

Constituency Proposal

- The constituency proposed a new distal biceps tendon repair fee code, valued at $700.00.
- The constituency also proposed a modifier code, valued at 50% ($350.00) of the new fee code. The proposed modifier would be payable where:
  1. The tendon is irreparable and requires reconstruction with a graft, and;
  2. The tendon rupture must be at least 6 weeks old to qualify (chronic setting).

Committee Comments

- The committee supports in principle, the creation of new fee codes for distal biceps tendon repair. One code would be for 'without use of graft', and the other would be for 'with use of graft.' The committee continues to deliberate the descriptors.
- The committee will deliberate the value of the new codes once their descriptors are determined.

40.7 Rxxx - Laterjet procedure (PFAF 25-008)

Constituency Proposal

- The constituency proposed a new laterjet procedure fee code, valued at $1,100.00. This procedure includes glenohumeral joint reduction, bone grafting, tendon transfers and repairs, and shoulder arthroscopy.
- The constituency proposed if the laterjet procedure is a revision surgery the E058 add-on code should also apply, valued at 30% ($330.00) of the new fee code.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as needed.

40.8 Rxxx - Distal triceps tendon repair

40.9 Exxx - Distal triceps tendon reconstruction modifier (PFAF 25-010)

Constituency Proposal

- The constituency proposed a new distal triceps tendon repair fee code, valued at $500.00.
- The constituency proposed the new fee code should also include a modifier code, valued at $350.00.
- The proposed modifier would be payable where:

1. The reconstruction requires an autograft, or allograft tendon, or a modification such as a tendon transfer, or modification to obtain a reconstruction of the triceps on the olecranon.
2. The tendon rupture must be at least 6 weeks old to qualify (chronic setting).

Committee Comments

- The committee supports in principle, the creation of new fee codes for distal triceps tendon repair. The committee continues to deliberate the descriptors.
- The committee will deliberate the value of the new codes once their descriptors are determined.

40.10 R505 - Arthrotomy – Metatarsal/phalangeal (PFAF 25-011)

Constituency Proposal

- The constituency proposed to delete the R505 fee code because arthrotomy of metatarsal and phalanges are not billed as an individual procedures.
- Constituency stated physicians will alternatively bill R425 or R414 once the fee code is deleted.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.11 R304 - Forefoot – Hallux Valgus – Mayo, Keller (PFAF 25-012)

Constituency Proposal

- The constituency proposed to delete the R304 fee code because Mayo and Keller procedures are not frequently performed anymore.
- Constituency stated physicians will alternatively bill R309 once the fee code is deleted.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.12 R446 - Forefoot – Overlapping 5th toe (PFAF 25-013)

Constituency Proposal

- The constituency proposed to delete the R446 fee code because the procedure is rarely performed anymore.
- Constituency stated physicians will alternatively bill R430 once the fee code is deleted.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.13 Fxxx - Open reduction intra-articular distal femur fracture (PFAF 25-015)

Constituency Proposal

- The constituency proposed a new open reduction intra-articular distal femur fracture fee code, valued at $1,161.48.00.

- The constituency proposed the new fee code should be co-billable with E048 if intra-medullary nail is used for fixation during the procedure.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.14 Fxxx - Open Reduction Sacral Fracture (PFAF 25-027)

Constituency Proposal

- The constituency proposed a new open reduction of a sacral fracture fee code, valued at $999.00.
- The constituency proposed the new fee code should be co-billable with F134 or F135 when reduction of the anterior pelvic ring is performed in addition to the reduction during the procedure.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.15 Fxxx - Closed Reduction Sacral Fracture (PFAF 25-028)

Constituency Proposal

- The constituency proposed a new closed reduction of a sacral fracture fee code, valued at $825.00.
- The constituency proposed the new fee code should be co-billable with E569 and/or E555.
- The constituency proposed the new fee code should be co-billable with F134 or F135 when reduction of the anterior pelvic ring is performed in addition to the reduction during the procedure.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.16 F030 - Radius distal - Colles', Smith's, or Barton's fracture open reduction (PFAF 25-029)

Constituency Proposal

- The constituency proposed a revision to the F030 fee code to allow an E-modifier code for intra-articular distal radius fracture procedures
- The constituency proposed the E-modifier should be valued at 50% of F030 ($261.10).
- The constituency proposed the new E-modifier should only be applied when:
    - The operative report indicates that both volar and dorsal surgical approaches were employed for fracture reduction of the distal radius.
    - Dual plating was required during the procedure.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.17 R597 - Musculoskeletal ligaments reconstruction of ankle – one (PFAF 25-036)

Constituency Proposal

- The constituency proposed the R597 fee code should be split to create a code specifically for foot and ankle procedures.
- Constituency stated R597 is currently being billed for both ankle and wrist surgeries.
- The constituency proposed the new revised R597 for ankle surgeries should be valued at $517.85 to account for the additional complexity in the procedure.

Committee Comments

- The committee supports in principle, the creation of foot and ankle ligament reconstruction fee codes, separate from wrist and elbow surgery. The committee is deliberating descriptions and will engage the section.

40.18 R548 - Extensive/multiple ligament reconstruction of the ankle joint (PFAF 25-037)

Constituency Proposal

- The constituency proposed the R548 fee code should be revised so that the procedure is specifically only for ankles.
- Currently the R548 fee code can be billed for ligament reconstruction in three different anatomic areas:
  i) Wrist
  ii) Elbow
  iii) Ankle
- The constituency proposed the new revised R548 for ankle surgeries should be valued at $750.00 to account for the additional complexity in the procedure.

Committee Comments

- The committee supports in principle, the creation of foot and ankle ligament reconstruction fee codes, separate from wrist and elbow surgery. The committee is deliberating descriptions and will engage the section.

40.19 F099 - Pelvic and hip reduction femoral neck trochanteric subtrochanteric – open reduction pin only (PFAF 25-052)

Constituency Proposal

- The constituency proposed the deletion of the F099 fee code because code is historic and if procedure is performed with pin only this would be considered below the standard of care.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.20 F100 - Pelvic and hip reduction femoral neck trochanteric subtrochanteric – open reduction pin and plate/screws (PFAF 25-053)

Constituency Proposal

- The constituency proposed to revise the F100 descriptor to specify what type of fracture qualifies. This is because the descriptor is historic, physicians now manage this fracture with a Gamma IM nail rather then plates and screws.
- The constituency proposed changes to F100 descriptor:

  Pelvis and Hip – Femoral neck, trochanteric, ~~subtrochanteric~~ intertrochanteric, pertrochanteric – open reduction – fixation by any method ~~– open reduction – pin and plate/screws (cannulated included).~~

  (revisions underline, deletions ~~strikethrough~~)

- The constituency proposed to revise the F100 descriptor to indicate it is co-billable with the E048 modifier if the fracture is stabilized with an IM nail (Gamma nail or equivalent). This proposed revision will require a revision to the E048 modifier code:

  Femur – Fractures – ~~Femoral shaft/supracondylar~~ – intramedullary nail with distal proximal locking screws.

  (deletions ~~strikethrough~~)

- The constituency proposed a revision to the F096:

  Femur - Fractures – ~~closed reduction - open reduction~~. Femoral Shaft/ supracondylar/ subtrochanteric.

  (deletions ~~strikethrough~~, revisions underlined)

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.21 R250 - Incision and Drainage - Saucerization and bone graft (PFAF 25-074)

Constituency Proposal

- The constituency proposed the deletion of the F250 fee code because code is historic and bone grafting in the presence of a bone infection is no longer recommended.
- Constituency stated physicians will alternatively bill R241 or R315 once the fee code is deleted.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.22 R364 - Pseudoarthrosis - pelvis (PFAF 25-075)

Constituency Proposal

- The constituency proposed the deletion of the R364 fee code because the code is historic and is extremely rare to bill.
- Constituency stated physicians will alternatively appeal to the MOH and apply for the hourly rate to be applied once the fee code is deleted.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

40.23 Rxxx - Thumb carpometacarpal (CMC) joint arthritis ligament reconstruction tendon interposition (LRTI) (PFAF 25-135)

Constituency Proposal

- The constituency proposed a new thumb carpometacarpal joint arthritis ligament reconstruction tendon interposition fee code, valued at $775.00.
- The constituency proposed the new fee code should only be billed when the surgery includes all the following:
    - Excision of the trapezium
    - Use of either tendon or non-biologic implants for suspensionplasty
    - Use of tendon auto or allograft for reconstruction of CMC ligament and interposition
- The constituency proposed the new fee code should be under the Arthoplasty heading in the hand and wrist section of Schedule of Benefits, and the E564 add-on code should be applicable.
- The constituency proposed the R597, R548, and R285 fee codes should not be co-billable with the new proposed fee code.
- The constituency proposed the deletion of R209 if this new fee code is accepted and introduced. Constituency states physician will alternatively bill the new fee code or R285 once R209 is deleted (see PFAF 25-136).

Committee Comments

- The committee does not support this proposal but will use the language from it to improve the description of R209.

40.24 R209 - Hand and Wrist, Arthroplasty - Hand - interposition - Basal thumb - first carpometacarpal joint (PFAF 25-136)

Constituency Proposal

- The constituency proposed the deletion of the R209 fee code, only if the constituency's LRTI new fee code proposal is accepted.
- Constituency stated physicians will alternatively bill R285 or the new LRTI code once the R209 fee code is deleted.

Committee Comments

- The committee does not support deletion of this code but proposes that the language from PFAF 25-135 be used to improve the description of R209.
- The committee will deliberate an increased value for R209 when the new description is complete.

40.25 E676 - Morbidly obese patient premium – qualify with knee arthroplasty fee codes (PFAF 25-140)

Constituency Proposal

- The constituency proposed a revision to the E676 morbidly obsess patient premium add-on code to include knee arthroplasty fee codes to qualify for the 25% premium.
- The constituency proposed the following fee codes to qualify for the E676 add-on code:

    - R244: Knee – Hemiarthroplasty – Revision total arthroplasty knee
    - R248: Knee – Hemiarthroplasty – Total knee replacement with take down of fusion
    - R441: Knee – Hemiarthroplasty – Total replacement/both compartments
    - R442: Knee – Hemiarthroplasty – Replacement Liner
    - R483: Knee – Hemiarthroplasty – double component (e.g. Marmar)
    - R496: Knee – Hemiarthroplasty – Removal of hemiarthroplasty – without replacement
    - R497: Knee – Hemiarthroplasty – Removal of total arthroplasty – without replacement

Committee Comments

- Committee data analysis fails to demonstrate an increase in time associated with an increased BMI for the procedures listed in this proposal.
- The committee does not support this proposal.

40.26 Preamble - Qualify pelvic, acetabular, and hip dislocation codes for second assistant (PFAF 25-143)

Constituency Proposal

- The constituency proposed to revise the list of fee codes eligible for a second assistant in the Schedule of Benefits to include pelvic, acetabular and hip dislocation fee codes.
- The constituency proposed the following fee codes be included in the list of eligible codes for a second assistant:

    - F135: Pelvis and Hip – Reduction – Fractures – Pelvic ring – open reduction
    - D043: Pelvis and Hip – Reduction – Dislocations – Hip – open reduction
    - D046: Pelvis and Hip – Reduction – Dislocations – Acetabulum – open reduction – one pillar
    - D047: Pelvis and Hip – Reduction – Dislocations – Acetabulum – open reduction – two pillar
    - D052: Pelvis and Hip – Reduction – Dislocations – Acetabulum – open reduction – lips
    - D060: Pelvis and Hip – Reduction – Dislocations – Sacro-iliac – open reduction

Committee Comments

- The committee notes that this proposal was made in conjunction with the Surgical Assistant MIG. Please see PFAF 25-292 for more details.

40.27 E676 - Morbidly obese patient premium – qualify with pelvic surgery fee codes (PFAF 25-145)

Constituency Proposal

- The constituency proposed a revision to the E676 morbidly obsess patient premium add-on code to include pelvic surgery fee codes to qualify for the 25% premium.
- The constituency proposed the following fee codes to qualify for the E676 add-on code:
    - R315: Pelvis and Hip – Excision – Bone – Head and neck, femur
    - R328: Pelvis and Hip – Reconstruction – Pseudoarthrosis – Hip
    - R415: Pelvis and Hip – Arthrotomy – Hip – with removal of loose body
    - R415: Pelvis and Hip – Aspiration/injection – Biopsy – Joint – open
    - R415: Pelvis and Hip – Incision and Drainage – Joint
    - R429: Knee – Examination/Manipulation – Excision – Meniscectomy
    - R570: Pelvis and Hip – Reconstruction – Tendon transfer – Iliopsoas
    - Z214: Pelvis and Hip – Biopsy – Bone – open
    - Z214: Hand and Wrist – Biopsy – Bone – open biopsy or taking of bone graft by other than operating surgeon
    - Z214: Elbow and Forearm - Biopsy – Bone – open
    - Z214: Shoulder, Arm and Chest - Biopsy – Bone – open

Committee Comments

- Committee data analysis fails to demonstrate an increase in time associated with an increased BMI for the procedures listed in this proposal.
- The committee does not support this proposal.

40.28 R226 - Biopsy of suspected sarcoma, or resection of a complex bone or complex soft tissue tumours (PFAF 25-173)

Constituency Proposal

- The constituency proposed value increase to the R226, from the current $100.00 value to their proposed $200.00 value (100% increase).
- The constituency stated the procedure has evolved since R226 was first introduced and the procedure involves much more technically challenging work to preserve current clinical structures.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.
- The committee notes that Schedule language clarifications for R226 have been shared with the constituency who have not brought forward any edits or concerns to date.

40.29 Multiple fee codes - Various value changes to surgical procedural codes (PFAF 25-181)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following surgical procedural codes:

Fee Code	Descriptor	Fee Value 2023	New Fee Value 2025	% Increase
Hand & Wrist / Upper Extremity (PFAF 25-181)				

R322	Hand and Wrist - Reconstruction - Bone - Pseudoarthrosis/non - Union/avascular necrosis - Scaphoid	$588.20	$865.00	47.1%
R410	Hand and Wrist - Arthrotomy - Wrist/open wrist/joint- Open wrist/Incision and drainage/wrist joint	$212.50	$248.93	17.1%
R466	Hand and Wrist/Elbow and Forearm/Foot and Ankle - Arthrodesis - Wrist/Elbow/Ankle	$714.70	$860.00	20.3%
R485	Hand and Wrist - Arthroplasty - Wrist - Total	$679.95	$1,200.00	76.5%
R316	Hand and Wrist - Excision - Bone - Proximal row carpectomy	$338.75	$450.00	32.8%
F019	Hand and Wrist - Reduction - Fractures - Scaphoid - Open reduction	$488.00	$700.00	43.4%
N190	Neurological Surgical Procedures - Peripheral nerves - Nerve Graft - Exploration and/or decompression and/or neurolysis of ulnar	$215.35	$285.00	32.3%
R288	Elbow and Forearm - Arthroplasty - Implant radial head	$269.90	$450.00	66.7%
R290	Elbow and Forearm - Excision - Bone - Olecranon	$207.90	$208.00	0.0%
R291	Elbow and Forearm - Excision - Bone - Olecranon with fascial repair	$309.00	$375.00	21.4%
R294	Elbow and Forearm - Excision - Bone tumours-Simple excision/Shoulder, Arm & Chest - Excision - Humerus - Benign tumour/exostosis	$165.20	$165.00	-0.1%
R421	Elbow and Forearm - Excision - Joint contents - Synovectomy/capsulectomy/debridement, etc.	$407.25	$488.00	19.8%
R422	Shoulder, Arm and Chest - Excision -joint - Synovectomy and debridement	$425.10	$488.00	14.8%
R438	Shoulder, Arm and Chest - Arthroplasty - Humeral prosthesis	$449.20	$733.00	63.2%
R486	Elbow and Forearm - Arthroplasty - Complete arthroplasty replacement	$927.70	$1,200.00	29.4%
R524	Elbow and Forearm/Pelvis and Hip/Femur - Muscles - Myositis ossificans/Myositis/Excision of myositis	$289.50	$377.00	30.2%
R527	Shoulder, Arm and Chest - Reconstruction - Muscles/soft tissues - Muscle transplant - Pectoralis major	$434.25	$624.00	43.7%
R548	Hand and Wrist/Elbow and Forearm/Foot and Ankle-Reconstruction - Ligaments - Extensive/multiple repair - Wrist/extensive/multiple	$511.45	$750.00	46.6%
R597	Hand and Wrist/Elbow and Forearm/Foot and Ankle - Reconstruction - Ligaments - Simple/single repair - Wrist/Simple/single repair/ankle- One	$301.60	$400.00	32.6%
Z223	Shoulder, Arm and Chest - Examination/Manipulation - Manipulation under general anaesthetic	$49.20	$200.00	306.5%

R487	Arthoplasty - Total prosthesis	$784.05	$925.18	18.0%
Trauma / General / Lower extremity				
D023	Shoulder, Arm and Chest - Reduction - Dislocations - Acromio- Clav./sterno- Clav. - Open reduction	$231.10	$325.00	40.6%
D028	Foot and Ankle - Reduction - Dislocations - Tarso-Metatarsal - Open reduction, one joint	$388.20	$543.19	39.9%
D046	Pelvis and Hip - Reduction - Dislocations - Acetabulum - Open reduction - One pillar	$967.90	$1,500.00	55.0%
D047	Pelvis and Hip - Reduction - Dislocations - Acetabulum - Open reduction - Two pillars	$1,451.45	$2,249.75	55.0%
D052	Pelvis and Hip - Reduction - Dislocations - Acetabulum - Open reduction - Lips	$612.45	$950.00	55.1%
D059	Pelvis and Hip - Reduction - Dislocations - Sacro-Iliac - Closed, traction, spica, etc.	$428.50	$825.00	92.5%
D060	Pelvis and Hip - Reduction - Dislocations - Sacro-Iliac - Open reduction	$593.00	$999.00	68.5%
F023	Elbow and Forearm - Reduction - Fractures - Radius and ulna - Monteggia - Open reduction of ulna plus closed reduction radial head	$416.65	$737.18	76.9%
F026	Elbow and Forearm - Reduction - Fractures - Radius and ulnar shaft - Open reduction	$567.15	$900.00	58.7%
F030	Elbow and Forearm - Reduction - Fractures - Radius - Distal, e.g. Colles', Smith's, or Barton's fracture - Open reduction	$522.20	$725.00	38.8%
F033	Elbow and Forearm - Reduction - Fractures -Radius or ulna - Open reduction	$438.05	$675.00	54.1%
F036	Elbow and Forearm - Reduction - Fractures - Olecranon - Open reduction	$494.10	$701.87	42.1%
F041	Elbow and Forearm - Reduction - Fractures - Transcondylar/condylar - open reduction	$983.45	$1,100.00	11.9%
F044	Shoulder, Arm and Chest - Reduction - Fractures - Shaft - Open reduction	$655.50	$900.00	37.3%
F052	Shoulder, Arm and Chest - Reduction - Fractures - Neck with dislocation of head - open reduction	$559.85	$1,000.00	78.6%
F055	Shoulder, Arm and Chest - Reduction - Fractures - Neck without dislocation of head - - Open reduction	$514.95	$850.00	65.1%
F064	Foot and Ankle - Reduction - Fractures - Metatarsus - Open reduction - One	$178.20	$420.00	135.7%
F065	Foot and Ankle - Reduction - Fractures - Metatarsus - Open reduction - Two or more	$249.65	$550.00	120.3%
F068	Foot and Ankle - Reduction - Fractures - Tarsus excluding Os calcis - Open reduction	$454.35	$810.00	78.3%
F072	Foot and Ankle - Reduction - Fractures - Os calcis - Open reduction - With repair of both the subtalar and calcaneocuboid joints	$588.20	$810.00	37.7%

F076	Foot and Ankle - Reduction - Fractures - Ankle - Open reduction - One malleolus	$309.70	$630.00	103.4%
F077	Foot and Ankle - Reduction - Fractures - Ankle - Open reduction - Multiple malleoli or ligaments	$571.30	$810.00	41.8%
F080	Fibula and Tibia - Reduction - Fractures - Tibia with or without fibula - Open reduction - Shaft	$604.15	$803.75	33.0%
F081	Fibula and Tibia - Reduction - Fractures - Intramedullary nail with distal and proximal locking screws - Medial or lateral tibial plateau	$660.00	$810.00	22.7%
F084	Fibula and Tibia - Reduction - Fractures - Fibula - Open reduction	$230.20	$650.00	182.4%
F087	Knee - Reduction - Fractures - Patella - Open reduction or excision with or without repair	$288.25	$502.17	74.2%
F096	Femur - Reconstruction - Fractures - Closed reduction - Open reduction	$670.00	$774.32	15.6%
F100	Pelvis and Hip - Reduction - Fractures - Femoral neck trochanteric, subtrochanteric - Open reduction - Pin and plate/screws (cannulated included)	$659.45	$810.00	22.8%
F108	Ankle fracture with tibial Plafond burst	$644.30	$999.00	55.1%
F118	Shoulder, Arm and Chest - Reduction - Fractures - Clavicle - Open reduction	$458.75	$767.90	67.4%
F121	Shoulder, Arm and Chest - Reduction - Fractures - Scapula - Open reduction	$799.25	$905.00	13.2%
F135	Pelvis and Hip - Reduction - Fractures - Pelvic ring- Open reduction	$680.30	$999.00	46.8%
R222	Shoulder, Arm and Chest - Biopsy - Incision and drainage - Humerus/clavicle/scapula	$262.60	$462.62	76.2%
R225	Shoulder, Arm and Chest - Biopsy - Incision and drainage - Sequestrectomy	$290.55	$500.00	72.1%
R231	Elbow and Forearm - Incision and drainage - Sequestrectomy	$355.35	$438.21	23.3%
R237	Fibula and Tibia - Incision and drainage - Bone	$308.10	$579.00	87.9%
R238	Fibula and Tibia - Incision and drainage - Saucerization and bone grafting	$411.20	$579.00	40.8%
R242	Femur - Incision and drainage - bone	$325.75	$579.00	77.7%
R243	Femur - Incision and drainage - Saucerization and graft	$619.90	$650.00	4.9%
R245	Femur - Incision and drainage - Sequestrectomy	$395.25	$650.00	64.5%
R255	Knee - Reduction - Dislocations - Patella - Open reduction - Late	$484.35	$657.12	35.7%
R262	Femur - Reconstruction - Deformity - Osteotomy femoral shaft	$727.15	$991.78	36.4%
R267	General Fees - Fixation - Removal of Internal fixation device - General anaesthetic	$158.65	$200.00	26.1%
R314	Femur - Excision - Bone - Simple cyst/extosis	$225.50	$328.84	45.8%

R323	Elbow and Forearm - Reconstruction- Bone-Pseudoarthrosis -Radius or ulna	$582.30	$950.00	63.1%
R325	Shoulder, Arm and Chest - Reconstruction-Pseudoarthrosis - Humerus	$632.05	$975.00	54.3%
R326	Fibula and Tibia - Reconstruction - Pseudoarthrosis, Tibia/fibula	$696.00	$1,050.00	50.9%
R328	Pelvis and Hip - Reconstruction - Pseudoarthrosis - Hip/Femur - Reconstruction - Pseudoarthrosis - Bone graft with or without external fixation	$872.65	$1,196.10	37.1%
R329	Shoulder, Arm and Chest - Reconstruction-Pseudoarthrosis - Clavicle	$514.80	$875.00	70.0%
R439	Pelvis and Hip - Arthroplasty - Unipolar	$490.95	$663.50	35.1%
R441	Hemiarthroplasty - Total replacement/both compartments	$631.20	$706.94	12.0%
R442	Knee - Arthroplasty - Hemiarthroplasty - Replacement Liner	$353.25	$449.15	27.1%
R444	Knee - Incision & drainage - Joint	$193.00	$255.16	32.2%
R491	Pelvis and Hip - Arthroplasty - Removal only - Replacement acetabular liner and/or femoral head	$353.25	$573.67	62.4%
R495	Elbow and Forearm-Decompression/Denervation-Fasciotomy for compartment syndrome (not including secondary closure wound/Fibula and Tibia - Decompression/Denervation - Decompression of fascial compartments	$320.20	$396.07	23.7%
R542	Knee - Reconstruction - Ligaments - Extensive ligament reconstruction (including synthetics) includes when rendered preparation of intracondylar notch	$517.85	$567.47	9.6%
R571	Femur - Reconstruction - Muscles/Tendons - Lengthening of hamstrings- Tendon or muscle transfer/Knee - Reconstruction - Muscles/Tendons - Transplant of tendon/single	$307.15	$458.90	49.4%
R595	Elbow and Forearm - Bursae - Olecranon	$101.25	$300.00	196.3%
R596	Shoulder, Arm and Chest - Reduction - Dislocations - Acromio-clavicular/Sterno-clavicular - Late	$286.70	$348.96	21.7%
R624	Fibula and Tibia - Amputation - Tibia/fibula	$328.65	$550.00	67.4%
R625	femur/Knee - Amputation - Gritti- Stokes or Callander/Through Knee - Disarticulation	$349.85	$600.00	71.5%
R626	Femur - Amputation - Through femur	$306.30	$600.00	95.9%
R627	Pelvis and Hip - Reduction - Fractures - Slipped epiphysis - Open reduction/fixation	$580.90	$810.00	39.4%
R630	Pelvis and Hip, Amputation - Hip disarticulation	$514.80	$750.00	45.7%
R642	Pelvis and Hip - Reduction - Fractures - Slipped epiphysis - Closed reduction/Internal fixation	$387.00	$500.00	29.2%
Foot and Ankle (PFAF 25-181)				

F060	Foot and Ankle - Reduction - Fractures - Phalanx - Open reduction	$172.30	$275.00	59.6%
R201	Foot and Ankle - Incision and drainage - Sequestrectomy	$193.00	$350.00	81.3%
R202	Foot and Ankle - Incision and drainage - Saucerization and bone graft	$387.00	$700.00	80.9%
R220	Foot and Ankle - Incision and drainage - Bone	$227.40	$338.98	49.1%
R277	Foot and Ankle - Reconstruction - Deformity - Osteotomy- Midtarsal/tarsal	$242.25	$399.71	65.0%
R282	Foot and Ankle - Excision - Bone - Exostosis (dorsal, subungual)	$100.15	$120.00	19.8%
R306	Foot and Ankle - Excision - Bone - Tarsal bar	$230.20	$436.05	89.4%
R309	Foot and Ankle - Excision - Bone - Metatarsal head	$175.45	$221.95	26.5%
E587	Foot and Ankle - Excision - Bone - Metatarsal head - Each additional add	$41.70	$80.00	91.8%
R311	Fibula and Tibia - Excision - Exostosis/cyst	$201.40	$323.45	60.6%
R321	Hand and Wrist- Reconstruction- Bone - Pseudoarthrosis/non - Union/avascular necrosis - Phalanx, metacarpal/Foot and Ankle - Reconstruction- Pseudoarthrosis- Tarsals/metatarsals/phalanx	$260.75	$430.00	64.9%
R338	Foot and Ankle - Reconstruction - Deformity - Shortening metatarsal - Two or more	$272.80	$700.00	156.6%
R420	Foot and Ankle - Excision - Joint - Ankle synovectomy	$273.75	$350.00	27.9%
R425	Hand an Wrist- Excision - Joint - Synovectomy/capsulectomy/debridement- Finger joint/Foot and Ankle - Excision - Metatarsophalangeal synovectomy - One	$226.40	$266.80	17.8%
R453	Foot and Ankle - Arthroplasty - Metatarsophalangeal interposition - Metatarsophalangeal (Swansons, etc.)	$289.50	$375.00	29.5%
R475	Arthrodesis - Pan-talar, one stage	$836.45	$1,338.32	60.0%
R493	Arthroplasty -Ankle - total replacement	$1,199.00	$1,258.95	5.0%
R471	Foot and Ankle - Arthrodesis - Interphalangeal	$151.85	$215.15	41.7%
E575	Foot and Ankle - Arthrodesis - Interphalangeal - Each additional	$41.70	$80.00	91.8%
R505	Foot and Ankle - Arthrotomy - Ankle - Metatarsal/phalangeal	$144.80	$238.35	64.6%
R544	Foot and Ankle - Tendons - Achilles or tibialis anterior/posterior tenotomy - Open	$171.70	$250.87	46.1%
R546	Foot and Ankle - Reconstruction - Club Foot - Plantar fascia release (Steindler)	$165.20	$286.96	73.7%
R572	Foot and Ankle - Reconstruction - Tendons - Tendon transfer Foot and Ankle - Tenodesis	$258.90	$339.72	31.2%

R576	Foot and Ankle - Excision - Soft tissue - Excision of fascia for Dupuytren's (plantar fibromatosis), one or more rays	$322.15	$450.00	39.7%
R581	Foot and Ankle - Reconstruction - Tendons - Tenotomy - Open - More than one toe	$193.00	$225.00	16.6%
R620	Foot and Ankle - Amputation - Metatarsal/phalanx disarticulation	$155.90	$225.00	44.3%
R621	Foot and Ankle - Amputation - Ray (single)	$217.15	$284.63	31.1%
R622	Foot and Ankle - Amputation - Transmetatarsal/transtarsal	$235.75	$325.00	37.9%
R640	Foot and Ankle - Reconstruction - Tendons - Exploration - Tendon sheath	$126.25	$200.00	58.4%
R695	Foot and Ankle - Arthrodesis - Subtalar	$627.35	$758.60	20.9%
R697	Foot and Ankle - Arthrodesis - Metatarsal- Tarsal (fusion of one or more joints)	$300.00	$525.00	75.0%
R355	Foot and Ankle - Reconstruction - Forefoot - Hallux valgus - E.g. Joplin, Mcbride	$413.65	$500.00	20.9%
R363	Foot and Ankle - Reconstruction - Pseudoarthrosis - Malleoli	$296.05	$402.63	36.0%
E512	Foot and Ankle - Arthrodesis- Additional midtarsal(s), to R696 add	$100.00	$200.00	100.0%
E511	Foot and Ankle - Arthrodesis - Additional midtarsal(s), to R695 add	$100.00	$200.00	100.0%
R430	Foot and Ankle - Reconstruction - Forefoot - Claw and hammer toe	$220.30	$297.41	35.0%
E594	Foot and Ankle - Reconstruction - Forefoot - Claw and hammer toe - Each additional hammer toe add	$41.70	$83.40	100.0%

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

41 Otolaryngology

41.1 Axxx - Audiologist-requested assessment (PFAF 21-D81)

41.2 Axxx - Special Audiologist-requested assessment (PFAF 21-D82)

41.3 Axxx - Dentist-requested assessment (PFAF 21-D83)

41.4 Axxx - Special dentist-requested assessment (PFAF 21-D84)

Constituency Proposal

- The constituency proposed new fees for Audiologist and Dentist-requested assessments as follows:

Fee code	Descriptor	Proposed value	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.

Committee Comments

- The effect of this change would be to expand the list of non-physicians able to request a consultation and expanding this list falls outside of the PPC's mandate.
- OMA staff will help the constituency to identify where to better direct this proposal.
- The committee notes the constituency's choice to withdraw these proposals.

41.5 M090 - Laryngoplasty (PFAF 23-136)

41.6 M080 - Teflon augmentation larynx (PFAF 23-137)

Constituency Proposal

- The constituency proposed a new assistant fee for M090 and M080, valued at 6 basic units.
- This fee follows a similar approach to procedures S789 and S790 – Thyroidectomy – subtotal and – hemi, both of which pay 6 basic units to assistants.
- The surgeon requires an assistant to hold the flexible laryngoscope in the larynx, while the surgeon injects the vocal cord.
- In the past, these procedures were typically done in academic centres with residents or fellows as assistants. However, there are now community-based laryngologists doing this procedure. It is hard to find assistants for this procedure given the lack of an assistant code.

Committee Comments

- The committee supports adding 6 assist units to M090 and M080. The committee notes that 6 assist units is the number of units for similar procedures.

41.7 S063 - Tonsillectomy and may include adenoidectomy (PFAF 23-138)

Constituency Proposal

- The constituency proposed a fee increase to S063, from $178.35 to $220.00 (23 per cent).
- Adult tonsillectomy is more challenging surgically and has a higher risk of postoperative bleeding. This fee code is currently undervalued.

Committee Comments

- The committee supports the fee value change, subject to fitting and relativity.

41.8 Mxxx - Advanced frontal sinus surgery – DRAF 2B Unilateral (PFAF 25-099)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for DRAF 2B endoscopic sinus surgery unilateral procedure, valued at $746.74.
- The constituency proposed the new fee code should only be billed when Anatomic extent of resection is dictated in the operative note.
- The constituency proposed the new fee code can not be billed in addition to the fee codes M083, E844, and Z318.

Committee Comments

- The committee supports moving DRAF procedures into the Schedule of Benefits in a cost-neutral manner.

41.9 Mxxx - Advanced frontal sinus surgery – DRAF 2B Bilateral (PFAF 25-101)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for DRAF 2B endoscopic sinus surgery bilateral procedure, valued at $293.80.
- The constituency proposed that this new fee code be billed in addition to their new fee code proposal in PFAF 25-099 (DRAF 2B endoscopic sinus surgery unilateral procedure). Constituency states this additional new bilateral procedure fee code will only be billed when the second (contralateral) side is dissected on the same day as the first unilateral procedure.
- The constituency proposed the same payment rules as the unilateral procedure in PFAF 25-099.

Committee Comments

- The committee supports moving DRAF procedures into the Schedule of Benefits in a cost-neutral manner.

41.10 Mxxx - Transoral robotic surgery (TORS) for resection of oropharyngeal tumour (PFAF 25-164)

Constituency Proposal

- The constituency proposed an introduction of a new fee code Transoral robotic surgery (TORS) for resection of oropharyngeal tumour, valued at $1317.20.
- The constituency proposed this new fee code should only be billed when the OR note includes the type of robotic technology used for the robotic-assisted surgery.

Committee Comments

- The committee notes that time to perform this procedure using TORS is not significantly different from performing this procedure by other modalities and is expected to decrease over time.
- The committee proposes modifying S067 to include this procedure and continues to deliberate on appropriate Schedule language.

41.11 Z296 - Endoscopy – Fiberoptic endoscopy of upper airway – with flexible endoscope & E839 - Excision - with flexible endoscope, to Z304 (PFAF 25-167)

Constituency Proposal

- The constituency proposed a value increase to the Z296 fee code, from its current value of $20.10 to the new proposed value of $35.25.
- The constituency stated Z296's current value does not adequately reflect the technical expertise required to perform the service and the knowledge/experience required to use the information gleaned from this procedure to make a diagnosis.
- Following discussion with the PPC, the constituency agreed that E839 should also receive the same fee value as the new value proposed for Z296.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

41.12 E676 - Morbidly obese patient surgery modifier BMI restriction (PFAF 25-187)

Constituency Proposal

- The constituency proposed a revision to the current E676 (25%) morbidly obese patient for surgery add-on code's payment rules, so that patients with a BMI greater then 40 qualify. Instead of the current rule where only patients with a BMI greater then 45 qualify.
- The constituency stated this new revision to E676's payment rules would better align neck surgery in obese patients with surgeries performed on other areas of the body in obese patients.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

41.13 A245 - Otolaryngology Consultation (PFAF 25-191)

Constituency Proposal

- The constituency proposed a fee value increase to the A245 fee code, from the current $83.95 value to their new proposed $94.00 value.
- The constituency stated Otolaryngology has the third lowest consultation fee for all surgical specialists. The proposed fee value increase would bring the A245 fee code in better relativity with the other surgical specialties consultation fee codes.

Committee Comments

- The committee supports the fee value change, subject to fitting and relativity.

41.14 A243 - Otolaryngology Specific assessment (PFAF 25-192)

Constituency Proposal

- The constituency proposed a fee value increase to the A243 fee code, from the current $43.20 value to their new proposed $45.00 value.
- The constituency stated A243 requires specific and separate set of skills with regards to expertise in pathology and medical treatment as well as counselling, that is distinct from surgical counselling expertise. The constituency's membership has repeatedly voiced their opinion that

the A243 fee code is undervalued and doesn't reflect the complexity required for when patients return for further assessment.

Committee Comments

- The committee supports the fee value change, subject to fitting and relativity.

41.15 A244 - Otolaryngology Partial assessment (PFAF 25-193)

Constituency Proposal

- The constituency proposed a fee value increase to the A244 fee code, from the current $27.00 value to their new proposed $31.00 value.
- The constituency stated A244 requires specific and separate set of skills with regards to expertise in pathology and medical treatment as well as counselling, that is distinct from surgical counselling expertise. The constituency's membership has repeatedly voiced their opinion that the A244 fee code is undervalued and doesn't reflect the complexity required for when patients return for further assessment.

Committee Comments

- The committee supports the fee value change, subject to fitting and relativity.

42 Pediatrics

42.1 E082 - Admission assessment by the MRP (PFAF 21-D85)

Constituency Proposal

- The constituency requested that E082 - Admission assessment by the MRP (add 30%) be revised to allow payment for sick newborns on first day of life.

Committee Comments

- The committee supports this proposal and continues to explore appropriate schedule language.

42.2 K704 - Paediatric outpatient case conference (PFAF 21-D86)

Constituency Proposal

- The constituency requested to change the payment rules to require only one other health professional participant to be eligible to bill K704.

Committee Comments

- This proposal involves a broad change to the definition of a case conference. If there are specific scenarios which need to be addressed, the section could bring those as new proposals. Such proposals could be modelled after K003 (Interviews with Children's Aid Society (CAS)).
- The committee does not support this proposal.
- The committee notes the constituency's choice to withdraw this proposal when they submitted PFAF 25-057.

42.3 Axx1 - Consultation (minimum 45 minutes) (PFAF 21-D87)

42.4 Axx2 - Consultation (minimum 60 minutes) (PFAF 21-D88)

Constituency Proposals

- The constituency requested the creation of two new time-based consultation fees (no longer requesting minimum time requirement for A265 Consultation):

    - Axx1 - Consultation requiring a minimum of 45 minutes at $225.00.
    - Axx1 - Consultation requiring a minimum of 60 minutes at $275.00.

Committee Comments

- The committee could only deliberate on this proposal if it could be costed very accurately. The committee does not see any method by which such an estimate could be achieved and guaranteed.
- The PPC therefore cannot support this proposal.

42.5 A/C815 - Midwife requested special assessment (PFAF 21-D91)

Constituency Proposal

- The Section requested that the paediatric age premiums found on page GP64 be applicable to A/C815 - Midwife requested special assessment.

Committee Comments

- The committee supports this change, subject to fitting and fee code relativity considerations.
- This change would also apply to A817.

42.6 A661 - Paediatrics Complex Medical Specific reassessment (PFAF 21-D89)

Constituency Proposal

- The constituency requested an increase to the annual limit for A661 - Complex medical specific re-assessment from 4 to 6 per 12-month period.

Committee Comments

- Changing the annual limit for complex medical specific reassessments would affect multiple sections as it is defined in the general preamble.
- The committee notes the constituency's decision to withdraw this proposal.

42.7 Exxx - Paediatrics Office Stabilization Premium (PFAF 21-D90)

Constituency Proposal

- The constituency requested a new add-on premium payable to a consultation fee provided in physician's private offices only at 10% to cover the cost of higher overhead in the community.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the scope of the PPC.
- The committee notes the constituency's choice to withdraw this proposal.

42.8 A262 - Level 2 Paediatric assessment (PFAF 23-255)

Constituency Proposal

- The constituency proposed increasing the value of a level 2 paediatric assessment from $43.45 to $45.70 (5 per cent increase).

Committee Comments

- The committee notes the constituency's choice to withdraw this proposal when submitting PFAF 25-059.

42.9 Kxxx - Paediatrician to allied professional telephone interview (PFAF 25-057)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for paediatricians performing a telephone interview providing medical advice, direction, or information to one of the following allied professionals, regarding an out-patient less than 18 years of age:

    a. Regulated social workers
    b. Regulated health professionals
    c. Educational professionals
    d. Law and law enforcement professionals
    e. Community case workers
    f. Intake workers
    g. Child Care providers
    h. Children's Aid Society

- The constituency proposed the new fee code to be valued at $23.37 per 10-minute unit.
- The constituency stated the date, medical advice, direction, or information provided in these phone interviews must be recorded in a patient's medical record if they are less than 18 years old, which takes a minimum of 10 minutes.
- The constituency proposed the following payment rules accompany the new code:

    1. No other Paediatrician to allied professional telephone interview or telephone consultation service is eligible for payment with for the same patient on the same day.
    2. Pediatrician to allied professional telephone interview is limited to a maximum of 6 services per patient, per physician, per 12-month period.
    3. Pediatrician to allied professional telephone interview is only eligible for payment when the physician most responsible has a specialty designation in Paediatrics (26).
    4. Pediatrician to allied professional telephone interview is only eligible for payment for a minimum of 10 minutes of patient related discussion and where there is an established physician-patient relationship.

Committee Comments

- The committee could only deliberate on this proposal if it could be costed accurately. The committee does not see any method by which such an estimate could be achieved and guaranteed.
- The PPC therefore cannot support this proposal.

42.10 Multiple fee codes - Various value changes to Paediatric consultations, visits, and other fee codes (PFAF 25-059)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following paediatric consultation, visit, and other fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Paediatrics - Consultations, Visits and Other codes (PFAF 25-059)					
A263	Paediatrics - Medical specific assessment	$82.90	$93.68	$10.78	13.0%
A262	Paediatrics - Level 2 - Paediatric assessment	$43.45	$49.10	$5.65	13.0%
A261	Paediatrics - Level 1 - Paediatric assessment	$21.50	$24.30	$2.80	13.0%
A264	Paediatrics - Medical specific re-assessment	$61.25	$69.21	$7.96	13.0%
A661	Paediatrics - Complex medical specific re-assessment	$74.75	$84.47	$9.72	13.0%
A665	Paediatrics - Prenatal consultation	$100.55	$181.45	$80.90	80.5%

Z111	Oral Cavity and Pharynx - Incision- Tongue tie, release of - Simple	$15.35	$30.70	$15.35	100.0%
G282	Cardiovascular - Venipuncture - Umbilical vein catheterization (including obtaining of blood sample)	$19.90	$39.80	$19.90	100.0%
K267	Paediatrics - Periodic health visit - 2 - 11 years of age	$41.60	$47.01	$5.41	13.0%
K269	Paediatrics - Periodic health visit -12 - 17 years of age	$77.20	$87.24	$10.04	13.0%
A260	Paediatrics - Special paediatric consultation	$310.45	$325.97	$15.52	5.0%
A662	Paediatrics - Extended special paediatric consultation	$401.30	$421.37	$20.07	5.0%
A268	Paediatrics - Enhanced 18 month well baby visit	$64.30	$72.66	$8.36	13.0%
A265	Paediatrics - Consultation	$181.45	$186.89	$5.44	3.0%

Committee Comments

- Except for fee codes A665 and Z111, the committee supports the fee value changes subject to fitting and relativity.
- The committee would support an increase in Z111 to $20.00, subject to fitting.
- The committee continues to deliberate on the proposed fee value increase to A665.

42.11 Multiple fee codes - Various value changes to Paediatric development codes (PFAF 25-061)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following paediatric development fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Paediatrics - Development codes (PFAF 25-061)					
K123	Paediatrics - Family developmental and/or behavioural care per unit	$101.75	$122.10	$20.35	20.0%
K122	Paediatrics - Individual developmental and/or behavioural care per unit	$89.70	$107.65	$17.95	20.0%
K119	Paediatrics - Paediatric developmental assessment incentive	$115.10	$138.12	$23.02	20.0%
A667	Paediatrics - Neurodevelopmental consultation	$401.30	$481.56	$80.26	20.0%

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity.

42.12 Multiple fee codes - Various value changes to injection and infusion - immunization codes (PFAF 25-062)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following injection and infusion immunization fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Injections and Infusions – Immunization codes (PFAF 25-062)					

G538	Injections and Infusions - Immunization - Other immunizing agents not listed above	$5.80	$9.00	$3.20	55.2%
G700	Basic fee- Per- Visit premium for procedures marked (+)	$5.60	$9.00	$3.40	60.7%
G840	Injections and Infusions - Immunization - Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP/IPV) - Paediatric	$5.40	$9.00	$3.60	66.7%
G841	Injections and Infusions - Immunization - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP- IPV- Hib) - Paediatric	$6.35	$9.00	$2.65	41.7%
G842	Injections and Infusions - Immunization - Hepatitis B (HB)	$5.40	$9.00	$3.60	66.7%
G843	Injections and Infusions - Immunization - Human Papillomavirus (HPV)	$5.40	$9.00	$3.60	66.7%
G844	Injections and Infusions - Immunization - Meningococcal C Conjugate (Men-C)	$5.40	$9.00	$3.60	66.7%
G845	Injections and Infusions - Immunization - Measles, mumps, rubella (MMR)	$5.40	$9.00	$3.60	66.7%
G846	Injections and Infusions - Immunization - Pneumococcal conjugate	$5.40	$9.00	$3.60	66.7%
G847	Injections and Infusions - Immunization - Diphtheria, Tetanus, acellular Pertussis (Tdap) - Adult	$5.40	$9.00	$3.60	66.7%

G848	Injections and Infusions - Immunization - Varicella (VAR)	$5.40	$9.00	$3.60	66.7%

Committee Comments

- The committee supports the proposed changes in fee values, subject to fitting and relativity.

42.13 Gxxx - Respiratory Syncytial Virus (RSV) for patient's first season (PFAF 25-064)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for the administration of RSV immunization to infants during their first RSV season or between 12-24 months of age if the infant meets high-risk criteria.
- The constituency proposed this new fee code will separate these cases from G538 billings. The constituency stated in these cases the RSV immunization often requires more counselling compared to other immunizations, since it is so new.
- The constituency proposed the new fee code be valued at $9.00.
- The constituency proposed the payment rules for this new code remain the same as the other immunization codes.

Committee Comments

- The committee supports paying all injectable immunization codes the same amount (see PFAF 25-062).
- The committee recommends physicians bill G538 for RSV administration.
- The committee continues to deliberate on the proposal to create a new fee code and will reach out to the constituency as required.

42.14 Gxxx - Oral rotavirus vaccine for patient's less than 8 months old (PFAF 25-065)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for the administration of oral rotavirus vaccine to infants less than 8 months of age.
- The constituency stated this type of immunizations may take more time compared to other immunizations since it is administrated orally, and it must be given slowly to avoid the infant vomiting. Additionally, there is also more time required counselling with families about this vaccine since it is the first live vaccine given in the Ontario Immunization schedule.
- The constituency proposed the new fee code be valued at $9.00.
- The constituency proposed the payment rules for this new code remain the same as the other immunization codes.

Committee Comments

- The committee proposes that G462 be expanded to include oral rotavirus, be increased to a value of $9.00, and have the "+" sign added to it.

42.15 Kxxx - Assessment of a well newborn/infant (PFAF 25-066)

Constituency Proposal

- The constituency proposed an introduction of a new fee code for the periodic assessment of a well newborn/infant during the first two years of life.
- The consistency stated the proposed new fee code will include a complete examination with weight and measurements, and instructions to the parent(s) or patient's representative regarding health care.
- The constituency proposed this new fee code be valued at $60.00. The justification for this fee value is that well baby care has become more complex, with more issues, more parental anxiety/questions, and new counselling requirements.
- The constituency stated this new fee code will be billed alternatively to A262, when the patient meets the correct criteria.

Committee Comments

- The committee is of the opinion that the current billing for periodic assessment of a well newborn is within relativity.
- The committee does not support this proposal.

42.16 H261 - Newborn care in hospital or home (PFAF 25-070)

Constituency Proposal

- The constituency proposed a fee value increase to the H261 fee code from $60.80 to $82.90 (36.3%).
- The constituency stated H261 should be increased to be on par with a medical specific assessment (A263), since it includes all the same elements due to the evolution over time
- The constituency also proposed a revision to the Schedule of Benefits definition of newborn care. The constituency stated many newborns only require a single discharge if they are well and daily rounding is not necessary.
- The constituency proposed the deletion of H262 and H263 (see PFAF 25-071) and all well newborn assessment be billed under H261 with the proposed value increase.
- The constituency also proposed that if any infant is medically unwell with a diagnostic code other than 916, should qualify for the MRP code, E082, as the first day of admission, and E083 on subsequent days of admission while unwell.

Committee Comments

- The committee supports a fee value change for H261 and notes that H001 would also increase to maintain relativity.
- The committee continues to deliberate the value of a fee change.
- The committee notes that the question of whether E082 should apply is a duplicate of PFAF 21-D85. Please see the comments for that proposal above.

42.17 H262 & H263 - Paediatrics - Low birth weight newborn uncomplicated care (PFAF 25-071)

Constituency Proposal

- The constituency proposed the deletion of the H262 and H263 fee codes.
- The constituency proposed the deletion of these fee codes due to their proposed revision to the Schedule of Benefits definition of newborn care (PFAF 25-070).
- The constituency stated physicians will alternatively bill the new proposed revised H261 fee code in their proposal outlined in PFAF 25-070.

Committee Comments

- The committee supports this proposal.

42.18 Multiple fee codes - Various value changes to subsequent visit codes (PFAF 25-072)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following subsequent visit fee codes due to hospital inpatients becoming more complex and taking longer to round on:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Subsequent visit codes (PFAF 25-072)					
C122	All specialties - Subsequent visits by the MRP - Day following hospital admission assessment	$61.15	$69.10	$7.95	13.0%
C123	All specialties - Subsequent visits - MRP - Second day following hospital assessment	$61.15	$69.10	$7.95	13.0%
C124	All specialties - Subsequent visits - MRP - Day of discharge	$61.15	$69.10	$7.95	13.0%
C262	Paediatrics - Non-emergency hospital in-patient services - Subsequent visits - First five weeks - Per visit	$34.10	$40.92	$6.82	20.0%

Committee Comments

- The committee notes that these codes are billed by all physicians providing inpatient care.
- The committee supports an increase in these fee codes, subject to fitting, relativity, and impact on other sections.

42.19 Gxxx - Follow up congenital Echocardiogram (PFAF 25-210)

Constituency Proposal

- The constituency proposed the introduction of a new fee code, when there is a follow up echocardiogram for patients with a known congenital heart disease which is performed by the operators and reviewed by physicians with specific training.
- The constituency proposed the new fee code should be valued at $144.30 (1.5x G571). The constituency notes the proposed value may change depending on final costing estimates.
- The constituency proposed the following payment rules accompany the new fee code:

    1. Procedure must include subcostal and suprasternal imaging (where appropriate).
    2. Physician must provide interpretation of Doppler signs and measurements including Z-score methods for assessment of size.
    3. Restricted to patients with known congenital heart disease and prior cardiac interventions detailed in the report, regardless of the patient's age.

Committee Comments

- The committee notes that Accreditation Canada does not currently accredit paediatric echocardiography.
- The committee does not support this proposal at this time.

42.20 Gxxx - Complete paediatric and congenital echocardiogram (PFAF 25-211)

Constituency Proposal

- The constituency proposed the introduction of a new fee code, when there is a complete echocardiographic examination performed by operators and reviewed by physicians with specific training.
- The constituency proposed the new fee code should be valued at $192.40 (2x G571). The constituency notes the proposed value may change depending on final costing estimates.
- The constituency proposed the following payment rules accompany the new fee code:
    1. Procedure must include a complete segmental analysis, subcostal, and suprasternal imaging.
    2. Physician must provide interpretation of Doppler signs and measurements including Z-score methods for assessment of size.
    3. Restricted for patients who are either:
        a. A pediatric patient (birth to 18 years of life).
        b. A patient with a know congenital heart defect, regardless of age.
        c. A patient with clinical suspicion of a heart defect to rule out a congenital or acquired heart defect, regardless of age.

Committee Comments

- The committee notes that Accreditation Canada does not currently accredit paediatric echocardiography.
- The committee does not support this proposal at this time.

42.21 Major Initiative - Midwives referrals (MI 25-03)

Constituency Proposal

- Midwives commonly refer their patients to pediatricians. While OHIP billing codes exist for midwives to directly refer their patients, there are no billing codes that exist for a direct referral for several consultations that may arise.
- Requesting a specific "Midwife Requested" consultation code will complicate the Schedule of Benefits and will lead to discrepancies in payment. When a patient is referred the payment should be the same whether the patient was referred by a midwife vs physician vs NP for the same service. The discrepancy in pay arises because the pediatric age premium does not apply to the A815 and A817 fee codes.
- When midwives request telephone consultations, pediatricians can not bill the K731 code which results in no remuneration for the physician.
- The pediatric section is aware that this issue may apply to other effected sections as midwives may potentially require telephone consultations from specialties other than pediatrics as well.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

42.22 Major Initiative - Pediatrics Modernization in the Schedule of Benefits (MI 25-06)

Constituency Proposal

- The current structure of the Schedule of Benefits with all pediatric subspecialties combined does not recognize that pediatrics is a unique specialty.
- Our colleagues caring for adults have access to bill under at least 12 different specialty billing codes and this affords far greater flexibility in directing funds to where they are needed most.
- Proposals approved by PPC submitted by subspecialty sections can often have a significant impact on the pediatric section budget, which worsens pediatric intra-sectional relativity and makes it challenging to adequately represent our membership.
- The proposed solution is to restructure pediatrics in the Schedule of Benefits with separate recognition of pediatric subspecialties. This will allow greater flexibility to address intra-sectional relativity issues and allow for novel codes that recognize additional time and complexity. This will also lead to improved billing tracking which will enable more accurate costing estimates.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

42.23 Major Initiative - Pediatrics Structure in the Schedule of Benefits (MI 25-07)

Constituency Proposal

- Pediatric care is fundamentally different from adult medicine, yet the current Schedule of Benefits does not adequately reflect these differences.

- Existing billing structures and regulations often disadvantage pediatricians, leading to inefficiencies, increased administrative burden, and reduced access to timely and comprehensive care for children.
- In addition to the Pediatric Section's submission outlined in the PPC Schedule Modernization Form titled "Pediatrics (26) Requires Modernization in the Schedule of Benefits", these proposals seek to better align with the unique aspects of pediatric care, ensuring fair remuneration for pediatricians, improved ability for the Pediatrics Section to represent all of their members and ultimately healthcare outcomes for children.
- The following challenges have been identified by the constituency:

    1. Reassessment of the Two-Year Consult Rule for Pediatric patients
        - Proposed Solution: Recognize a rapid development in children and introduce an exemption for pediatric patients, allowing new consults with no minimum time requirement when the presenting problem is unrelated to the previous consultation issue.
    2. Allowance for Multiple Pediatric Consults on the Same Day
        - Proposed Solution: Establish a pediatric-specific exception allowing multiple consults for same patient when different pediatric subspecialties are involved.
    3. Billing K Codes with A Codes
        - Proposed Solution: Permit K122 and K123 codes to be billed alongside A codes when the service provided are distinct and necessary within the same visit.
    4. Expansion of Diagnostic Codes for Pediatric Conditions
        - Proposed Solution: Work with stakeholders to expand and update pediatric diagnostic codes within the Schedule of Benefits to better capture conditions unique to childhood. This will allow for better tracking and costing in the future.
    5. Improved Compensation for Scoring and Interpretation of questionnaires
        - Proposed Solution: Introduce new billing codes or adjust existing codes to adequately compensate pediatricians for these crucial assessments.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

42.24 Major Initiative - Develop billing codes that reflect tertiary care pediatric work in academic centres (MI 25-08)

Constituency Proposal

- Highly subspecialized care in pediatric academic centres is difficult to accurately capture using existing billing codes and the Schedule should be modernized to reflect this unique work.
- Examples highlighted by pediatricians working in academic centres include:

    1. Transport advice

- Proposed Solution: Increase limits for consultation physicians in academic centres for telephone consultation codes for providing telephone advice and transport support in excess of the current 20-minute critical consultation limit.

2. Level 3 NICU care in tertiary care centers
    - Proposed Solution: Create level 3 NICU billing codes that can more accurately reflect the time-intensive acute care required in academic centres, without exacerbating intra-sectional relativity.
3. Child Abuse and Neglect work
    - Proposed Solution: Work with academic centres to create a dedicated code for clinical scenarios such as child abuse and neglect cases where current schedule of benefit codes cannot capture the complexity of the work involved. These can be restricted to specific location codes or specific physicians.
4. Daily rounding on complex patients
    - Proposed Solution: Introduce an additional academic pediatric centre daily rounds complexity modifier.
5. Limitations on case conferences
    - Proposed Solution: Increase limits for both inpatient and outpatient conference codes for tertiary care academic centres. This can be restricted to specific location codes.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

42.25 Major Initiative - Pediatricians access to specific procedural and premium codes (MI 25-09)

Constituency Proposal

- General Pediatricians and Pediatric Subspecialists do not have access to specific procedural codes or premiums that reflect the additional time and complexity of dealing with an infant or young child.
- Proposed Solution: Introduce pediatric premiums for carefully selected pediatric procedures where additional complexity exists and additional time is required when caring for infants and children requiring these procedures.
- This is necessary to address intra-sectional relativity, the gender pay gap and equitable access to pediatric patients for necessary procedures.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

43 Palliative Medicine

43.1 A/C945 - Special Palliative Care Consultation (PFAF 21-D92)

Constituency Proposal

- The constituency requested a fee increase from $159.20 to $203.30, by 27.7 per cent.

Committee Comments

- The committee notes the constituency's choice to withdraw this proposal with the submission of PFAF 25-128.

43.2 B966 - Palliative care home visit – travel premium (PFAF 25-115)

Constituency Proposal

- The constituency proposed a value increase to the B966 fee code, from $36.40 to $45.50 (25%).
- The constituency notes that they have received support from SGFP, Care of the Elderly, and Geriatrics. Request for support was also sent to Emergency Medicine with no response and Internal Medicine who didn't have sufficient funds for this proposal.

Committee Comments

- All travel premiums in the Schedule of Benefits are the same value, and therefore this proposal affects many constituencies who would need to be consulted prior to a value change.
- The committee does not support the proposed value change.

43.3 A/C/W771 - Certification of death (PFAF 25-116)

Constituency Proposal

- The constituency proposed a value increase to the A771, C771, and W771 fee codes, from $20.60 to $41.20 (100%).
- The constituency notes that they received support from SGFP and Care of the Elderly. Request for support was also sent to Emergency Medicine with no response and Internal Medicine who didn't have sufficient funds for this proposal.

Committee Comments

- The committee supports a value change for A/C/W771, subject to fitting and relativity.

43.4 B998 & B988 - Special visit premiums (PFAF 25-118)

Constituency Proposal

- The constituency proposed a value increase to the B998 and B988 fee codes, from $82.50 to $91.78 (11.25%).
- The constituency notes they have received support from SGFP and Geriatrics.

Committee Comments

- The committee supports the proposed change, subject to fitting and relativity.

43.5 K023 - Palliative care support per unit value change (PFAF 25-114)

Constituency Proposal

- The constituency proposed a value increase to the K023 fee code, from $74.70 to $84.40 (13%).
- The constituency notes that they have received support from SGFP and Care of the Elderly.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

43.6 K023 - Palliative care support, per unit - Approach #1 (PFAF 25-124)

Constituency Proposal

- The constituency proposed a value change, revision to the payment rules, and revision to medical record keeping requirements for the K023 fee code.
- The constituency proposed a value change to K023, from $74.70 to $84.40 (13%).
- The constituency proposed that palliative care should be paid according to the rules set forth in the OHIP payment for MAID. Since the scope of practiced and subject matter overlap significantly.
  The constituency proposed the following payment rules and medical record keeping requirement revisions:

  Payment rules:
  1. With the exception of A945/C945, A/C771, 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.
  2. Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee.
  3. When the duration of A945 or C945 exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 units occurs 50 minutes after the start time for A945 or C945
  4. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.
  5. Palliative care support (K023) should be claimed for the duration of time spent on the provision of palliative care provision. This includes time spent with the patient and family, pronouncement and certification of death, counselling of relatives as necessary, meeting reporting requirements and notification of the coroner's office. For discussions with other health care providers (e.g., other physicians, pharmacist, coroner, CCAC) involved in the management of an individual patient's palliative care provision (e.g. procedural planning for palliative sedation or MAID), palliative care support (K023) fee is

eligible for payment for the duration of time spent. The total time represents the cumulative time of all discussions on that day pertaining to the same patient.

6. K023 may be billed by a maximum of two physicians per day to a maximum of 12 units per 24 hours.

(Revisions Underline)

Medical record keeping requirements:

1. Record time in/out for discussion with nursing/social worker/pharmacist/CCAC/other physicians that are part of care team of the patient.
2. Record time in/out for review of chart.
3. Record time in/out for direct patient care and counselling of loved ones.
4. Record time in/out for documentation of death/communication with coroner and/or funeral home
5. Maximum of 12 units per 24-hour period.
6. Maximum of 2 physicians may bill K023 per 24-hour period (in case of MAID consult same day as palliative physician care provision).

(Revisions Underline)

- The constituency also states that if the proposed revision is supported, they would consider the deletion of case conference codes (K700 etc.).

Committee Comments

- The committee supports a value change for K023, subject to fitting and relativity (see PFAF 25-114).
- The committee notes that the rule changes proposed are not consistent with the Schedule of Benefits' approach to similar services, with the exception of MAiD provision.
- Proposed Schedule of Benefits language related to the provision of MAiD is new and may be subject to change as we better understand how the schedule language performs.
- The committee does not support changing K023 in a manner which makes it consistent with proposed schedule language related to the provision of MAiD, and inconsistent with the rest of the Schedule of Benefits.

43.7 K023 - Palliative care support, per unit – Approach #2 (PFAF 25-125)

Constituency Proposal

- The constituency proposed a value change, revision to descriptor, revision to the payment rules, and revision to medical record keeping requirements for the K023 fee code.
- The constituency proposed a value change to K023, from $74.70 to $84.40 (13%).
- The constituency proposed that palliative care should be paid according to the rules set forth in the OHIP payment for MAID. Since the scope of practiced and subject matter overlap significantly.
- The constituency proposed the following descriptor, payment rules, and medical record keeping requirement revisions:

  Descriptor:

1. Palliative care support is a time-based service payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care including one-time day of death emotional support and counselling to deceased patient's loved ones by MRP.

   (Underline Revisions)

Payment rules:

1. With the exception of A945/C945, 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.
2. Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee.
3. When the duration of A945 or C945 exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 units occurs 50 minutes after the start time for A945 or C945.
4. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.
5. Eligible for payment with Special Visit Premiums, Palliative Care Table VII.
6. Eligible for payment with A/C771.

   (Underline Revisions)

Medical record keeping requirements:

1. Record names of deceased as well as loved ones involved in counselling session.
2. Record statement that physician is MRP for the deceased.
3. Record date of death and date of bereavement counselling (must be same date).
4. Record time in and out on medical record.

(Underline Revisions)

Committee Comments

- The committee supports a value change for K023, subject to fitting and relativity (see PFAF 25-114).
- The committee supports the need to clarify how grief counselling should be billed, where required, following the death of a palliative patient. The committee continues to deliberate and will reach out to the constituency as required.

43.8 A/C945 - Special palliative care consultation (PFAF 25-128)

Constituency Proposal

- The constituency proposed a value change, revision to the payment rules, and revision to medical record keeping requirements for the A945 and C945 fee codes.
- The constituency is proposed a value change to A945 and C945, from $159.20 to $204.75 (28.6%).

- The constituency stated palliative care is a priority area for many health care sectors with aging and complex care environments. Investment in physician care will impact delivery/access/feasibility of care as seen in geriatric care. The current Schedule of Benefits incentivises MAID over palliative end of life care and/or palliative sedation, although elements of care have significant overlap.
- The constituency proposed the following descriptor, payment rules, and medical record keeping requirement revisions:

  Descriptor:

  A special palliative care consultation is a consultation requested because of the need for specialized management for palliative care where the physician spends a minimum of 50 minutes with the patient and/or patient's representative/family in consultation (majority of time must be spent in consultation with the patient). In addition to the general requirements for a consultation, the service includes a psychosocial assessment, comprehensive review of pharmacotherapy, discussion regarding goals of care inclusive of education regarding, seeking out patient's beliefs regarding and, if appropriate, referral for consultation for MAID services, appropriate counselling and consideration of appropriate community services, where indicated.

  (Underline Revisions)

  Payment rules/Medical record keeping requirements:

  1. Start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
  2. When the duration of a palliative care consultation (A945 or C945) exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 are met. The time periods for A945 or C945 and K023 are mutually exclusive (i.e. the start time for determination of minimum time requirements for K023 occurs 50 minutes after start time for A945 or C945).
  3. Time spent is to be inclusive of duration of cumulative time spent on the day of consultation with the patient and family, for certification of death, for counselling of relatives as necessary and for meeting reporting requirements, notification of coroner's office if applicable and discussions with other health care providers (e.g. other physicians, pharmacist, CCAC) involved in the management of the patient's end of life care.

     (Underline Revisions)

Committee Comments

- The committee supports a change in the fee value of A/C496, subject to fitting and relativity.
- The committee does not support the proposed rule changes because they are not consistent with standard language of consultations and assessments in the Schedule of Benefits.
- The committee believes the work involved with MAiD is different from the work involved with palliative care.

43.9 A/C/Wxxx - Comprehensive palliative medicine consultation (PFAF 25-130)

43.10 A/C/Wyyy - Extended comprehensive palliative medicine consultation: (PFAF 25-130)

Constituency Proposal

- The constituency proposed the introduction of two new fee codes. One for a comprehensive palliative medicine consultation and another for an extended comprehensive palliative medicine consultation
- The constituency stated these two services are novel as palliative medicine recently received its own Royal College Specialty OHIP billing number and currently the billing number has no codes specific to its specialty.
- The constituency stated physicians currently bill A/C945, but Palliative physician will now bill these new proposed fee codes for comprehensive consultations.

A/C/Wxxx - Comprehensive palliative medicine consultation:

- This service has a proposed value of $310.45 (equivalent to A130, A775, and other RCS consultation codes).
- The constituency proposed the following descriptor, payment rules, and medical record keeping requirement for the new fee codes:

Proposed Descriptor:

> This service is a consultation rendered by a specialist in palliative 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. In addition to the general requirements for a consultation, the service includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling and consideration of appropriate community services, where indicated.

Proposed Payment Rules and Medical Record keeping Requirements:

1. A130 must satisfy all the elements of a consultation (see page GP16).
2. The calculation of the 75-minute minimum time for comprehensive palliative medicine consultations excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.
3. Billable by Royal College Palliative Medicine trained specialists (RCPSC) only under specialty OHIP code 45.
4. The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

A/C/Wyyy - Extended comprehensive palliative medicine consultation:

- This service has a proposed value of $401.30 (equivalent to A770).
- The constituency proposed the following descriptor, payment rules, and medical record keeping requirement for the new fee codes:

Proposed Descriptor:

An extended comprehensive palliative medicine consultation is a consultation performed by a physician with a RCPSC specialty certification on a patient:

a. At least 65 years of age; or

b. When the consultation is for the assessment of pain and symptom management and end of life care; and where the physician spends at least 90 minutes with the patient exclusive of time spent rendering any other service to the patient.

Proposed Payment Rules and Medical Record keeping Requirements:

1. Eligible for payment when the consultation is for the assessment of pain and symptom management and end of life care regardless of the patient's age.
2. An extended comprehensive palliative medicine consultation is only eligible for payment if this service has not been rendered on the same patient by the same consultant within the previous 2 years.
3. Billable by Royal College Palliative Medicine trained specialists (RCPSC) only under specialty OHIP code 45.
4. The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

Committee Comments

- The committee notes that this OHIP Specialty did not exist in FY2023, which was the year which was used to determine allocation.
- The committee is therefore unable to create unique codes for this new OHIP speciality at this time.

43.11 Major Initiative - Extended Travel Modifier (MI 25-13)

Constituency Proposal

- The constituency proposed a new extended travel modifier code to be billed in conjunction with special visit premium table VII, palliative medicine home visit B966 when travel to patient's home is farther (or longer) than a certain set amount (what is felt to be appropriate for current B966 payment).
- The constituency proposed this new fee code be valued at $25.00.
- The constituency proposed the following descriptor and payment rules for the new fee code:

Definition/required elements of service:

1. A travel modifier premium is only eligible for payment for travel from one location to another location ("the destination") subject to the payment rules below when the distance travelled is greater than 50km to the patient's home.

2. A travel premium is not eligible for payment when a physician is required to travel from one location to another within the same long-term care facility, hospital complex or within buildings situated on the same hospital campus.

Commentary:

1. A first person seen premium may be eligible for payment in this circumstance.
2. Only one travel premium is eligible for payment for each separate trip to a destination regardless of the number of patients seen in association with each trip.

Payment Rules:

1. The physician must document in the patient's medical record the distance travelled in km in agreement with electronic mapping services (i.e. Google Maps, Waze, etc.).

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

44 Physical Medicine & Rehabilitation

44.1 E446 - Peripheral joint injection using image guidance (PFAF 25-252)

Constituency Proposal

- The constituency proposed a revision to the E446 descriptor and payment rules.
- The constituency stated the current descriptor is historic and standard of care for intra-articular injections has moved form landmark-based injections to using image guidance (eg. Ultrasound).
- The constituency proposed the following revisions to the descriptor for E446:

  Peripheral joint injection using image guidance ~~following a failed blind attempt, to G370 or G371.~~

  (~~strikethrough~~ deletion)

- The constituency proposed the following new payment rule:
  "Eligible for payment for injection and/or aspiration of the joint/bursa/ganglion/tendon sheath using any method of image guidance without requiring prior failed landmark-based attempt(s)."

Committee Comments

- Topics related to this proposal are under review by the Appropriateness Working Group (AWG).
  Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

44.2 G456 - Needle Electromyography and Nerve Conduction Studies - professional component (PFAF 25-264)

Constituency Proposal

- The constituency proposed an increase in value to the G456 fee code, from $99.90 to $125.00 (25.1%).
- The constituency stated the G456 EMG code has fallen out of relativity and EMG fees were unilaterally reduced by the MOH prior to previous arbitration or mediated agreements.

Committee Comments

- For comments, please refer to the proposal on G456 in the Neurology section (PFAF 21-D41).

45 Plastic Surgery

45.1 Z142 - Removal of breast prosthesis (PFAF 23-021)

Constituency Proposal

- The constituency requested clarification to the payment rules in the Schedule on whether Z142 is eligible/ineligible for payment with Z135 or Z182 when performed on the same (ipsilateral) breast.

Committee Comments

- The committee awaits feedback from the section regarding the committee's counter proposal for time-based payment for breast surgery.

45.2 Multiple skin cancer excisions/reconstructions for same patient/day (PFAF 23-065)

Constituency Proposal

- The constituency raised the issue of multiple skin cancer excisions/reconstructions on the same patient on the same date not being paid.
- Clarification of the payment rules around the maximum number of procedures per patient per day in the Schedule was requested.

Committee Comments

- Given that the concern raised is not a schedule benefits language issue and no proposal has been made for changes to the Schedule of Benefits, this is beyond the scope the PPC.
- OMA staff will help the constituency to identify where to better direct their concerns.

45.3 R110B - Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral (PFAF 23-168)

Constituency Proposal

- The constituency requested a value change in surgical assist base units from 6 to 8 units.
- An increasing number of patients are undergoing prophylactic mastectomy and breast reconstruction for high risk of genetic markers. Patients with large ptotic breasts are not candidates for nipple sparing mastectomy, due to the risk of blood flow to the nipple. As a result, patients may undergo a breast reduction as a first stage procedure to prepare them and allow them to be candidates for a second stage nipple sparing mastectomy and reconstruction.

Committee Comments

- The Surgical Assistant MIG made the same request. Please see Surgical Assistant MIG submission (PFAF 23-287)

45.4 R110 - Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral (PFAF 23-169)

Constituency Proposal

- The constituency requested descriptor revision to allow reduction mammoplasties for patients as a first stage procedure, with scheduled nipple sparing mastectomy as a second stage procedure.

Committee Comments

- The committee awaits feedback from the section regarding the committee's counter proposal for time-based payment for breast surgery.

45.5 R118 - Post Mastectomy Breast Reconstruction - Breast skin reconstruction by local flaps or grafts (PFAF 21-D96)

Constituency Proposal

- Revise descriptor and notes associated with R118 Post Mastectomy Breast Reconstruction.
- Add note on page M20 indicating reduction does not apply to free island flap breast reconstruction following post-mastectomy or post-lumpectomy
- The Section requested a revision to the descriptor and notes associated with R118 to (Page M26) as follows:

  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)

Committee comments

- The committee awaits feedback from the section regarding the committee's counter proposal for time-based payment for breast surgery.

45.6 Free Island Flaps (PFAF 21-D97)

Constituency Proposal

- 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)

Committee comments

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

45.7 Cosmetic Surgery (PFAF 21-D93)

45.8 Contralateral balancing mastopexy or reduction (PFAF 21-D95)

45.9 Septorhinoplasty (PFAF 23-099)

Constituency Proposal

- The constituency requested 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)

Committee comments

- The requested clarifications for items related to cosmetic surgery relate to uninsured services and fall outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.

45.10 E832 - Excision of fascia for Dupuytren's, one or more additional rays, to R551 (PFAF 21-D98)

Constituency Proposal

- The constituency requested a revision to E832 to allow payment for each additional ray.

Committee comments

- The committee supports allowing additional payment when three or more rays are operated on.
- The value of that payment is subject to fitting and relativity.

45.11 Surgical Assistant base units (PFAF 21-D100)

Constituency Proposal

- The constituency requested 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

Committee comments

- The committee does not support the creation of surgical assistant base units for this long list of procedures given that the section has not provided evidence that these procedures routinely require a surgical assistant.

45.12 Multiple fee codes - Increase to various Plastic Surgery consultation and visit fee codes (PFAF 25-212)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following plastic surgery consultation and visit fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Plastic Surgery - Consultation & Visit fee codes (PFAF 25-212)					
A085	Plastic Surgery - Consultation	$91.35	$107.45	$16.10	17.6%
C085	Plastic Surgery - Non-emergency hospital in-patient services - Consultation	$91.35	$107.45	$16.10	17.6%
A086	Plastic Surgery - Repeat consultation	$54.00	$63.51	$9.51	17.6%
C086	Plastic Surgery - Non-emergency hospital in-patient services - Repeat consultation	$54.00	$63.51	$9.51	17.6%

A083	Plastic Surgery - Specific assessment	$46.80	$55.05	$8.25	17.6%
C083	Plastic Surgery - Non-emergency hospital in-patient services - Specific assessment	$46.80	$55.05	$8.25	17.6%
A084	Plastic Surgery - Partial assessment	$29.90	$35.17	$5.27	17.6%
C084	Plastic Surgery - Non-emergency hospital in-patient services - Specific re-assessment	$30.00	$35.29	$5.29	17.6%

Committee Comments

- The committee supports this proposal subject to fitting and prioritization.

45.13 F012, F013, and F015 - Deletion of Bennett's fracture fee codes (PFAF 25-213)

Constituency Proposal

- The constituency proposed the deletion of the F012, F013, and F015 fee codes.
- The constituency stated the procedures described by these three fee codes are adequately covered under other, more frequently billed fee codes.
- The constituency stated the F008 fee code will be billed in replacement of F012, which have equivalent values.
- The constituency stated the F006 fee code will be billed in replacement of F013, which the codes have a $0.05 difference in value.
- The constituency stated the F010 fee code will be billed in replacement of F015, which have equivalent values.

Committee Comments

- The committee supports this proposal.

45.14 Multiple fee codes - Increase to various hand and wrist – bone reconstruction and amputation fee codes (PFAF 25-214)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following hand and wrist, bone reconstruction and amputation fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Hand and Wrist - Bone Reconstruction & Amputation fee codes (PFAF 25-214)					
R606	Hand and Wrist - Amputation - Phalanx	$161.45	$275.00	$113.55	70.3%
R610	Hand and Wrist - Amputation - Trans. metacarpal 2nd to 5th ray	$279.35	$551.00	$271.65	97.2%
R217	Hand and Wrist - Incision and drainage - Phalanx/metacarpal/carpus - Saucerization and bone graft	$242.25	$350.00	$107.75	44.5%
R258	Hand and Wrist - Reconstruction - Bone - Deformity - Osteotomy - Phalanx - Middle proximal or metacarpal	$193.20	$425.00	$231.80	120.0%
R608	Hand and Wrist - Amputation - Metacarpal or metaphalangeal joint	$190.20	$275.00	$84.80	44.6%
R465	Hand and Wrist - Arthrodesis - Finger- Thumb	$321.30	$400.00	$78.70	24.5%

Committee Comments

- The committee continues to deliberate and will reach out to the section as necessary.

45.15 R603 - Hand and Wrist - Extremities - Digital reimplantation involving microvascular and neuro anastomosis (PFAF 25-217)

Constituency Proposal

- The constituency proposed an increase to the R603 fee code, from $1,586.20 to $1,850.00 (16.6%).
- The constituency stated the R603 fee code should receive an increase due to its high level of complexity and long duration in time to perform.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

45.16 Z231 - Hand and Wrist - Tenotomy or fasciotomy (closed) - Finger - palmar or plantar (PFAF 25-218)

Constituency Proposal

- The constituency proposed an increase to the Z231 fee code, from $73.70 to $125.00 (69.6%).

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

45.17 Multiple fee code - Increase to various hand and wrist – Fracture fee codes (PFAF 25-219)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following hand and wrist, fracture fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Hand and Wrist - Fracture fee codes (PFAF 25-219)					
F007	Hand and Wrist - Reduction - Fractures - Phalanx - Open reduction	$298.45	$350.00	$51.55	17.3%
F010	Hand and Wrist - Reduction - Fractures - Intra-Articular - Open reduction	$335.80	$425.00	$89.20	26.6%
F011	Hand and Wrist - Reduction - Fractures - Metacarpal - Open reduction	$262.60	$325.00	$62.40	23.8%
F017	Hand and Wrist - Reduction - Fractures - Carpus - Open reduction, one or more	$346.15	$450.00	$103.85	30.0%
E559	Hand and Wrist - Reduction - Fractures - Metacarpal - Each additional (open) add	$142.90	$176.85	$33.95	23.8%

D003	Hand and Wrist - Reduction - Dislocations - Finger - Open reduction	$196.50	$295.00	$98.50	50.1%
D006	Hand and Wrist - Reduction - Dislocations - Metacarpal/phalangeal - Open	$181.85	$290.00	$108.15	59.5%

Committee Comments

- The committee supports the fee value increases subject to fitting and relativity.

45.18 R436 - Hand and Wrist, Arthroplasty - Hand - interposition – multiple (PFAF 25-220)

Constituency Proposal

- The constituency proposed the deletion of the R436 fee code.
- The constituency stated the procedures described by this code are adequately covered under other, more frequently used codes within the Schedule of Benefits.
- The constituency also stated physicians will alternatively bill the R435 fee code twice or will bill the R489 fee code up to four times for total joint arthroplasty once the R436 fee code is deleted.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency, as required.

45.19 Multiple fee codes - Increase to various hand and wrist fee codes (PFAF 25-221, PFAF 25-224, and PFAF 25-236)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following hand and wrist fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Hand and Wrist fee codes (PFAF 25-221, 25-224, 25-236)					
R549	Hand and Wrist/Foot and Ankle- Excision - Soft tissue - Ganglion - Simple or complex	$177.80	$225.00	$47.20	26.5%
R037	Skin and Subcutaneous Tissue - Excision (with or without biopsy) - Lesions - Single or multiple sites (iop) - Group 4 other lesions - Giant cell tumour	$200.00	$255.00	$55.00	27.5%

R601	Hand and Wrist - Reconstruction- Ligaments - Metacarpal phalangeal repair	$316.75	$375.00	$58.25	18.4%
R489	Hand and Wrist - Arthroplasty - Hand - Interposition - Single joint - Total (arthrodesis and/or arthroplasties) maximum of 4	$290.55	$363.50	$72.95	25.1%
R536	Hand and Wrist - Release - Tendon release (open) - Finger/palm	$156.50	$188.50	$32.00	20.4%
E592	Hand and Wrist - Release - Tendon release (open) fingers - More than one, to R536 add	$133.05	$160.25	$27.20	20.4%
R585	Hand and Wrist/Elbow and Forearm/Foot and Ankle - Reconstruction - Tendon/s - Flexor- Single/Suture flexor tendon- Single/one	$307.60	$442.16	$134.56	43.7%
E581	Hand and Wrist, Elbow and Forearm, Foot and Ankle - Reconstruction - Flexor/Suture flexor tendon - Each additional to R585 add	$128.95	$185.37	$56.42	43.8%
R578	Hand and Wrist- Reconstruction - Tendon- Tendon repair- Extensor- Single/Elbow and Forearm- Reconstruction- Tendons- Suture extensor tendon- Single/Foot and Ankle - Reconstruction - Tendons- Suture extensor tendon - One	$164.10	$284.22	$120.12	73.2%
E580	Hand and Wrist, Elbow and Forearm, Foot and Ankle - Reconstruction - Tendons - Tendon repair - Extensor - Each additional - Add to R578	$70.95	$122.90	$51.95	73.2%
R534	Hand and Wrist - Incision and drainage - Phalanx/metacarpal/carpus - Tendon sheath	$225.00	$320.00	$95.00	42.2%

R537	Hand and Wrist - Release - Tendon release (open) - Wrist	$175.00	$210.80	$35.80	20.5%
E571	Hand and Wrist - Tendon release (open) more than one, to R537 add	$148.75	$179.17	$30.42	20.5%
R559	Hand and Wrist one - Reconstruction - Tendon - Tendon graft- One	$306.30	$387.82	$81.52	26.6%
E052	Hand and Wrist - Reconstruction - Tendon graft - Each additional add	$259.85	$329.00	$69.15	26.6%
R563	Hand and Wrist/Elbow and Forearm - Reconstruction - Tendons - Transplant/transfer/Transposition/transplantation/transfer- Single	$284.95	$382.63	$97.68	34.3%
E054	Hand and Wrist - Reconstruction - Tendon - Transplant/transfer- Each additional add	$236.10	$317.05	$80.95	34.3%

Committee Comments

- The committee continues to deliberate and will reach out to the constituency, as required.

45.20 Multiple fee codes - Increase to various nerve procedure fee codes (PFAF 25-227)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following nerve procedure fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Nerve procedure fee codes (PFAF 25-227)					
N290	Musculoskeletal - Hand and wrist - Decompression/denervation -Decompression median nerve at wrist/carpal tunnel syndrome/Neurological Surgical Procedures - Peripheral nerves - Carpal tunnel release	$156.75	$200.05	$43.30	27.6%

N285	Musculoskeletal/Neurological Surgical Procedures - Hand and wrist/pelvis and hip/Knee/peripheral nerves - Decompression/denervation - Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding carpal tunnel nerve/- Major nerve - Excluding carpal tunnel or ulnar nerve at elbow/Denervation of gastrocnemius	$256.15	$285.50	$29.35	11.5%
N289	Peripheral Nerves - Nerve suture - Minor - (sensory/cutaneous nerve)	$250.00	$300.00	$50.00	20.0%
N287	Peripheral Nerves - Nerve suture - Major - (mixed sensory and motor nerve, or pure motor nerve)	$500.00	$600.00	$100.00	20.0%
N291	Nerve transfer - major – (mixed sensory and motor nerve, or pure motor nerve)	$727.80	$850.00	$122.20	16.8%
N189	Neurological Surgical Procedures - Peripheral nerves - Nerve Graft - Ulnar nerve transposition at elbow - May include exploration, decompression and/or neurolysis	$279.25	$375.00	$95.75	34.3%
N190	Neurological Surgical Procedures - Peripheral nerves - Nerve Graft - Exploration and/or decompression and/or neurolysis of ulnar	$215.35	$285.50	$70.15	32.6%

Committee Comments

- The committee supports the proposed changes subject to fitting and relativity.

45.21 N282 - Peripheral Nerves - Brachial plexus (excluding thoracic outlet syndrome or cervical rib) (PFAF 25-229)

Constituency Proposal

- The constituency proposed an increase in the N282 fee code value, from $1,000.00 to $1,500.00 (50% increase).
- The constituency stated the exposure of the brachial plexus is a complex surgery that is associated with significant risk of iatrogenic nerve injury (including to the phrenic nerve) as well as pneumothorax. These procedures are often several hours in duration, and patients require extensive post-operative care in their recovery.

Committee Comments

- The committee supports the proposed value change subject to fitting and relativity.
- The committee proposes adding to this code and all peripheral nerve codes a descriptor to ensure they are open procedures.

45.22 R573, R574, R577, R582 - Deletion of select tendon repair/reconstruction fee code (PFAF 25-232)

Constituency Proposal

- The constituency proposed the deletion of the R573, R574, R577, and R582 fee codes.
- The constituency stated the procedures described by these 4 fee codes are adequately covered under other more frequently billed fee codes.
- The constituency stated the R578 fee code will be alternatively billed in replacement of R573.
- The constituency stated the D001 + E569 fees codes will be alternatively billed in replacement of R574.
- The constituency stated the R578 fee code will be alternatively billed in replacement of R577.
- The constituency stated the R578 fee code will be alternatively billed in replacement of R582.

Committee Comments

- The committee continues to deliberate and will reach out to the constituency as required.

45.23 Multiple fee codes - Increase to various skull and mandible fee codes (PFAF 25-242)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following skull and mandible fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Skull and Mandible fee codes (PFAF 25-242)					
E174	Skull and Mandible - Reduction - Fractures - Orbit - Blowout fracture of floor	$667.00	$775.00	$108.00	16.2%
F139	Skull and Mandible - Mandible - Open reduction, per fracture, to include intermaxillary fixation	$575.00	$775.00	$200.00	34.8%
E828	Skull and Mandible - Reduction - Fractures - Rigid Internal fixation, any method, to F139 add	$104.00	$200.00	$96.00	92.3%

Committee Comments

- The committee supports the proposed value changes, subject to fitting and relativity.

45.24 Multiple fee codes - Increase to various breast operation fee codes (PFAF 25-244)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following breast operation fee codes:

Fee Code	Descriptor	2023 Fee Value	Proposed	$ Change	% Change
Operations of the Breast fee codes (PFAF 25-244)					
R156	Operations of the Breast - Repair -- Post-Mastectomy breast reconstruction - Breast mound creation by insertion of tissue expander, includes creation of submuscular pocket	$425.00	$500.00	$75.00	17.6%
R143	Operations of the Breast - Repair - Contralateral balancing mastopexy or reduction to includes nipple transplantation or grafting, if rendered	$472.15	$550.00	$77.85	16.5%
R110	Operations of the Breast - Repair - Reduction mammoplasty and augmentation mammoplasty (other than pos- Mastectomy breast reconstruction) -Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral	$472.15	$550.00	$77.85	16.5%
Z182	Operations of the Breast - Reduction mammoplasty and augmentation mammoplasty (other than postmastectomy breast reconstruction) - Breast capsulectomy	$255.05	$350.00	$94.95	37.2%
Z135	Operations of the Breast - Reduction mammoplasty and augmentation mammoplasty (other than post- Mastectomy breast reconstruction - Open capsulotomy with or without replacement of breast prosthesis	$195.95	$245.00	$49.05	25.0%
R144	Operations of the Breast - Repair - Contralateral balancing augmentation mammoplasty	$350.00	$400.00	$50.00	14.3%

R114	Operations of the Breast - Repair - Post-Mastectomy breast reconstruction - Revision of breast mound	$230.30	$325.00	$94.70	41.1%
R146	Operations of the Breast - Excision - unilateral - Mastectomy male (benign)- for treatment of adolescent gynecomastia, gynecomastia secondary to Endocrine or genetic disorders (e.g. Klinefelter's Syndrome) or chemotherapy - Simple	$177.50	$275.00	$97.50	54.9%
R147	Operations of the Breast - Excision - unilateral - Mastectomy male (benign) - for treatment of adolescent gynecomastia, gynecomastia secondary to Endocrine or genetic disorders (e.g. Klinefelter's Syndrome) or chemotherapy - Subcutaneous with nipple preservation	$273.95	$375.00	$101.05	36.9%
Z740	Operations of the Breast - Incision - Drainage of intramammary abscess or haematoma - Single or multiloculated - General anaesthetic	$133.80	$250.00	$116.20	86.8%
R119	Operations of the Breast - Repair - Post-Mastectomy breast reconstruction - Breast mound creation by prosthesis as sole procedure	$350.00	$500.00	$150.00	42.9%
R118	Operations of the Breast - Repair - Post-Mastectomy breast reconstruction - Breast skin reconstruction by local flaps or grafts, includes Wise pattern skin flaps and de- Epithelialized skin flaps	$405.60	$450.00	$44.40	10.9%

Committee Comments

- The committee awaits feedback from the section regarding the committee's counter proposal for time-based payment for breast surgery

46 Primary Care Mental Health

46.1 Value change to select K-codes (PFAF 23-256)

Constituency Proposal

- The constituency requested a 15.7 per cent across-the-board fee increase to the following psychotherapy and primary care mental health K-codes:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
K004	Psychotherapy - Family - 2 or more family members in attendance at the same time	$76.10	$88.05	$11.95	15.7%
K005	Primary mental health care - Individual care	$70.10	$81.11	$11.01	15.7%
K006	Hypnotherapy - Individual care	$70.10	$81.11	$11.01	15.7%
K007	Psychotherapy - Individual care	$70.10	$81.11	$11.01	15.7%
K012	Psychotherapy - Group - per member - first 12 units per day - 4 people	$17.65	$20.42	$2.77	15.7%
K019	Psychotherapy - Group - per member - first 12 units per day - 2 people	$35.10	$40.61	$5.51	15.7%
K020	Psychotherapy - Group - per member - first 12 units per day - 3 people	$23.35	$27.02	$3.67	15.7%
K024	Psychotherapy - Group - per member - first 12 units per day - 5 people	$14.55	$16.83	$2.28	15.7%
K025	Psychotherapy - Group - per member - first 12 units per day - 6 to 12 people	$12.35	$14.29	$1.94	15.7%
K623	Application for psychiatric assessment	$117.05	$135.43	$18.38	15.7%
K624	Certification of involuntary admission.	$144.15	$166.78	$22.63	15.7%
K629	All other re-certification(s) of involuntary admission including completion of appropriate forms.	$42.70	$49.40	$6.70	15.7%

Committee Comments

- The committee supports a value change to the listed fee codes, subject to fitting and relativity.

46.2 K701 - Mental Health Out-Patient Case Conference (PFAF 21-D101)

Constituency Proposal

- The constituency requested that K701 be revised to include designated GP Psychotherapist.

Committee Comments

- The committee has not been persuaded that GP psychotherapists have a comparable level of training to a psychiatrist in order to qualify for a psychiatric specialty code.
- The committee does not support this proposal.

46.3 Focused Practice Psychotherapy Premium (PFAF 21-D102)

Constituency Proposal

- The constituency proposed that the Focused Practice Psychotherapy premium be increased by 3 percentage points - from 17% to 20%.
- The constituency updated this proposal in 2025 to an increase of 40%.

Committee Comments

- The committee prefers addressing intrasectional relativity through appropriate pricing of fee codes rather than expanding premiums.

- The committee has been working with psychiatry to create patient specific premiums related to higher levels of mental health need. For the next allocation, similar work may be appropriate for family practice psychotherapy.
- The committee does not support this proposal.

47 Public Health Physicians

47.1 Various fee value changes to consultations & assessment fee codes (PFAF 23-298)

Constituency Proposal

- The constituency requested the following increases to select community medicine fees:

Fee Code(s)	Descriptor	Current value	Proposed Value	$ Change	% Change
A/C/W055	Consultation	$125.60	$180.00	$54.40	43.3%
A/C/W050	Special Community Medicine Consultation	$144.75	$207.00	$62.25	43.0%
A/C/W400	Comprehensive CM consultation	$240.55	$300.70	$60.15	25.0%
A/C/W405	Limited consultation	$84.20	$105.25	$21.05	25.0%
A/C053	Medical specific assessment	$79.85	$85.00	$5.15	6.4%
A058	Partial assessment	$38.05	$47.56	$9.51	25%

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity.

48 Primary Care Solo Doctors MIG

48.1 Kxxx - Cancer patient comprehensive care (PFAF 23-251)

Constituency Proposal

- The constituency requested a new time-based fee code Kxxx for comprehensive cancer patient care valued at $70.10 for the first 20 minutes and $35 for each additional 10-minute period.
- No other consultation, assessment, visit, or time-based service is eligible for payment when rendered the same day as Kxxx to the same patient by the same physician.
- This service is intended to be a comprehensive all-inclusive service with a family physician who sees a patient with cancer in the office or in their home. This is intended to include any combination of assessment, counselling, and primary mental health care that might be needed to address the patient's concerns in that visit. As such it parallels the elements that would be included in fibromyalgia care but oriented to a patient with cancer.

Committee Comments

- The committee does not support having additional units paid at $35.00 for each additional 10-minute period as this is not consistent with other time-based K-codes.

- The committee is of the opinion that there are existing codes within the Schedule of Benefits that can be billed for this service and a new fee code is not necessary.
- The committee does not support this proposal.

48.2 Kxxx - Same day urgent follow-up (PFAF 23-253)

Constituency Proposal

- The constituency requested a new fee code Kxxx for same day urgent follow-up valued at $37.95.
- The proposed code is for situations where the physician has assessed the patient in an office or home visit and felt the situation was serious enough that urgent investigations were ordered for that day/ physician requested or expected the results would come back that day. The physician then interpreted those results and contacted the patient the same day to arrange further treatment for that day or the subsequent day.

Committee Comments

- The proposed code is not consistent with the specific elements of assessments found on page GP15, items F-G:

  F. Discussion with, and providing advice and information, including prescribing therapy to the patient or the patient's representative, whether by telephone or otherwise, on matters related to:

  1. the service; and
  2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

  G. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is provided.
- The committee does not support this proposal.

48.3 Axxx - Non-Patient-Facing Care Code (PFAF 21-D104)

Constituency Proposal

- The constituency requested a time-based fee of $48.00 per 15 minutes (1 unit of time) for daily care provided to patients that is not associated with the patient encounter.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and a fundamental change to the specific elements of assessments (GP15). Such a change exceeds the scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

49 Psychiatry

49.1 Gxxx - Repetitive Transcranial Magnetic Stimulation (rTMS) (PFAF 23-258)

Constituency Proposal

- The constituency requested a new fee code Gxxx Repetitive Transcranial Magnetic Stimulation (rTMS) for the treatment of clinical depression and other disorders, paid at $215.00.
- Requires a moderate amount of mental and physical effort over an extended period of time.
- Comparable fee codes are G479 Electroconvulsive therapy (ECT) cerebral, paid at $103.40, and G456 Needle electromyography and nerve conduction studies (EMG), paid at $99.90. However, compared to the above, rTMS requires significantly more monitoring and involvement of the psychiatrist.

Committee Comments

- The committee supports in principle the creation of a rTMS initiation fee for treatment resistant depression (consistent with current practice guidelines) for the work of determining the threshold at the initiation of therapy. This fee code would include any necessary assessment on the day the code is billed.
- The committee proposes the value of the code at $140.00 subject to fitting and relativity.

49.2 Kxxx - Level I modifier

49.3 Kxxx - Level II modifier (PFAF 23-259)

Constituency Proposal

- The constituency requested expanding the system already implemented in OHIP to provide additional "Clinical Care Modifiers" that identify and recognize psychiatric services of higher complexity/intensity/risk.

- The Section proposes expanding this system to include other markers of high complexity/intensity/risk, as follows:

  Kxxx Level I modifiers – 15% premium to psychiatric services rendered
  Kxxx Level II modifiers – 30% premium to psychiatric services rendered

  Modifiers would be provided for psychiatric services identified through the following principles:
  1. Care that is more difficult or intense.
  2. Care that carries higher risk (for either the patient or physician).
  3. Care involving higher degrees of judgement and skill.
  4. 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.

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

49.4 K198, K199, K197, K190 - Psychiatric Care and Psychotherapy (PFAF 23-277)

Constituency Proposal

- The constituency requested a definition revision of psychiatric care/psychotherapy to allow provision of necessary indirect/non-face-to-face clinical services. The following fee codes would be affected by this:
  - K198/K199 – Psychiatric care
  - K197/K190 – Psychotherapy
- The Section proposes modifying the definition of Psychiatric Care/Psychotherapy to allow time providing the clinically related indirect/non-face-to-face services outlined on page A24 to count towards accrual of Psychiatric Care/Psychotherapy time-based units (the Section's proposal is intended to account for indirect time necessary for clinical care, not for administrative issues such as report writing or documentation).

Committee Comments

- Professional fees in the Schedule of Benefits are currently tied to the provision of direct patient care. Indirect patient care and general administration costs that are elements of a service are not eligible for separate fee codes.
- The committee does not support this proposal.

49.5 K701 - Mental health out-patient case conference, per unit (PFAF 23-279)

Constituency Proposal

- The constituency requested a revision of the payment rules for K701 Mental health out-patient case conference, per unit.
- The request is to modify the payment rules of Case Conference Codes to allow conferences to be billed with the participation of 1 other health care provider (rather than 2 other providers, as is currently the case), and to increase the number of allowable services (mental health case conferences) to 12 per year per patient.

Committee Comments

- Across the Schedule of Benefits, a case conference must involve at least three eligible participants. Changing psychiatry case conferences to only two participants sets a precedent which has implications across multiple sections.
- Committee analysis indicates that psychiatrists rarely reach the four (4) case conferences per year limit. Increasing the limit therefore appears to be unnecessary.
- The committee does not support this proposal.

49.6 K300A and K301A - Identifiers for video & telephone claim submissions (PFAF 23-293)

Constituency Proposal

- The Section recommends that the following additional mental health codes be added to the codes which would also qualify for the exemption of the requirement of an in-person visit or video consultation in the preceding 24 months:
    - K005 Primary mental health care – individual care
    - K007 Psychotherapy – individual care
    - K198 Out-patient psychiatric care
    - K199 In-patient psychiatric care
    - K196 Out-patient family psychiatric care
    - K191 In-patient family psychiatric care
    - K197 Individual out-patient psychotherapy
    - K190 Individual in-patient psychotherapy
    - K195 Out-patient family psychotherapy
    - K193 In-patient family psychotherapy

- The Section proposed that Mental Health group codes K208, K209, K203, K204, K205, and K206 should also be sufficient for establishing "existing/ongoing patient-physician relationship" for purposes of comprehensive virtual care, and those codes should be exempt from the requirement of an in-person visit or video consultation in the preceding 24 months.
- The current requirements for a video consult or in-person visit every 24 months to establish an ongoing patient physician relationship are also a barrier to provision of cross-coverage on mental health teams, which is the current standard of care. The above changes would also address this issue.

Committee Comments

- As the changes to virtual care are relatively recent, PPC is not considering further changes at this time. We expect to have better data to support more informed discussion on virtual care changes as time progresses.
- The committee does not support this proposal.

49.7 Axxx - Consultative interview with third party for psychiatric forensic assessment

49.8 Ayyy - Consultative interview with patient for psychiatric forensic assessment (PFAF 25-349)

Constituency Proposal

- The constituency proposed the introduction of two new fee codes. One fee code for consultative interviews with a third party for psychiatric forensic assessment and the other for consultative interviews with patient for psychiatric forensic assessment.
- The constituency proposed the new fee codes should be valued at $237.45 (equivalent to other consultative interview codes: A191, A192, A197, and A198).
- The constituency proposed the new codes should be accompanied with payment rules that are payable as per other similar consultative interview codes (A191, A192, A197, A198) but for psychiatric forensic assessment (rather than child/adolescent or psychogeriatric assessments).
- The constituency stated currently physicians are alternatively billing A195 plus K630 twice (A195 + K630*2) when performing this service.

Committee Comments

- If a forensic psychiatrist is performing a medically necessary service, they should use the codes already in the Schedule.
- The committee does not support the proposal.

49.9 Kxxx - Measurement based care (MBC) psychiatric assessment scales interpretation (PFAF 25-350)

Constituency Proposal

- The constituency proposed the introduction of a new fee code to interpret measurement-based care (MBC) psychiatric scales, valued at $30.05.
- The constituency proposed the new fee code should be accompanied with the following payment rules:
  1. Payable for MBC scales included/allowed for identifying complexity markers.
  2. Maximum billing of once per month per patient per physician.

Committee Comments

- The committee is of the opinion that this work is bundled in consult and assessment codes.
- The committee does not support the proposal.

50 Radiation Oncology

50.1 Multiple fee codes - Increase to various radiation oncology assessment and consultation fee codes (PFAF 25-278)

Constituency Proposal

- The constituency proposed multiple fee value changes to the radiation oncology assessment and consultation fee codes:

Fee code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A345	Radiation Oncology (34) - Consultation	$158.05	$164.90	$6.85	4.3%

A745	Radiation Oncology (34) - Limited consultation	$102.90	$105.25	$2.35	2.3%
A346	Radiation Oncology (34) - Repeat consultation	$102.90	$105.25	$2.35	2.3%
A343	Radiation Oncology (34) - Medical specific assessment	$80.40	$81.55	$1.15	1.4%
A348	Radiation Oncology (34) - Partial assessment	$37.55	$38.05	$0.50	1.3%
C345	Radiation Oncology (34) - Consultation	$158.05	$164.90	$6.85	4.3%
C745	Radiation Oncology (34) - Limited consultation	$102.90	$105.25	$2.35	2.3%
C346	Radiation Oncology (34) - Repeat consultation	$102.90	$105.25	$2.35	2.3%
C343	Radiation Oncology (34) - Medical specific assessment	$80.40	$81.55	$1.15	1.4%

- The constituency stated radiation oncology consult and assessment visit codes have historically paralleled those for internal medicine and proposed that they continue to parallel them.

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity.

50.2 Multiple fee codes - Placement of fiducial markers and Insertion of rectal spacers, (PFAF 25-281)

Constituency Proposal

- The constituency proposed the introduction of following three new fee codes:
  Xxxx1 – Placement of fiducial markers.
  Xxxx2 – Insertion of rectal spacers.
  Xxxx3 – Both placement of fiducial markers and insertion of rectal spacers.

- The constituency stated they submitted a request which was approved by the Ministry of Health for an R990 arrangement. Under this arrangement, radiation oncologists submit claims with a flag for manual review using code R990 which requires submission of the operative report to ensure the below criteria has been met:
  - Physician payment for placement of fiducial markers will be R990 ($122.30).
  - Physician payment for insertion of rectal spacers will be R990 ($223.65).
  - Physician payment for both placement of fiducial markers and insertion of rectal spacers will be R990 ($345.95).
  - For all of these R990 arrangements, the fee includes payment for any imaging or other guidance required.
- The constituency proposed to transition the R990 code agreement to permanent codes to align with initiatives currently undertaken by OH-CCO.

Committee Comments

- The committee supports this proposal, pending drafting of appropriate schedule language.

50.3 Multiple fee codes - Increase to AFP base funding component of various radiation oncology fee codes (PFAF 25-316)

Constituency Proposal

- The constituency proposed a portion of their allocation be applied to their AFP base funding as a normative adjustment and redress/catch-up amount.
- The constituency stated they have a similar funding arrangement through the provincial oncology AFP with a base funding component and a shadow billing component.
- Below is the list of AFP fee codes with the proposed value changes to the base funding component of the codes:

Fee code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
X324	Radiation Oncology - Interstitial application of radium or sealed radioisotope	$223.65	$447.3	$223.65	100.00%
X323	Radiation Oncology - Intracavitary application of radium or sealed sources including dilatation and curettage carried out at the same time as application - first application	$223.65	$447.30	$223.65	100.0%
X334	Radiation Oncology - Intracavitary application of radium or sealed sources including dilatation and curettage carried out at the same time as application - repeat application	$111.90	$223.80	$111.90	100.0%
X322	Radiation Oncology - Treatment planning, dosage calculation and preparation of any special treatment device	$71.30	$142.60	$71.30	100.0%
X325	Radiation Oncology - Application of radium or radioisotope plaque or mould	$69.80	$139.60	$69.80	100.0%
Z296	Fiberoptic Endoscopy of upper airway (nose, hypopharynx or larynx) (IOP) - with flexible endoscope - if only operative procedure performed	$20.10	$35.25	$15.15	75.4%

Committee Comments

- The committee declines to engage in matters which alter AFP contracts.
- Therefore, the committee does not support the proposal to move funds from the fee-for-service allocation to the base AFP allocation.
- The committee continues to deliberate the proposed fee value changes band will reach out to the constituency, as required.

51 Reproductive Biology

51.1 S745 - Oophorectomy - and/or oophorocystectomy (PFAFs 23-218 & 23-221)

Constituency Proposal

- The constituency proposed two revisions to S745:
  1. The addition of laparoscopic ovarian tissue harvesting for the purpose of ovarian tissue cryopreservation to the list of indications for laparoscopic oophorectomy/ ovarian biopsy.
  2. The revision of the code for ovarian surgery to perform ovarian tissue transplantation, which requires similar training and skills to perform other ovarian/ pelvic surgeries.

- This was also requested by the Section on Obstetrics & Gynaecology. Please see Section on Obstetrics & Gynaecology PFAF 23-262 for more information.

Committee Comments

- Such a change exceeds the scope of the PPC. The committee recommends that the constituency direct the request to the Ontario Fertility Program.

51.2 Gxxx - Ovarian tissue processing and cryptopreservation (PFAF 23-226)

51.3 Gxxx - Ovarian tissue thawing and preparation for transplantation (PFAF 23-230)

Constituency Proposal

- The constituency proposed the creation of two new fees for:
  - Ovarian tissue processing and cryptopreservation, valued at $1,000.00.
  - Ovarian tissue thawing and preparation for transplantation, valued at $250.00.
- The procedure is performed by skilled reproductive endocrinologists trained and certified to process ovarian tissue through dedicated professional workshops and clinical training programs.

Committee Comments

- Such a change exceeds the scope of the PPC. The committee recommends that the constituency direct the request to the Ontario Fertility Program.

52 Respiratory Diseases

52.1 G412 - Nephrological component of renal transplantation-1st day following transplantation (PFAF 21-D105)

52.2 G408 - Nephrological component of renal transplantation, 2nd to 10th day, inclusive per diem (PFAF 21-D106)

52.3 G409 - Nephrological component of renal transplantation, 11th to 21st day, inclusive per diem (PFAF 21-D107)

Constituency Proposal

- The constituency requested the addition of "pulmonary component of organ transplantation" to the descriptor of G412, G408, G409 - Nephrological component of renal transplantation as follows:

  # 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:

  3. G412, G408, G409 are not eligible for payment following transplantation of an organ other than the kidney or lung.

  (Revisions underlined, deletions ~~strikethrough~~)

Committee comments

- The committee notes the constituency's choice to withdraw PFAFs 21-D105, 21-D106 and 21-D107

52.4 Kxxx - Multidisciplinary Respiratory Case Conference (PFAF 21-D108)

Constituency Proposal

- The constituency requested a new code Kxxx - Multidisciplinary Respiratory Case Conference, valued at $31.35 per unit per patient per actively participating respirologist.

Committee Comments

- The committee notes the section's request that the language regarding this case conference focus on case conferences related to Interstitial Lung Disease.
- The committee supports this proposal.

52.5 Multiple fee codes - Increase to various respiratory disease consultation fee codes (PFAF 25-194)

Constituency Proposal

- The constituency proposed multiple fee value changes due to the increase in complexity of the following respiratory disease consultation fee codes:

Fee code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A475	Respiratory Disease - Consultation	$175.55	$193.11	$17.56	10.0%
A476	Respiratory Disease - Repeat consultation	$108.95	$119.85	$10.90	10.0%
C475	Respiratory Disease - Non-emergency hospital in-patient services - Consultation	$169.65	$186.62	$16.97	10.0%

A575	Respiratory Disease - Limited consultation	$108.95	$119.85	$10.90	10.0%
A765	Medical Specialist (13, 15, 16, 34, 41, 44, 46, 47, 48, 60, 61, 62) - Consultation, patient 16 years of age and under	$165.50	$182.05	$16.55	10.0%
C476	Respiratory Disease - Non-emergency hospital in-patient services - Repeat consultation	$105.25	$115.78	$10.53	10.0%
C575	Respiratory Disease - Non-emergency hospital in-patient services - Limited consultation	$105.25	$115.80	$10.55	10.0%

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

52.6 Multiple fee codes - Increase to various respiratory disease assessment fee codes (PFAF 25-195 & PFAF 25-196)

Constituency Proposal

- The constituency proposed multiple fee value changes due to the increase in complexity of the following respiratory disease assessment fee codes:

Fee code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A474	Respiratory Disease - Medical specific re-assessment	$65.90	$75.79	$9.89	15.0%
A478	Respiratory Disease - Partial assessment	$39.60	$45.54	$5.94	15.0%
C478	Respiratory Disease - Non-emergency hospital in-patient services - Concurrent care - Per visit	$34.10	$39.22	$5.12	15.0%
C474	Respiratory Disease - Non-emergency hospital in-patient services - Medical specific re-assessment	$63.70	$73.26	$9.56	15.0%
A473	Respiratory Disease - Medical specific assessment	$87.60	$103.37	$15.77	18.0%
A471	Respiratory Disease - Complex medical specific re-assessment	$76.30	$90.03	$13.73	18.0%
A570	Respiratory Disease - Complex Respiratory assessment	$93.00	$109.74	$16.74	18.0%
C570	Respiratory Disease - Non-emergency hospital in-patient services - Complex respiratory assessment	$89.85	$106.02	$16.17	18.0%
C471	Respiratory Disease - Non-emergency hospital in-patient services - Complex medical specific re-assessment	$73.75	$87.03	$13.28	18.0%

C473	Respiratory Disease - Non-emergency hospital in-patient services - Medical specific assessment	$84.65	$99.89	$15.24	18.0%

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

52.7 Multiple fee codes - Increase to various pulmonary function study fee codes (PFAF 25-198)

Constituency Proposal

- The constituency proposed multiple fee value changes due to the increase in interpretation complexity of the following pulmonary function study fee codes:

Fee code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
J304	Pulmonary Function Studies - Flow volume loop - 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	$11.55	$12.94	$1.39	12.0%
J310	Pulmonary Function Studies - Functional residual capacity - Carbon monoxide diffusing capacity by single breath method	$19.40	$21.73	$2.33	12.0%
J307	Pulmonary Function Studies - Functional residual capacity - By body plethysmography	$19.20	$21.50	$2.30	12.0%
J306	Pulmonary Function Studies - Functional residual capacity - Airways resistance by plethysmography or estimated using oesophageal catheter	$17.25	$19.32	$2.07	12.0%
J327	Pulmonary Function Studies - Flow volume loop - Repeat after bronchodilator	$6.90	$7.73	$0.83	12.0%
J333	Pulmonary Function Studies - Oxygen saturation - Non- Specific bronchial provocative test (histamine, methacholine, thermal challenge)	$37.35	$41.83	$4.48	12.0%
J315	Pulmonary Function Studies - Stage I - Graded exercise to maximum tolerance (exercise must include continuous heart rate, oximetry and ventilation at rest and at each workload)	$50.75	$56.84	$6.09	12.0%

J340	Pulmonary Function Studies - Functional residual capacity - maximum inspiratory and expiratory pressures	$3.43	$3.84	$0.41	12.0%
J311	Pulmonary Function Studies - Functional residual capacity - By gas dilution method	$18.90	$21.17	$2.27	12.0%
E451	Pulmonary Function Studies - Stage 1- J315 plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise add	$25.05	$28.06	$3.01	12.0%
E450	Pulmonary Function Studies - Stage 1 - J315 plus J301 or J304 before and/or after exercise add	$8.05	$9.02	$0.97	12.0%
J330	Pulmonary Function Studies - Stage II - Assessment of exercise induced asthma (workload sufficient to achieve heart rate 85% of predicted maximum performance of J301 or J304 before exercise and 5-10 minutes post exercise)	$24.50	$27.44	$2.94	12.0%
J316	Pulmonary Function Studies - Stage II - Repeated steady state graded exercise (must include heart rate, oximetry, ventilation, VO2, VCO2, BP, ECG, end tidal and mixed Venous CO2 at rest, 3 levels of exercise and recovery)	$65.40	$73.25	$7.85	12.0%

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

52.8 Multiple fee codes - Increase to various respiratory disease non-emergency hospital in-patient service subsequent visit fee codes (PFAF 25-199)

Constituency Proposal

- The constituency proposed multiple fee value changes due to the increase in patient management and interpretation complexity of the following subsequent visit fee codes:

Fee code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
C472	Respiratory Disease - Non-emergency hospital in-patient services - Subsequent visits - First five weeks per visit	$34.10	$39.90	$5.80	17.0%
C479	Respiratory Disease - Non-emergency hospital in-patient services - Subsequent visits - After 13th wk. (max. of 6/patient/month) - Per visit	$34.10	$39.90	$5.80	17.0%
C477	Respiratory Disease - Non-emergency hospital in-patient services - Subsequent	$34.10	$39.90	$5.80	17.0%

	visits - 6th-13th wks inclusive (maximum 3 per patient per week) per visit				

Committee Comments

- The committee supports a value change to these fee codes, subject to fitting and relativity.

52.9 J306 - Airways resistance by plethysmography, oscillometry, or estimated using oesophageal catheter (PFAF 25-200)

Constituency Proposal

- The constituency proposed a value change and descriptor revision to the J306 fee code.
- The constituency stated the descriptor revision is to reflect the modern practice and the value change is due to the increase in interpretation complexity. A value change was proposed in PFAF 25-198.
- The constituency proposed the following revision to the J306 fee code descriptor:

  J306 - Airways resistance by plethysmography, oscillometry, or estimated using oesophageal catheter.
  (revisions underlined)

Committee Comments

- The committee does not support adding oscillometry to J306 as this is a simpler technique whose physician work is not equivalent to the current code.

53 Rheumatology

53.1 Consultation, Assessment, and Counselling Fee Value Changes (PFAF 23-025 to 23-029, 23-035, 23-037, 23-117)

Constituency Proposal

- The constituency requested the following consultation and visit fee value changes:

Fee code	Descriptor	Current Value	Proposed Value	Increase	% Increase
A590	Comprehensive rheumatology consultation	$310.45	$319.80	$9.35	3.0%
A485	Consultation	$177.80	$183.10	$5.30	3.0%
A481	Complex medical specific re-assessment	$73.80	$76.00	$2.20	3.0%
A483	Medical specific assessment	$83.10	$85.55	$2.45	2.9%
A484	Medical specific re-assessment	$63.70	$65.60	$1.90	3.0%
A486	Repeat consultation	$109.90	$113.10	$3.20	2.9%

A488	Partial assessment	$39.25	$40.40	$1.15	2.9%
C485	Consultation	$170.10	$183.15	$13.05	7.7%

Committee Comments

- The committee notes the constituency's choice to withdraw this proposal, with the submission of PFAF 25-009.

53.2 Management Fees and Complex Assessment (PFAF 23-040, 23-121)

Constituency Proposal

- The constituency requested the following fee value changes:

Fee code	Descriptor	Current Value	Proposed Value	Increase	% Increase
K481	Rheumatoid arthritis management by a specialist	$75.00	$77.25	$2.25	3.0%
G382	Monthly telephone supervision - Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, monthly	$39.25	$40.40	$1.15	2.9%

Committee Comments

- The committee notes the constituency's choice to withdraw PFAF 23-40 and PFAF 23-121.

53.3 A480 - Complex Rheumatology Assessment (PFAF 23-036)

Constituency Proposal

- The constituency requested the fee value for A480 be increased from $93.75 to $96.55 (3%) and the following payment rules 3 and 4 be deleted:

    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

Committee Comments

- Changes to the limits for complex medical assessments, of which A480 is one, requires consultations across all medical sections which bill complex medical assessments. The PPC therefore does not support this rule change.
- The committee notes the constituency's decision to withdraw this proposal and that the proposed value change is superseded by PFAF 25-009.

53.4 Exxx - Geriatric Age Premium (PFAF 23-125 & 21-D116)

Constituency Proposal

- The constituency requested that a geriatric age premium of 25% be created for all consultations and assessments rendered on patients 65 years of age and older.
- The applicable fee codes include: A486, A590, A595, A486, A483, A484, A481, A488 and A480.

Committee Comments

- The committee lacked evidence that this premium would address intra-sectional relativity.
- The committee does not support this proposal.
- The committee notes the section's choice to withdraw the PFAF 21-D116 proposal.

53.5 Kxxx - Psoriatic arthritis management by a specialist-annual (PFAF 23-123)

Constituency Proposal

- The constituency requested the creation of a new fee code for psoriatic arthritis management valued at $77.25.
- This code would be payable for service rendered by a specialist in Rheumatology who is most responsible for providing ongoing management of a patient with rheumatoid 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.

Committee Comments

- Committee analysis fails to demonstrate that this proposal would address intrasectional relativity.
- The committee does not support this proposal.
- The committee notes the constituency's choice to withdraw this proposal.

53.6 G370 - Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath (PFAF 23-042)

53.7 G371 - Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath - each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5 (PFAF 23-043)

53.8 G328 - Aspiration of bursa or complex joint, with or without injection (PFAF 23-114)

53.9 G329 - Aspiration of bursa or complex joint, with or without injection - each additional bursa or complex joint, to a maximum of 2 (PFAF 23-115)

Constituency Proposal

- The constituency requested that G328 be increased from $20.25 to $20.85 (3 per cent), G371 be increased $19.90 to $20.50 (3 per cent), G328 be increased from $39.80 to $41.00 (3 per cent) and G329 be increased from $20.25 to $41.00 (102 per cent).
- The section proposed deleting payment rules 2 and 3:

    2. Only one of G370, G371, G328 and G329 is eligible for payment for the same bursa, joint or complex joint, and

3. Aspiration and/or injection of the olecranon bursa is only eligible for payment as G370/G371

- The section proposed that this code should apply to all joints. The section requests that the distinction between a complex and non-complex joint be removed.
- As part of the 2025 submission process, the section noted that they are not requesting an increase to these fee codes.

Committee Comments

- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

53.10 Gxxx - Initiating or switching of biologic or small molecule advanced therapeutic (PFAF 23-044)

Constituency Proposal

- The constituency requested the creation of a new fee code for switching of biologic or small molecule advanced therapeutic valued at $125.00.
- The section proposed the following payment rules: "This code would be in addition to the regular A and E codes but would be billed when initiating or switching biologics/JAKs therapies."
- The proposed fee code has the following medical record keeping requirements: "Recording the biologic agent or small molecule selected for treatment. Risks and benefits of the proposed treatment discussed with the patient. Screening for TB completed with chest x-ray, TB skin test and/or QuantiFERON Gold test and results of these tests documented in the patient chart with initial initiation of a new biologic or small molecule (not necessary when switching a biologic or small molecule). When switching a biologic or small molecule, record whether there was an intolerance/ specific adverse event to the therapy being discontinued or a lack of efficacy to the biologic or small molecule."

Committee Comments

- The elements described by the section for this new code are already compensated with existing visit codes, which averages patient encounters that take shorter and longer amounts of time.
- If the codes compensating for these visits are on average inadequate then they could be increased, subject to fitting.
- The committee notes that K900 was created because the work of switching to a biosimilar was not medically necessary. K900 exists outside of the Schedule to compensate for ODB patients to be transferred from original biologics to biosimilars which is uninsured work. K900 is therefore not a valid comparator code to the proposed new code.
- The committee does not support this proposal.
- The committee notes the section's choice to withdraw this proposal.

53.11 Multiple fee codes - Increase to various rheumatology consultation and visit fee codes (PFAF 25-009)

Constituency Proposal

- The constituency proposed multiple fee value changes to improve intra-sectional relativity of the following rheumatology consultation and visit codes:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
A485	Rheumatology (48) - Consultation	$177.80	$204.05	$26.25	14.8%
A481	Rheumatology (48) - Complex medical specific re-assessment	$73.80	$84.70	$10.90	14.8%
A483	Rheumatology (48) - Medical specific assessment	$83.10	$95.35	$12.25	14.7%
A484	Rheumatology (48) - Medical specific re-assessment	$63.70	$73.10	$9.40	14.8%
A480	Rheumatology (48) - Complex rheumatology assessment	$93.75	$115.20	$21.45	22.9%
A488	Rheumatology (48) - Partial assessment	$39.25	$45.05	$5.80	14.8%
K481	Rheumatology (48) - Rheumatoid arthritis management by a specialist	$75.00	$86.05	$11.05	14.7%
A590	Rheumatology (48) - Comprehensive rheumatology consultation	$310.45	$356.25	$45.80	14.8%
A486	Rheumatology (48) - Repeat consultation	$109.90	$126.10	$16.20	14.7%
C485	Rheumatology (48) - Consultation	$170.10	$204.05	$33.95	20.0%
C481	Rheumatology (48) - Complex medical specific re-assessment	$72.65	$83.35	$10.70	14.7%
C483	Rheumatology (48) - Medical specific assessment	$81.70	$93.75	$12.05	14.7%
A595	Rheumatology (48) - Limited consultation	$109.35	$125.50	$16.15	14.8%
C488	Rheumatology (48) - Concurrent care, per visit	$34.10	$39.15	$5.05	14.8%
C480	Rheumatology (48) - Complex rheumatology assessment	$92.20	$113.30	$21.10	22.9%
C590	Rheumatology (48) - Comprehensive rheumatology consultation	$310.45	$356.25	$45.80	14.8%
C486	Rheumatology (48) - Repeat consultation	$109.35	$125.50	$16.15	14.8%
C484	Rheumatology (48) - Complex medical specific re-assessment	$62.60	$71.85	$9.25	14.8%
C595	Rheumatology (48) - Limited consultation	$109.35	$125.50	$16.15	14.8%

Committee Comments

- The committee supports the fee increases subject to fitting and relativity.

53.12 Major Initiative - Differential in visit fees for hospital vs academic centre setting physicians (MI 25-01)

Constituency Proposal

- The constituency stated community specialists are paid the same fees for consultations and assessments as those based in an academic centre. Community specialists must fund all their overhead expenses, whereas those in academic practice may have some or all their overhead expenses funded by a hospital or university.
- The constituency proposed that community specialists be paid higher fees for these services than those who provide them in a hospital outpatient setting to compensate for these overhead costs.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

53.13 Major Initiative - Annual continuity of care retention bonus (MI 25-04)

Constituency Proposal

- The constituency proposed that the PPC should consider implementing a yearly continuity of care retention bonus to be paid to health care providers who provide ongoing longitudinal care to patients seen at least twice yearly for 5 years or more.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

53.14 Major Initiative - Consultations and assessments premium when requiring the use of interpreters (MI 25-05)

Constituency Proposal

- The constituency proposed the introduction of fee code as a premium percentage add on fee for all visits requiring the use of an interpreter, including for patients who are deaf/hearing impaired.
- The constituency stated consultations and assessments requiring the use of interpreters are by their very nature more time consuming as all communication between patient and provider needs to be repeated twice and it leads to worse health outcomes for the patient.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

54 Rural Medicine Forum

54.1 K101, K111, and K112 - Changes to transfer and return trip fee code values (PFAF 25-207)

Constituency Proposal

- The constituency stated the current fee values to transport a patient by ground and air, as well as the return trip from a ground transplant are under remunerated for the work and time the physician needs to provide.
- The constituency proposed the following value changes:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
K101	Assessments - Ground ambulance transfer with patient per quarter hour or part thereof	$42.10	$60.00	$17.90	42.5%
K111	Assessments - Air ambulance transfer with patient per quarter hour or part thereof	$126.40	$60.00	-$66.40	-52.5%
K112	Assessments - Return trip without patient to place of origin following air or ground ambulance transfer, per half hour or major part thereof	$25.05	$100.00	$74.95	299.2%

Committee Comments

- The committee supports the proposed fee value change for K101 and K111.
- To improve schedule language consistency, the committee recommends changing the descriptors for K101, K111, K112 and K001 to, “per quarter hour or major part thereof.”
- The committee supports increasing K112 to the value of K001.
- The committee recommends changing the definition of K112 to “Trip to collect patient or return trip without patient…”

55 Sleep Medicine

55.1 J896, J897, J895, J890, J889, J893, J894 Diagnostic and Therapeutic Sleep Studies Fee Value Changes (PFAF 23-231, PFAF 23-234)

Constituency Proposal

- The constituency requested fee value changes to the following fee codes:

Fee Code	Descriptor	Current	Proposed	% Increase
J896	Initial Diagnostic Study - Level 1	$97.50	$113.49	16.41%
J897	Repeat Diagnostic Study – Level 1	$97.50	$113.49	16.41%
J895	Therapeutic study for sleep related breathing disorders - Level 1	$97.50	$113.49	16.41%

Fee Code	Descriptor	Current	Proposed	% Increase
J890	Specialized facility diagnostic study	$97.50	$113.49	16.41%
J889	Specialized facility therapeutic study	$97.50	$113.49	16.41%
J893	Multiple sleep latency test	$49.90	$58.10	16.43%
J894	Maintenance of wakefulness test	$49.90	$58.10	16.43%

- The constituency notes that pulmonary function codes have increased in the span of the agreement with similar training skill and time required.
- The proposal only has a significant impact on respiratory disease. The section was supportive of the Sleep Medicine members of the MIG that were also members of the respiratory disease section.
- The constituency updated the proposed fee values in 2025 to reflect a 16% increase.

Committee Comments

- Committee analysis indicates that the proposed fee value change will likely worsen intrasectional relativity.
- The committee does not support this proposal.

56 Sports and Exercise Medicine

56.1 A917 - Sports medicine focused practice assessment (PFAF 23-286)

Constituency Proposal

- The constituency requested a value change for A917 Sports medicine focused practice assessment, from $37.95 to $54.00, by 42.3 per cent.
- The constituency would like to delink A917 from A007 and increase the A917 fee to reflect the additional time required to perform the assessment (25 minutes versus 15 minutes).
- The constituency also mentioned they would like to take A917 out-of-basket.

Committee Comments

- The committee does not support delinking focus practice assessments and consultations from equivalent general practice assessments and consultations. The fee value will change according to changes to the linked codes.
- With respect to the proposal to remove A917 from basket, such a change to modify PEM agreements exceeds the scope of the PPC.

56.2 A005 - Consultation (PFAF 23-289)

Constituency Proposal

- The constituency requested a value change for A005 from $87.90 to $118.00, by 34.2 per cent.
- A005 is currently similar in value to A003 (general assessment). The value does not reflect the additional depth of the assessment, nor does it account for the additional year of training possessed by sport and exercise medicine physicians.

Committee Comments

- The committee supports an increase in the value of A005, please see the General and Family Practice Section.
- The committee believes that the workload associated with A005 and A003 are comparable in terms of time and intensity, and the value will change according to changes in the linked codes.
- Therefore, the committee does not support this proposal.

56.3 Kxxx - Sports medicine counselling (PFAF 23-292)

Constituency Proposal

- The constituency requested a new fee code Kxxx for counselling related to sports and exercise medicine, with a proposed value of $70.10 per ½ hour unit and no limit on the number of units that can be billed.
- Currently SEM physicians use K013 to bill for counselling but there is a limit of 3 units that can be billed within a 12-month period. After 3 units, only a K033 code can be billed which is considerably less than the K013 ($70.10 vs. $49.35).

Committee Comments

- The committee is of the opinion that the existing K013 and K033 are the appropriate codes for providing counselling regarding medical diagnosis and therefore does not support this proposal.
- Increasing the number of K013 codes which can be billed annually would require a broad discussion within the profession.
- The committee notes the constituency's choice to withdraw this proposal when they submitted PFAF 25-222.

56.4 Kxxx - Concussion neurocognitive assessment (PFAF 23-295)

Constituency Proposal

- The constituency requested a new fee code Kxxx for Concussion neurocognitive assessment, which includes the administration of the SCAT6 and Child SCAT6 test. The proposed value is $70.10.
- Comparable fee code is K032 Specific neurocognitive assessment, valued at $70.10.

Committee Comments

- The committee does not support the proposal to create a fee code specific to the SCAT6.

56.5 Kxxx - Exercise counselling – Counselling one or more persons, per unit (PFAF 25-222)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for exercise consulting.
- The constituency stated sports & exercise physicians currently bill K013/K033, but the values of these codes do not reflect the additional expertise needed.
- The constituency proposed this new fee code be valued at $80.00, per ½ hour unit.
- The constituency proposes that this fee code would be billable with injections codes with no maximums.

Committee Comments

- The choice to pay differing amounts for counselling, has broad implications across the Schedule of Benefits.
- The committee does not support this proposal.

56.6 Major Initiative - Time modifier add-on fee (MI 25-10)

Constituency Proposal

- The constituency proposed time modifier codes. Once a visit goes over the average allotted time for a given service, one could bill a time modifier for every extra time block.
- The constituency stated Family Medicine benefits from capitation payments as well as additional incentives for managing various health conditions and preventive care. In contrast, sports and exercise medicine follows a fee-for-service structure and does not receive this form of remuneration even with their additional year of training.
- The constituency stated although they are pursuing their own specialty unique codes, they believe this proposal is a better solution for their wage disparity and this proposal would address relativity in other specialties as well.

Committee Comments

- Deliberations on major initiatives are ongoing. The committee will reach out to the constituency, as required. Work on long-term projects is expected to continue following the completion of recommendations for April 1, 2026, implementation.

57 Surgical Assistants MIG

57.1 Special visit premiums (PFAF 23-281)

Constituency Proposal

- The constituency requested the following revisions to the table of special visit premiums for surgical assistant services (see table).
- The underlying rationale for this proposal is to align the payment model for surgical assistants with the models utilized by other physicians providing their services under the same set of circumstances, specifically when providing care during after-hours or at such a time that office hours are sacrificed.

Revision	Fee code	Descriptor	Current	Proposed fee value
Deletion	C988B	SVP - Sacrifice of Office Hours	$76.40	
Deletion	C998B	SVP - Evenings (17:00- 24:00) Monday through Friday	$67.05	
Deletion	C983B	SVP - Sat., Sun. and Holidays (07:00- 24:00)	$85.60	
Deletion	C999B	SVP - Nights (00:00- 07:00)	$117.65	
New code	Cxx1B	SVP - Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours - Travel Premium		$36.40

Revision	Fee code	Descriptor	Current	Proposed fee value
New code	Cxx2B	SVP - Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours - First Person Seen		$40.00
New code	Cxx3B	SVP - Weekdays Daytime (07:00- 17:00) with Sacrifice of Office Hours - Additional Person(s) Seen		$40.00
New code	Cxx4B	SVP - Evenings (17:00- 24:00) Monday through Friday - Travel Premium		$36.40
New code	Cxx5B	SVP - Evenings (17:00- 24:00) Monday through Friday - First Person Seen		$60.00
New code	Cxx6B	SVP - Evenings (17:00- 24:00) Monday through Friday - Additional Person(s) Seen		$60.00
New code	Cxx7B	SVP - Sat., Sun. and Holidays (07:00- 24:00) - Travel Premium		$36.40
New code	Cxx8B	SVP - Sat., Sun. and Holidays (07:00- 24:00) - First Person Seen		$75.00
New code	Cxx9B	SVP - Sat., Sun. and Holidays (07:00- 24:00) - Additional Person(s) Seen		$75.00
New code	Cxx10B	SVP - Nights (00:00- 07:00) - Travel Premium		$36.40
New code	Cxx11B	SVP - Nights (00:00- 07:00) - First Person Seen		$100.00
New code	Cxx12B	SVP - Nights (00:00- 07:00) - Additional Person(s) Seen		$100.00

- The constituency proposed a revision to this proposal as part of the 2025 intake process.
- The constituency notes that it is the *unscheduled nature* of the encounter that triggers the SVP claim, not the specific service provided nor the time during which it is provided.
- The constituency proposed the following four revisions to C998/C983/C999:
  1. Eliminate the requirement to travel;
  2. Apply the SVPs to both the First and Additional persons seen, subject to the maximum limits for each time period;
  3. Increase the maximum number of SVP claims permitted in each time period; and
  4. Increase the fees.

Committee Comments

- The committee is of the opinion that the current model (GP87-GP89) for compensating travel for unscheduled surgical assist is consistent with the payment rules for special visits found on GP65. Changes to the rules on GP65 would have broad implications across the profession. Therefore, the committee does not support that part of this proposal.
- The committee supports increasing the value of C998, C983, and C999 consistent with the constituency's proposal, subject to fitting.

57.2 C988B - Special visit premium to assist at non-elective surgery with sacrifice of office – first patient seen (PFAF 23-281)

Constituency Proposal

- The constituency proposed deleting the payment rule applicable to C988B, which defines eligibility threshold of surgical assistant billings. The payment rule is as follows (page GP88):

"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."

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

57.3 Surgical assistant unit fee (PFAF 23-291)

Constituency Proposal

- The constituency requested that all of their remaining allocation be directed towards increasing the surgical assistant unit fee.

Committee Comments

- The committee supports this proposal, subject to fitting.

57.4 Time units – GP86 (PFAF 23-285)

Constituency Proposal

- The constituency requested that the calculation of triple time units for surgical assistants' services be revised from 3 units after 2.5 hours to 3 units after 1.5 hours.
- Anaesthesia has a similar unit value method of billing, but their time units triple at 1.5 hours - ours triple at 2.5 hours.
- Surgical procedures of longer durations warrant greater compensation for a number of reasons, such as:
    - The general nature of longer surgeries. For example:
        1. The procedures themselves are more difficult.
        2. The patient's characteristics may factor in, such as a higher BMI, the presence of adhesions from prior surgery or radiation and age with the concomitant increased fragility of tissues.
        3. There is a greater risk for complications.
        4. Greater training, skills and experience are required to assist with these more complex procedures.
    - Impact of longer procedures on the physicians (assistants, surgeons and anaesthesiologists). For example:
        1. Greater vigilance is required.
        2. Longer procedures are more physically challenging.
        3. The stresses from these longer procedures coupled with reduced pay can also contribute to physician burnout.
        4. There are no extra codes to account for the increased complexity and stress of longer procedures.

Committee Comments

- The committee supports this proposal, subject to fitting.

57.5 S738B, S758B, S745B, S757B, P018B, S816B, R110B (PFAF 23-287)

Constituency Proposal

- The constituency requested a value change from 6 to 8 base units for the following codes (see table).
- These codes were selected to address the gender pay gap and the share of female surgical assistants in billing is greater than 50%.

Fee Code	Current Basic Units	Proposed Basic Units	Increase in Basic Units	% Increase
P018B	6	8	2	33%
P041B	6	8	2	33%
P042B	8	10	2	25%
R045B	6	8	2	33%
R046B	6	8	2	33%
R047B	6	8	2	33%
R072B	6	8	2	33%
R073B	6	8	2	33%
R074B	6	8	2	33%
R075B	6	8	2	33%
R076B	6	8	2	33%
R081B	6	8	2	33%
R110B	6	8	2	33%
R114B	6	8	2	33%
R118B	6	8	2	33%
R120B	6	8	2	33%
R143B	6	8	2	33%
R156B	6	8	2	33%
S318B	6	8	2	33%
S710B	6	8	2	33%
S716B	6	8	2	33%
S717B	6	8	2	33%
S718B	6	8	2	33%
S719B	6	8	2	33%
S720B	6	8	2	33%
S722B	6	8	2	33%
S727B	8	10	2	25%
S738B	6	8	2	33%
S741B	6	8	2	33%
S743B	8	10	2	25%
S745B	6	8	2	33%
S747B	6	8	2	33%

S757B	6	8	2	33%
S758B	6	8	2	33%
S759B	6	8	2	33%
S761B	7	9	2	29%
S763B	8	10	2	25%
S764B	6	8	2	33%
S782B	6	8	2	33%
S784B	6	8	2	33%
S812B	6	8	2	33%
S815B	6	8	2	33%
S816B	6	8	2	33%
Z182B	6	8	2	33%
Z427B	6	8	2	33%
Z552B	6	8	2	33%
Z553B	6	8	2	33%
Z737B	6	8	2	33%

Committee Comments

- The committee supports increasing the assist base units to 7 for a portion of the proposed codes (as well as related codes).
- The committee continues to deliberate the list of codes and will reach out to the constituency as required.

57.6 S757B - Hysterectomy - with or without adnexa (unless otherwise specified) - abdominal - total or subtotal (PFAF 23-288)

Constituency Proposal

- The constituency requested that S757 be added to the table of services where a second assistant's services are payable, and authorization is not required (GP 90).
- Using a second assistant facilitates the uneventful and successful performance of the procedure and reduces the duration of the surgery. In short, it is better for patient care.
- Consulted with the Section on Obstetrics and Gynaecology.

Committee Comments

- The committee supports the proposal, subject to fitting.

57.7 R852 & R885 - Insertion and removal of peritoneal cannula by laparotomy or laparoscopy (PFAF 25-258)

Constituency Proposal

- The constituency proposed the R852 and R885 fee codes should have 6 basic units for assistants (equivalent to the current anaesthesiologist units).

- The constituency stated, these procedures require the surgeon to use both hands, relying on the assistant to expose the operative site. In the case of a laparoscopy the assistant must hold the scope and keep it trained on the areas of interest.
- The constituency stated S310 and S315 are easier to perform since they don't require tunnelling the catheter and these two fee codes have 6 basic units for the assistant.

Committee Comments

- The committee supports the proposal, subject to fitting.

57.8 Cxx2A - Cancelled surgery prior to induction of anaesthesia (PFAF 25-271)

Constituency Proposal

- The constituency proposed a value change and revision to the payment rules of subsequent hospital visits when claimed for cancelled surgery prior to induction of anaesthesia.
- The constituency stated this fee code is intended to compensate for the assistant's commitment of time and their opportunity cost.
- The constituency stated currently physicians are compensated either $31.00, $31.60, or $24.10 depending upon the specialty of the assistant submitting the claim. The constituency proposed a value increase to $125.00.
- The constituency proposed introducing this fee code as a B-suffix code in order to insulate it from other specialties.
- The constituency proposed the following payment rule revisions and commentary:

  Payment Rules:
  - When an operation is cancelled prior to commencement of anaesthesia, the service is payable as ExxxB. ~~If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.~~
  - When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the assistant has scrubbed but is not required to do anything further, the service is payable as E006B with the actual number of time units added to 6 basic units for this service.

  Commentary:
  - If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee listed at the start of this section.
  - ExxxB is payable with After-hours Premiums and Special Visit Premiums.
  - In procedures where two assistants are permitted, both may claim ExxxB.

  (revisions underlined, deletions ~~strikethrough~~)

Committee Comments

- The committee notes that the effect of this proposal would be to take the surgical assist out of relativity with the surgeon and anesthetist.
- The committee does not support this proposal.

57.9 E401B - After hours premiums nights (PFAF 25-284)

Constituency Proposal

- The constituency proposed a value change to the E401B after hours nights premium fee code.
- The constituency proposed the fee code to increase from an additional 75% payment of the base code to 125%.
- The constituency noted this is their first step in addressing the negative effects that sleep deprivation has on patient care and physician well-being, and particularly how it contributes to physician burnout.

Committee Comments

- The committee notes that the surgical assist premium matches the surgeon's and anesthetist's premiums.
- This proposal would take the surgical assist premium out of relativity with the surgeon's and anesthetist's premiums.
- The committee does not support this proposal.

57.10 Preamble - Eligible second assistant codes (PFAF 25-292)

Constituency Proposal

- The constituency proposed to add the following codes to the list of eligible second assistant codes:
    - F135 - Pelvis and Hip - Fractures - Pelvic ring - open reduction
    - D046 - Pelvis and Hip - Dislocations - Acetabulum - open reduction - one pillar
    - D047 - Pelvis and Hip - Dislocations - Acetabulum - open reduction - two pillars
    - D043 - Pelvis and Hip - Dislocations - Hip - open reduction
    - D052 - Pelvis and Hip - Dislocations - Acetabulum – lips
    - D060 - Pelvis and Hip - Dislocations - Sacro-iliac - open reduction
- The constituency stated the complexity of these injuries requires a second assistant to repair them safely.

Committee Comments

- The committee notes that the constituency indicated that this was not a priority and that the constituency's PFAFs significantly exceed its available funding.
- The committee does not support this proposal as it does not fit within allocation.

57.11 E676B - Eligible fee codes for morbidly obese patient surgical assistant premium (PFAF 25-327)

Constituency Proposal

- The constituency proposed to add the following codes to the list of fee codes eligible with the E676 premium on page SP6:

  General Surgery fee codes:
    - E807 Multivisceral transplant – recipient, with evisceration, to S197
    - S174 Ileostomy – Two-surgeon team – perineal

- S201 Small bowel transplant – donor
- S202 Small bowel transplant – recipient
- S216 Protectomy – Two surgeon team – perineal surgeon
- S226 Repair -Rectal prolapse – perineal repair – major
- S231 Rectum – Closure of fistula – rectovaginal (any repair)
- S283 Biliary Tract – Cholecystoenterostomy
- S330 Repair - Inguinal and/or femoral – Strangulated or incarcerated – with resection of bowel
- S525 Rectum – Closure of fistula – rectovesical

Orthopaedic Surgery fee codes:

- R244 Knee – Arthroplasty – Revision total arthroplasty knee
- R248 Knee – Arthroplasty – Total knee replacement with take down of fusion
- R441 Knee – Arthroplasty – Total replacement / both compartments
- R442 Knee – Arthroplasty – Replacement Liner
- R483 Knee – Hemiarthroplasty – double component (e.g. Mamar)
- R496 Knee – Arthroplasty - Removal of hemiarthroplasty – without replacement
- R497 Knee – Arthroplasty - Removal of total arthroplasty – without replacement
- R249 Pelvis and Hip – Incision and Drainage -Sequestrectomy
- R315 Pelvis and Hip – Excision – Head and Neck, femur
- R328 Pelvis and Hip – Reconstruction – Pseudoarthrosis – Hip
- R415 Pelvis and Hip – Arthrotomy – Hip – with removal of loose body
- R415 Pelvis and Hip – Incision and Drainage – Joint
- R415 Pelvis and Hip – Biopsy – Joint - open
- R570 Pelvis and Hip – Reconstruction – Tendon transfer – Iliopsoas
- Z214 Pelvis and Hip – Biopsy – Bone – open

Otolaryngology Head and Neck Surgery fee codes:

- M103 Segmental resection of trachea with either sternotomy or thoracotomy
- S043 Parotid gland – total (with preservation of facial nerve)
- S044 Parotid gland - total (without preservation of facial nerve)
- S045 Parotid gland – subtotal (with preservation of facial nerve)
- S047 Parotid gland – repeat subtotal (with preservation of facial nerve)
- S068 Pharyngo-laryngectomy
- S796 Exploration and/or removal, parathyroids or parathyroid tumour – if requiring splitting of sternum
- Z325 Emergency tracheotomy
- Z741 Tracheotomy

Urology Surgery fee codes:

- E763 Donor nephrectomy – live donor
- S401 Drainage of kidney abscess
- S400 Laparoscopic placement of probe(s) for ablation of renal tumour
- S429 Ruptured or lacerated kidney – repair or removal
- S562 Reimplantation of ureter
- S459 Ureterostomy – Ureterovaginal fistula
- S484 Complete cystectomy without transplant
- S485 Complete cystectomy with ureterointestinal transplant

- S524 Bladder – Closure of fistula – transvesical approach (with or without omental flap)
- S525 Bladder – Closure of fistula – Vesicorectal or vesicosigmoid
- S645 Prostatectomy – Perineal
- S646 Prostatectomy – Perineal with vesiculectomy

Committee Comments

- Committee data analysis fails to demonstrate an increase in time associated with an increased BMI for the procedures listed in this proposal. Therefore, there is no justification to add this to the E676 list for surgeons.
- The committee does not support creating a separate E676 list for surgical assistants, separate from the current list.
- The committee does not support this proposal.

58 Urology

58.1 Consultation and assessment fees (PFAF 23-280)

Constituency Proposal

- The constituency proposed a minimum increase of 5% to each of the following consultation & visit codes, or an evenly distributed percentage increase based on available funds:

Fee code	Descriptor	Current value	Proposed value	$ Increase	% Increase
A/C/W355	Consultation	$84.70	$88.95	$4.25	5.0%
A/C/W356	Repeat consultation	$59.00	$61.95	$2.95	5.0%
A/C353	Specific assessment	$46.80	$49.15	$2.35	5.0%
A354	Partial assessment	$27.80	$29.20	$1.40	5.0%
C354	Specific re-assessment	$26.70	$28.05	$1.35	5.1%
C352	Subsequent visits - first five weeks	$31.60	$33.20	$1.60	5.1%

Committee Comments

- The committee supports the fee value changes, subject to fitting; except:
  - C352 - Given the potential change in pre- and post-operative care related to unbundling, the committee does not support a change in value to C352 at this time.

58.2 Z606 - Endoscopy - Cystoscopy - diagnostic with or without urethroscopy (PFAF 23-280)

Constituency Proposal

- The constituency proposed a minimum 5% increase to Z606, or an evenly distributed percentage increase based on available funds.

Committee Comments

- The committee supports a fee value change, subject to fitting and relativity.

58.3 Slit of prepuce codes S567, S568, S569 (PFAF 23-280)

Constituency Proposal

- The constituency proposed that the 'slit of prepuce' codes (S567, S568, S569) be changed from S codes to Z codes.
- This is to help with Schedule modernization.

Committee Comments

- The committee notes that this proposal was withdrawn by the constituency when they submitted PFAF 25-324.

58.4 Zxxx – Reduction of paraphimosis or phimosis to include incision of foreskin as necessary (PFAF 25-132)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for the reduction of paraphimosis or phimosis to include incision of foreskin as necessary.
- The constituency proposed the new fee code to be valued at $40.00.
- The constituency proposed the following descriptor for the new fee code:

  Zxxx - For use in emergent situations in cases of phimosis and paraphimosis.

- The new fee code cannot be billed with any other procedure, e.g. circumcision (S573, S577).
- The constituency stated reduction of phimosis and paraphimosis in emergency situations is a technically complex and time-sensitive procedure that requires specialized urological expertise. Given the skill, risk, and urgency involved, introducing a dedicated fee code is justified to ensure appropriate remuneration.

Committee Comments

- With the committee's decision to modify and not delete S567, S568, and S569, the committee believes this proposal is no longer required.
- The committee does not support this proposal.

58.5 Zxxx – Proximal cavernous shunt for management of priapism (PFAF 25-134)

Constituency Proposal

- The constituency proposed the introduction of a new fee code a proximal cavernous shunt.
- The constituency proposed the new fee code be valued at $500.00.
- The constituency proposed the following descriptor and payment rules for the new fee code:

  Zxxx - A proximal cavernoso-spongiosal or other venous shunt for relief of priapism.
  - Cystoscopy to rule out urethral injury may be paid in addition at 100%.
  - Include assist and anesthesia units.

- The constituency stated there currently is no fee code that accurately captures this rare but important surgical procedure.

Committee Comments

- The committee supports this proposal to be instead created an 'S' code.

58.6 S535 & S553 – Increase the value of urethra rupture and repair fee codes (PFAF 25-168 and 25-169)

Constituency Proposal

- The constituency proposed an increase in value to the S535 and S553 fee codes.
- The constituency proposed the increase in value of the S535 fee code, from $618.25 to $950.00 (53.7%).
- The constituency proposed the increase in value of the S553 fee code, from $643.35 to $1,125.00 (74.9%).
- The constituency stated the proposed value increases to the S535 and S553 fee codes will help incentivize curative surgery for patients, and to recognize the operative time, surgical complexity, and extra training that is associated with providing this procedure.

Committee Comments

- For S535, the committee supports the proposed value change, subject to fitting and relativity.
- For S553, the committee supports the proposed value change, subject to fitting and relativity.
- The committee notes that this PFAF supersedes the fee value increase proposed in PFAF 25-333.

58.7 S551 & S552 – Deletion of urethra rupture and repair fee codes (PFAF 25-170)

Constituency Proposal

- The constituency proposed the deletion of the S551 and S552 fee codes.
- The constituency stated for the S551 fee code there are no clinically relevant scenario to bill the code and the code that is not billed frequently.
- The constituency also stated for the S552 fee code patients with posterior urethral injuries are often multi-trauma victims with pelvic fractures. Also, there is no indication to perform an immediate repair, and doing so is associated with worse outcomes.

Committee Comments

- The committee supports the deletion of S552.
- The committee continues to deliberate on the deletion of S551 and awaits feedback from the constituency.
- The committee notes that this PFAF supersedes the fee value increase proposed in PFAF 25-333.

58.8 Zxxx & Exxx – Priapism Emergency Management (PFAF 25-172)

Constituency Proposal

- The constituency proposed the introduction of two new fee codes for priapism emergency management.
- The constituency notes that there is no surgical code for this well-defined procedure, so physicians currently bill a consult fee.
- The constituency proposed the following two fee code descriptors, values, and payment rules:

  Zxxx - Includes aspiration and irrigation of the corporal bodies and vasoactive injections into the corporal body ($200.00)

  Exxx - Distal corpora-glandular shunt ($50.00)

  Payment Rules:
  1. Paid at 100% if the entire procedure is completed on the same day.
  2. Can be billed a maximum for 2 times per day.
  3. Will need to include assist and anaesthesia units.
  4. Cystoscopy to rule out urethral injury may be paid in addition at 100%.

Committee Comments

- The committee supports creating the proposed code as a procedural fee code, which would require all three elements (i.e., aspiration and irrigation of the corporal bodies and vasoactive injections into the corporal body) with or without distal corpora-glandular shunt.
- The committee would set the value of the code at $250 and not create the proposed E-code.
- The committee does not support an assist code for this procedure.

58.9 Zxxx – Laser enucleation of prostate (e.g. ThuLEP, HoLEP) (PFAF 25-175)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for laser enucleation of the prostate.
- The constituency proposed the new fee code be valued at $650.00.
- The constituency stated the $650.00 proposed value is proportionate to the more time, risk, complexity, and intensity than a standard TURP or existing laser resection code in the Schedule of Benefits.
- The constituency proposed the following descriptor and payment rules with the new fee code:

  Zxxx - Laser enucleation of the prostate (e.g. ThuLEP, HoLEP) including morcellation of prostatic tissue.

  Payment rules:
  1. Not intended for photoselective vaporization (PVP) / KTP (“green light”) or similar procedures.
  2. Not to be claimed in addition to any cystoscopy (Zxxx), urethral dilation (Zxxx), or vasectomy (Sxxx) fee code if performed during the same operative session.
- The constituency proposed the following indications with the new fee code:
  - Bladder outlet obstruction is secondary to benign prostatic hypertrophy (BPH).
  - Prostate volume > 60 grams.

- The constituency stated the new fee code will replace around 5% of simple prostatectomy procedures for patients that meet the proposed criteria.

Committee Comments

- The committee continues to deliberate on this proposal and will reach out to the constituency as required.

58.10 Zxxx – Repair of penile fracture or traumatic laceration of cavernous tissue. (PFAF 25-177)

Constituency Proposal

- The constituency proposed the introduction of a new fee code for the surgical correction of a traumatic rupture of the tunica albuginea of the penis, which may also include repair of traumatic lacerations of the corpus cavernosum.
- The constituency proposed the new fee code to be valued $750.00 with the following payment rules:
    1. Restricted to only Urologists.
    2. Surgeons may bill for a consultation and applicable visit premiums as per standard rules.
    3. Any diagnostic cystoscopy done to rule out urethral involvement is separately billable at 100%.
    4. The procedure note must document the nature of the injury (e.g., rupture of the tunica albuginea, corpus cavernosum tear) and the surgical steps taken to repair it.
- The constituency stated the proposed value of the new fee code was made to reflect the level of technical skill/anatomical knowledge, risk/stress, and operative time associated with this procedure.

Committee Comments

- The committee supports this proposal, to be created as an 'S' code.
- The committee proposes to set the value of the fee code at $650.

58.11 Z610 & Gxxx – Intravesical instillation and intravesical instillation management of BCG or immunotherapeutic agent or chemotherapeutic agent for the treatment of bladder (PFAF 25-178)

Constituency Proposal

- The constituency proposed a revision to the Z610 fee code payment rules and proposed the introduction of a new fee code for intravesical instillation management of BCG, immunotherapeutic agent, or chemotherapeutic agent for the treatment of bladder.
- The constituency proposed the following revision to the Z610 fee code's payment rules:

    - ~~This service is only eligible for payment when the service, including the catheterization and preparation and disposal of the agents, is rendered personally by the physician.~~
    - Z602, Z603 or Z611 is not eligible for payment in addition to Z610.

    (deletions ~~strikethrough~~)

- The constituency proposed the value of the new fee code to be $25.65 (in line with Z610).
- The constituency proposed the following payment rules:
    1. The physician is responsible for supervising the treatment and must be immediately available for the 24-hour period after administration.
    2. The actual instillation may be delegated to a nurse or other regulated health professional, provided the physician remains responsible for the patient's management and is available to address complications.
    3. Clinical documentation should reflect:
        - The agent(s) used (e.g., BCG, mitomycin, etc.).
        - The date and time of initiation.
        - Confirmation of patient instructions and any follow-up or interventions within the 24-hour post-instillation period.
- The constituency stated the proposed revision to the Z610 fee code's payment rules enables delegation of the actual instillation to a qualified nurse or other health professional while ensuring physician oversight and timely intervention if complications arise.
- The constituency stated the proposed payment model will be closer to chemotherapy supervision (e.g. G388).

Committee Comments

- The committee does not support the proposed rule change for Z610 as the committee believes this is not a procedure commonly delegated to employees of the physician.
- The committee believes that care after bladder instillation is appropriately compensated through existing consultations and assessments.

58.12 S650 – Prostatectomy – Retropubic - with or without removal of bladder stones (PFAF 25-233)

58.13 S647 – Deletion of Prostatectomy - Suprapubic - with or without removal of bladder stones (PFAF 25-336)

Constituency Proposal

- The constituency proposed a revision to the S650 fee code descriptor and an increase to the fee code value.
- The constituency proposed the S650 fee code value to increase, from $643.35 to $688.40 (6.8%).
- The constituency proposed the following revision to the S650 fee code's descriptor:

    S650 - Prostatectomy – ~~Retropubic – with or without removal of bladder stones~~ – simple.
    (deletions ~~strikethrough~~)

- The constituency stated that the proposed revision to the fee code's descriptor will encompass all simple prostatectomies. S647 (PFAF 25-336) has been proposed to be deleted and replaced with the revised S650 fee code.
- The constituency stated the proposed value increase to S650 was made to offset the deletion of S647.

Committee Comments

- The committee supports these proposals in principle.
- The committee has shared draft language on these changes with the constituency and awaits feedback.

58.14 Exxx – Transperineal prostate biopsy, needle (PFAF 25-250)

58.15 S644 – Deletion of Prostate -Biopsy, perineal, open operation fee code (PFAF 25-325)

- The constituency proposed the introduction of a new E-addon modifier fee code for a transperineal prostate biopsy where unlike the traditional biopsies the biopsy needles are introduced through the perineum rather than the rectum under ultrasound guidance.
- The constituency proposed the new fee code be valued at $20.00, with the following descriptor and payment rules:

  Exxx - Needle biopsy of prostate via transperineal method.
  - Fee code must be billed in conjunction with Z712 (Prostate Biopsy, Needle) to accurately reflect the transperineal approach.

- The constituency proposed the deletion of the S644 fee code and stated the proposed new fee code will replace all S644 billings.
- The constituency stated replacing S644 with the new add-on code for Z712 (Needle Prostate Biopsy) acknowledges that while transperineal biopsy remains more labour-intensive and technically demanding than the transrectal approach, it is far less invasive than open surgery.

Committee Comments

- The committee supports these proposals.

58.16 E791 – Endoscopy - Cystoscopy - with periurethral injection of bulking agents, add (PFAF 25-251)

Constituency Proposal

- The constituency proposed a revision to the E791 fee code payment rules and an increase to the fee code value.
- The constituency proposed the value of E791 to increase, from $26.00 to $50.00 (92.3%).
- The constituency stated increasing reimbursement for urethral bulking injections better reflects the technical skill and expertise required for this procedure, which is a key treatment for female stress urinary incontinence (SUI).
- The constituency also proposed the following new payment rules for the E791 fee code:

  - Cannot be billed with any other procedure code other than Z606.
  - Can only be billed once every 16 weeks.

Committee Comments

- The committee supports the proposed descriptor and fee value change, subject to fitting and relativity.

58.17 S651 – Prostatectomy – Retropubic - with or without removal of bladder stones – radical (PFAF 25-291)

58.18 S653 – Deletion of Prostatectomy - Laparoscopic radical prostatectomy fee code (PFAF 25-329)

Constituency Proposal

- The constituency proposed a revision to the S651 fee code descriptor and an increase to the fee code value.
- The constituency proposed the S651 fee code value to increase, from $1,008.35 to $1,170.00 (16.0%).
- The constituency proposed the following revision to the S651 fee code's descriptor:

  S651 - Radical Prostatectomy ~~– Retropubic – with or without removal of bladder stones – radical~~.

  (revisions underlined, deletions ~~strikethrough~~)

- The constituency stated that the proposed revision to the fee code's descriptor will encompass all radical prostatectomies. Laparoscopic cases will be identified by the E792 fee code.
- The following fee codes have been proposed to be deleted and replaced with the revised S651 fee code and E792:
  - S653 (PFAF 25-329)
- The constituency stated cases previously billed as S653 will now be billed as S651+E792. The total number of radical prostatectomies will remain constant.

Committee Comments

- The committee supports these proposals in principle.
- The committee has shared draft language on these changes with the constituency and awaits feedback.

58.19 S416 – Nephrectomy - thoraco-abdominal or radical nephrectomy (PFAF 25-295)

Constituency Proposal

- The constituency proposed a revision to the S416 fee code descriptor and an increase to the fee code value.
- The constituency proposed the S416 fee code value to increase, from $907.00 to $970.50 (7.0%).
- The constituency proposed the following revision to the S416 fee code's descriptor:

S416 - Nephrectomy ~~- thoraco-abdominal or radical nephrectomy~~.

(deletions ~~strikethrough)~~

- The constituency stated their proposed revision to the fee code descriptor is to simplify the Schedule of Benefits so that S416 is the only nephrectomy fee code.
- The constituency also stated that partial nephrectomy, nephro ureterectomy and donor nephrectomy would remain as they represent unique procedures.

Committee Comments

- The committee supports this proposal.

58.20 Multiple fee codes – Introduction of various hypospadias repair fee codes (PFAF 25-296)

Constituency Proposal

- The constituency proposed the following multiple fee code introductions for various hypospadias repairs:

Fee code	Descriptor	Proposed fee value
Distal Hypospadias – Single-Stage Repair (PFAF 25-296)		
Sxxx	1-stage distal hypospadias repair	TBD
Exxx	Flap; island pedicle	TBD
Exxx	Adjacent tissue transfer or rearrangement (e.g., Byar's flap)	TBD
Exxx	Full thickness graft, free (e.g., buccal or skin graft)	TBD
Exxx	Scrotoplasty	TBD
Exxx	Chordee Repair: curvature correction, such as plication, corporotomy, plus graft or flap coverage and additional tissue (i.e. dartos) flap coverage to the layers if appropriate	
Mid-Shaft Hypospadias – Single-Stage Repair (PFAF 25-296)		
Sxxx	1-stage mid-shaft hypospadias repair	TBD
Exxx	Flap; island pedicle	TBD
Exxx	Full thickness graft, free (e.g., buccal or skin graft)	TBD
Exxx	Adjacent tissue transfer or rearrangement (e.g., Byar's flap)	TBD
Exxx	Scrotoplasty	TBD
Exxx	Chordee Repair: curvature correction, such as plication, corporotomy, plus graft or flap coverage and additional tissue (i.e. dartos) flap coverage to the layers if appropriate	
Proximal Hypospadias – Single-Stage Repair (PFAF 25-296)		

Sxxx	One-stage proximal penile or penoscrotal hypospadias repair (urethroplasty by skin graft tube and/or island flap)	TBD
Exxx	Adjacent tissue transfer or rearrangement (e.g., Byar's flap)	TBD
Exxx	Flap; island pedicle	TBD
Exxx	Full thickness graft, free (e.g., buccal or skin graft)	TBD
Exxx	Scrotoplasty	TBD
Exxx	Chordee Repair: curvature correction, such as plication, corporotomy, plus graft or flap coverage and additional tissue (i.e. dartos) flap coverage to the layers if appropriate	
Multi-Stage Hypospadias Repairs		
Proximal – First Stage (PFAF 25-296)		
Sxxx	Plastic operation on penis for first-stage hypospadias repair (with or without transplantation of prepuce/skin flaps)	TBD
Exxx	Adjacent tissue transfer or rearrangement (e.g., Byar's flap)	TBD
Exxx	Split-thickness autograft (genitalia)	TBD
Exxx	Full thickness graft, free (e.g., buccal or skin or skin graft)	TBD
Exxx	Flap; island pedicle	TBD
Exxx	Tissue graft harvest (dermal graft)	TBD
Exxx	Scrotoplasty	TBD
Exxx	Chordee Repair: curvature correction, such as plication, corporotomy, plus graft or flap coverage and additional tissue (i.e. dartos) flap coverage to the layers if appropriate	
Proximal – Subsequent Stage (PFAF 25-296)		
Sxxx	Urethroplasty for subsequent stage hypospadias repair	TBD
Exxx	Adjacent tissue transfer or rearrangement (e.g., Byar's flap)	TBD
Exxx	Split-thickness autograft (genitalia)	TBD
Exxx	Full thickness graft, free (e.g., buccal or skin or skin graft)	TBD
Exxx	Flap; island pedicle	TBD
Exxx	Tissue graft harvest (dermal graft)	TBD
Exxx	Scrotoplasty	TBD
Exxx	Chordee Repair: curvature correction, such as plication, corporotomy, plus graft or flap coverage and additional tissue (i.e. dartos) flap coverage to the layers if appropriate	

- The constituency stated the existing fee codes are outdated and do not capture the increasing high complexity, delicate nature, and increasing specialized approach required for modern hypospadias repair, especially for multi-stage proximal or penoscrotal variants.

Committee Comments

- The committee recommends hypospadias repair, be converted to a time-based surgical fee code, rather than creating numerous add-on fee codes.
- The committee notes the constituency's support for this approach and will reach out to the constituency, as required.

58.21 S401 – Drainage of kidney abscess (PFAF 25-299)

58.22 S402 – Deletion of drainage of perinephric abscess fee code (PFAF 25-303)

Constituency Proposal

- The constituency proposed a revision to the S401 fee code descriptor and an increase to the fee code value.
- The constituency proposed an increase to the S401 fee code value, from $411.30 to $440.10 (7.0%).
- The constituency proposed the following revision to the S401 fee code's descriptor:

  S401 - Surgical drainage of ~~kidney~~ renal or perirenal abscess.
  (revisions underlined, deletions ~~strikethrough~~)

- The constituency stated currently there are two similar fee codes, the S402 fee code was proposed for deletion as the new revised S401 fee code will now be billed as replacement.

Committee Comments

- The committee supports these proposals.

58.23 Exxx – Insertion of testicular prosthesis (PFAF 25-328)

Constituency Proposal

- The constituency proposed the introduction of a new modifier fee code for the insertion of testicular prothesis.
- The constituency stated that the insertion of testicular prosthesis currently exists as a code (S596) but is excluded at the time of orchiectomy.
- The constituency proposed the new fee code be valued at $50.00, with the following fee code descriptor and payment rules:

  Exxx - Insertion of Testicular Prosthesis – with insertion of testicular prosthesis at time of orchiectomy (add to S589, S598).
    - Payable up to 2 times (bilateral).

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

58.24 S405 – Nephrolithotomy - open (PFAF 25-330)

58.25 S408 – Deletion of pyelolithotomy - open fee code (PFAF 25-305)

Constituency Proposal

- The constituency proposed an increase to the S405 fee code value and a revision to the fee code's descriptor and payment rules.
- The constituency proposed the S405 fee code value to increase, from $482.40 to $600.00 (24.4%).
- The constituency proposed the following revisions to the S405 fee code's descriptor and payment rules:

  S405 - Nephrolithotomy or Pyelolithotomy – open.
  - The E792 (aparoscopic premium) is applicable.

  (revisions underlined)

- The constituency proposed the deletion of the S408 fee code and stated the revised S405 fee code will replace all S408 billings.

Committee Comments

- The committee supports the deletion of S408 and the revision of the descriptor for S405.
- The committee supports the proposed fee value change, subject to fitting and relativity.
- The committee does not support making the laparoscopic premium applicable given the higher fee value proposed is consistent with intrasectional relativity.
- The committee recommends the descriptor be changed to, "Open or laparoscopic"

58.26 Z611 – Catheterization hospital (PFAF 25-332)

58.27 Z602 & Z603 – Deletion of catheterization home and office fee codes (PFAF 25-323)

Constituency Proposal

- The constituency proposed a revision to the Z611 fee code descriptor and an increase to the fee code value.
- The constituency proposed an increase to the Z611 fee code value, from $8.55 to $9.15 (7.0%).
- The constituency proposed the following revision to the Z611 fee code's descriptor:

  Z611 - Catheterization ~~– Hospital~~

  (deletions ~~strikethrough~~)

- The constituency proposed the deletion of the Z602 and Z603 fee codes. The constituency stated that all Z602 and Z603 billings will be converted to the revised Z611 fee code.
- The constituency stated the proposed value change to Z611 is to offset the deletion of the Z602 and Z603 fee codes.

Committee Comments

- The committee recommends the descriptor for Z611 be changed to say catheterization – hospital or office.
- The committee agrees with the deletion of Z602.
- The committee does not support the deletion of Z603.
- The committee supports the proposed fee value change, subject to fitting and relativity.

58.28 Multiple fee codes – Increase to various fee codes associated with urology (PFAF 25-333)

Constituency Proposal

- The constituency proposed multiple fee value changes to the following urology associated fee codes:
- The constituency stated fee value changes were set at 7% for relativity unless the code was specified as undervalued. Certain increases were proposed to reflect the deletion of other similar codes.

Fee code	Descriptor	Current value	Proposed value	$ Increase	% Increase
Urology – Adrenalectomy fee codes (PFAF 25-333)					
S798	Adrenalectomy or exploration - unilateral	$646.30	$691.54	$45.24	7.0%
S799	Adrenalectomy or exploration - bilateral, with or without oophorectomy	$1,032.70	$1,104.99	$72.29	7.0%
S800	Adrenalectomy - unilateral for pheochromocytoma	$871.80	$932.83	$61.03	7.0%
Urology – Bladder fee codes (PFAF 25-333)					
E750	Bladder - when done in conjunction with another procedure, add	$26.05	$27.87	$1.82	7.0%
S427	Bladder flap (Boari) - to include re-implantation of ureter	$502.45	$700.00	$197.55	39.3%
S476	Bladder - Cutaneous vesicostomy	$437.20	$467.80	$30.60	7.0%
S521	Bladder - Litholapaxy and removal of fragments	$215.80	$230.91	$15.11	7.0%
S522	Bladder - Closure of fistula - External, suprapubic	$260.85	$279.11	$18.26	7.0%
S523	Bladder/Vagina - Closure of fistula - Vesicovaginal/vaginal approach (See Schedule for add'l details)	$791.85	$847.28	$55.43	7.0%

S524	Bladder - Closure of fistula - Vesicovaginal - transvesical approach (with or without omental flap)	$544.40	$582.51	$38.11	7.0%
S525	Rectum/Bladder/Closure of fistula - rectovesical/Vesicorectal or vesicosigmoid (See Schedule for add'l details)	$446.90	$478.18	$31.28	7.0%
S491	Plastic repair of extrophy using bladder and including skin flaps	$657.75	$703.79	$46.04	7.0%
S512	Repair of ruptured bladder	$346.45	$370.70	$24.25	7.0%
S518	Plastic repair of bladder neck - child	$494.90	$529.54	$34.64	7.0%
S519	Plastic repair of bladder neck - adolescent or adult	$437.20	$467.80	$30.60	7.0%
Urology – Circumcision fee codes (PFAF 25-333)					
S573	Circumcision - for physical symptomatology only - for patients aged one year or older	$210.80	$225.56	$14.76	7.0%
S577	Circumcision - for physical symptomatology only - for infants less than one year of age	$188.05	$201.21	$13.16	7.0%
Urology – Condylomata fee codes (PFAF 25-333)					
S599	Condylomata - Excision plaque for Peyronies disease	$286.20	$306.23	$20.03	7.0%
Z701	Condylomata - local anaesthetic	$32.60	$34.88	$2.28	7.0%
Z767	Condylomata - general anaesthetic	$78.60	$84.10	$5.50	7.0%
Urology Cystectomy/Cystolithotomy/Cystosplasty/Cystoscopy/Cystotomy fee codes (PFAF 25-333)					
E819	Cystoscopy and diagnostic Ureteroscopy - diagnostic ureteroscopy of second ureter, to Z628, add	$54.65	$70.00	$15.35	28.1%
E820	Cystoscopy and diagnostic Ureteroscopy – with Biopsy of one or more sites in ureter and/or pelvis using ureteroscope, add	$49.75	$53.25	$3.50	7.0%
E823	Cystoscopy and diagnostic Ureteroscopy - resection and	$233.65	$250.00	$16.35	7.0%

	fulgarization of one or more ureteral or renal pelvic tumours, to Z628, add				
S438	Cystectomy - Complete - Retroperitoneal lymph node dissection for bladder cancer, specimen must include obturator, internal iliac and external iliac nodes as a minimum to the level of the iliac bifurcation, bilateral	$630.00	$674.10	$44.10	7.0%
S440	Cystectomy - Complete - with continent urinary diversion	$1,475.70	$1,579.00	$103.30	7.0%
S441	Cystectomy - Complete - Creation of continent urinary diversion	$1,013.45	$1,084.39	$70.94	7.0%
S453	Cystectomy - Complete - with ureteroileal conduit	$1,250.30	$1,337.82	$87.52	7.0%
S471	Cystectomy - Complete - Excision of urachal cyst or sinus with or without umbilical hernia repair	$296.30	$317.04	$20.74	7.0%
S481	Cystolithotomy - when sole operative procedure	$260.65	$278.90	$18.25	7.0%
S482	Cystectomy - Partial - partial for tumour or diverticulum (single or multiple)	$381.60	$408.31	$26.71	7.0%
S483	Cystectomy - Partial - with reimplantation of ureter	$552.30	$590.96	$38.66	7.0%
S484	Cystectomy - Complete - complete cystectomy, without Transplant	$791.85	$847.28	$55.43	7.0%
S485	Cystectomy - Complete - complete cystectomy, without transplant	$984.65	$1,053.58	$68.93	7.0%
S490	Cystectomy - Partial - with reimplantation of ureters	$733.50	$784.85	$51.35	7.0%
S513	Cystoplasty, using intestine	$692.85	$741.35	$48.50	7.0%
Z480	Cystotomy with trochar and cannula and insertion of tube	$85.30	$91.27	$5.97	7.0%
Z628	Cystoscopy and diagnostic Ureteroscopy - above intramural	$125.70	$160.00	$34.30	27.3%
E751	Endoscopy - Cystoscopy - with insertion of chemotherapeutic agent(s), add	$54.70	$58.53	$3.83	7.0%

E773	Endoscopy - Cystoscopy - with placement of ureteric stent past obstructing lesion (unilateral), add	$49.90	$53.39	$3.49	7.0%
E775	Endoscopy - Cystoscopy - with catheterization of the ureter and collection of theureteral specimen, unilateral, add	$15.35	$16.42	$1.07	7.0%
E776	Endoscopy - Cystoscopy - with unilateral brush Biopsy of renal pelvis and/or ureter, and/or transurethral Biopsy of bladder, add	$24.90	$26.64	$1.74	7.0%
E777	Endoscopy - Cystoscopy - with cystometrogram (to include urethral pressure profile if necessary), add	$11.50	$12.31	$0.81	7.0%
E781	Endoscopy - Cystoscopy - with electrocoagulation - tumour(s), add	$49.90	$53.39	$3.49	7.0%
E782	Endoscopy - Cystoscopy - with electrocoagulation - Hunner ulcer, add	$49.90	$53.39	$3.49	7.0%
E783	Endoscopy - Cystoscopy - with secondary surgical evacuation of bladder clots and control of haemorrhage, add	$99.65	$106.63	$6.98	7.0%
E784	Endoscopy - Cystoscopy - with hydrodistention of bladder - general anaesthetic, add	$49.85	$53.34	$3.49	7.0%
E786	Endoscopy - Cystoscopy - with resection or incision bladder neck, female, add	$99.70	$106.68	$6.98	7.0%
E787	Endoscopy - Cystoscopy - with resection or incision bladder neck, male, add	$260.40	$278.63	$18.23	7.0%
E789	Endoscopy - Cystoscopy - with removal foreign body or calculus, add	$99.70	$106.68	$6.98	7.0%
E790	Endoscopy - Cystoscopy - with removal of ureteric catheter, add	$8.80	$9.42	$0.62	7.0%
E817	Endoscopy - Cystoscopy - with catheterization of the ureter and retrograde injection of opaque media, unilateral, add	$15.35	$16.42	$1.07	7.0%

E818	Endoscopy - Cystoscopy - with insertion of ureteric stent, unilateral, add	$24.90	$26.64	$1.74	7.0%
E824	Endoscopy - Cystoscopy - with bladder Biopsy - general anaesthetic, add	$49.85	$53.34	$3.49	7.0%
Z606	Endoscopy - Cystoscopy - Diagnostic with or without urethroscopy	$71.85	$76.88	$5.03	7.0%
Z607	Endoscopy - Cystoscopy - Repeat within 30 days	$35.50	$37.99	$2.49	7.0%
Z632	Endoscopy - Cystoscopy - single tumour 1 to 2 cm diameter	$271.35	$290.34	$18.99	7.0%
Z633	Endoscopy - Cystoscopy - single tumour over 2 cm diameter	$437.20	$467.80	$30.60	7.0%
Z634	Endoscopy - Cystoscopy - multiple tumours	$437.20	$467.80	$30.60	7.0%
Z636	Endoscopic ureterotomy or pyelotomy	$273.25	$292.40	$19.15	7.0%
Urology – Epididymis fee codes (PFAF 25-333)					
S601	EPIDIDYMIS - Spermatocele or spermatic granuloma excision	$207.85	$222.40	$14.55	7.0%
S602	EPIDIDYMIS - Epididymectomy – unilateral	$170.65	$182.60	$11.95	7.0%
Z707	EPIDIDYMIS - Incision of abscess	$55.15	$59.01	$3.86	7.0%
Urology – Extrophy fee codes (PFAF 25-333)					
S424	Extrophy - plastic closure of bladder with closure of abdominal wall and urethral lengthening with closure of pelvic floor with or without reimplantation of ureters	$1,237.25	$1,323.85	$86.60	7.0%
S488	Extrophy - excision of bladder and repair of abdominal wall - inclusive of graft	$215.80	$230.91	$15.11	7.0%
Urology – Fistula fee codes (PFAF 25-333)					
S554	Fistula - penile urethra (diversion of urine extra)	$92.10	$98.55	$6.45	7.0%
S555	Fistula - perineal urethra	$325.95	$348.77	$22.82	7.0%
S556	Fistula - Rectourethral with diversion, colostomy and closure of colostomy	$552.30	$590.96	$38.66	7.0%

Urology – Hydrocele/Hypospadias fee codes (PFAF 25-333)					
E755	Hypospadias or Epispadia - with inflatable prosthesis, add	$69.30	$74.15	$4.85	7.0%
S581	Hypospadias or Epispadia - Closure urethro-cutaneous fistula	$296.95	$317.74	$20.79	7.0%
S597	Hypospadias or Epispadia - Penile prosthesis for impotence	$395.90	$423.61	$27.71	7.0%
S611	Hydrocele excision - unilateral	$207.85	$222.40	$14.55	7.0%
S630	Hydrocele excision - single	$205.35	$219.72	$14.37	7.0%
Z708	Hydrocele aspiration	$19.80	$21.19	$1.39	7.0%
Urology – Kidney fee codes (PFAF 25-333)					
E771	Kidney re-Transplant - team fee (not to be billed when assistant fees are billed), add	$343.40	$350.25	$6.85	2.0%
S400	Laparoscopic placement of probe(s) for ablation of renal tumour	$404.95	$433.30	$28.35	7.0%
S401	Drainage of kidney abscess	$411.30	$440.09	$28.79	7.0%
S411	Partial or heminephrectomy	$907.00	$953.16	$46.16	5.1%
S434	Kidney re-Transplant	$1,858.15	$1,895.30	$37.15	2.0%
S435	Kidney Transplant	$1,553.15	$1,584.20	$31.05	2.0%
Z623	Insertion of stent	$95.10	$101.75	$6.65	7.0%
Z630	Extracorporeal shock wave lithotripsy	$314.20	$320.50	$6.30	2.0%
Urology – Nephrectomy fee codes (PFAF 25-333)					
E767	Nephrectomy - with repair of vena cava for thrombus - below the hepaticvein, add	$138.15	$276.30	$138.15	100.0%
E768	Nephrectomy - with repair of vena cava for thrombus - above the hepatic vein, add	$236.70	$473.40	$236.70	100.0%
S416	Nephrectomy - thoraco-abdominal or radical nephrectomy	$907.00	$970.50	$63.50	7.0%
S420	Nephrectomy - Nephroureterectomy, total, with resection of ureterovesical junction	$673.10	$1,317.55	$644.45	95.7%

S436	Donor nephrectomy - unilateral or bilateral (to include renal perfusion with hypothermia when rendered by surgeon)	$653.20	$698.92	$45.72	7.0%
Z626	Nephroscopy, percutaneous or retrograde	$95.95	$102.65	$6.70	7.0%
Z629	Percutaneous nephrostomy	$153.35	$164.10	$10.75	7.0%
Urology – Orchidectomy/Orchidopexy fee codes (PFAF 25-333)					
S589	Orchidectomy - unilateral	$170.65	$182.60	$11.95	7.0%
S591	Orchidopexy - for undescended testis, any type, one or two stages to include hernia repair where required	$433.95	$464.33	$30.38	7.0%
S593	Orchidopexy - Exploration for undescended testicle, without orchidopexy	$433.95	$464.33	$30.38	7.0%
S595	Orchidopexy - Ruptured testicle	$418.55	$447.85	$29.30	7.0%
S596	Orchidopexy - Insertion of testicular prosthesis	$197.95	$211.81	$13.86	7.0%
S600	Orchidopexy - Reduction of torsion of testis or appendix testis andorchidopexy (one or both sides) if required	$426.25	$456.09	$29.84	7.0%
Urology – Penis fee codes (PFAF 25-333)					
S574	Penis - Amputation - partial	$284.15	$304.04	$19.89	7.0%
S575	Penis - Amputation - partial with inguinal glands 1 or 2 stages	$437.20	$467.80	$30.60	7.0%
S576	Penis - Amputation - radical with inguinal and femoral glands 1 or 2 stages	$719.30	$769.65	$50.35	7.0%
Z702	Penis -Biopsy	$39.60	$42.37	$2.77	7.0%
Urology – Prostate fee codes (PFAF 25-333)					
Z712	Prostate -Biopsy, needle	$85.45	$91.43	$5.98	7.0%
Z713	Prostate -Biopsy, needle - with drainage abscess	$92.10	$98.55	$6.45	7.0%
Urology – Pyeloplasty fee codes (PFAF 25-333)					
E754	Pyeloplasty (with or without nephropexy) - with removal of calculus, add	$57.50	$61.55	$4.05	7.0%

S422	Pyeloplasty (with or without nephropexy)	$907.00	$970.50	$63.50	7.0%
Urology – Radical orchidectomy fee codes (PFAF 25-333)					
S590	Radical orchidectomy for malignancy - Retroperitoneal lymph node dissection (RPLND) for testicular tumour	$834.25	$892.65	$58.40	7.0%
S598	Radical orchidectomy for malignancy - unilateral	$337.15	$360.75	$23.60	7.0%
Urology – Re-implantation fee codes (PFAF 25-333)					
S451	Re-implantation - Ureterovesical anastomosis or re-implantation unilateral	$490.25	$524.57	$34.32	7.0%
S561	Re-implantation - Re-implantation of ureter with extensive tapering with or without ureterolysis	$693.45	$741.99	$48.54	7.0%
S562	Re-implantation - Re-implantation of bifid ureter	$539.50	$742.00	$202.50	37.5%
Urology – Renal fee codes (PFAF 25-333)					
E753	Renal Transplantation Procedures - live donor, add	$241.20	$425.00	$183.80	76.2%
E759	Removal of renal calculi - if disintegrated by any method, to Z627, add	$95.95	$102.65	$6.70	7.0%
E762	Renal Transplantation Procedures - reconstruction or repair of renal artery done in addition to renal Transplantation procedures, add	$301.05	$307.05	$6.00	2.0%
E772	Removal of renal calculi - percutaneous removal of staghorn calculus filling renal pelvis and extending into calyces, add	$175.50	$187.80	$12.30	7.0%
Z601	Renal Biopsy, needle	$143.55	$153.60	$10.05	7.0%
Z627	Removal of renal calculi	$168.25	$180.05	$11.80	7.0%
Z627	Removal of renal calculi	$168.25	$240.00	$71.75	42.6%
Urology – Retropubic urethropexy fee codes (PFAF 25-333)					
S539	Retropubic urethropexy for stress incontinence - Insertion of artificial urinary sphincter	$776.70	$831.07	$54.37	7.0%

S540	Retropubic urethropexy for stress incontinence - Revision or removal of artificial urinary sphincter	$239.75	$256.53	$16.78	7.0%
Urology – Scrotum fee codes (PFAF 25-333)					
S616	Scrotum - Abscess or haematocele - and exploration - unilateral	$99.00	$105.93	$6.93	7.0%
S618	Resection of scrotum	$215.80	$230.91	$15.11	7.0%
Z709	Scrotum - Abscess or haematocele - local anaesthetic	$39.60	$42.37	$2.77	7.0%
Z768	Scrotum - Abscess or haematocele - general anaesthetic	$99.00	$105.93	$6.93	7.0%
Urology – Sepermatic fee codes (PFAF 25-333)					
S631	Varicocele excision - single	$205.35	$219.72	$14.37	7.0%
Urology – Subsequent visit fee codes (PFAF 25-333)					
C352	Subsequent visit - first five weeks	$31.60	$33.81	$2.21	7.0%
C357	Subsequent visit - sixth to thirteenth week inclusive (maximum 3 per patient per week)	$31.60	$33.81	$2.21	7.0%
C359	Subsequent visit - after thirteenth week (maximum 6 per patient per month)	$31.60	$33.81	$2.21	7.0%
Urology – Testis fee codes (PFAF 25-333)					
Z703	Testis – Abscess	$55.15	$59.01	$3.86	7.0%
Z704	Testis, Biopsy - Single	$55.15	$59.01	$3.86	7.0%
Z705	Testis, Biopsy - Bilateral	$83.35	$89.18	$5.83	7.0%
Z706	Testis, Biopsy - with vasography	$120.80	$129.26	$8.46	7.0%
Urology – Traumatic rupture fee codes (PFAF 25-333)					
S465	Traumatic rupture, or transection (partial or complete) - Immediate - upper 2/3	$381.60	$408.31	$26.71	7.0%
S466	Traumatic rupture, or transection (partial or complete) - Immediate - lower 1/3	$437.20	$467.80	$30.60	7.0%

S467	Traumatic rupture, or transection (partial or complete) - Late repair - upper 2/3	$437.20	$467.80	$30.60	7.0%
S468	Traumatic rupture, or transection (partial or complete) - later repair - lower 1/3	$482.40	$516.17	$33.77	7.0%
Urology – Urethra fee codes (PFAF 25-333)					
S449	Ureterectomy - including ureterovesical junction	$445.40	$476.58	$31.18	7.0%
S450	Ureterectomy - other e.g. partial	$331.70	$354.92	$23.22	7.0%
S452	Ureteroileal conduit	$788.15	$843.32	$55.17	7.0%
S454	Ureteroileal conduit - with ureterectomy and ileal replacement	$893.50	$956.05	$62.55	7.0%
S455	Ureterointestinal anastomosis -unilateral	$331.70	$354.92	$23.22	7.0%
S457	Ureteroureterostomy	$552.30	$590.96	$38.66	7.0%
S458	Ureterostomy - Cutaneous – unilateral	$494.90	$529.54	$34.64	7.0%
S459	Ureterovaginal fistula	$557.85	$596.90	$39.05	7.0%
S460	Ureterolysis for periureteral fibrosis - unilateral	$448.00	$479.36	$31.36	7.0%
S461	Ureteroplasty (Hutch) – unilateral	$331.70	$354.92	$23.22	7.0%
S462	Ureterointestinal anastomosis – bilateral	$438.35	$469.03	$30.68	7.0%
S463	Ureterostomy - Cutaneous - with lower third ureterotomy	$381.60	$408.31	$26.71	7.0%
S530	Urethrotomy – external	$215.80	$230.91	$15.11	7.0%
S531	Urethrotomy – Urethrostomy	$215.80	$230.91	$15.11	7.0%
S532	Urethrotomy - transurethral (visual)	$166.05	$177.67	$11.62	7.0%
S536	Caruncle	$118.80	$127.12	$8.32	7.0%
S537	Urethral papilloma, single or multiple	$118.80	$127.12	$8.32	7.0%
S538	Urethrotomy - repeat procedure within 6 months by same surgeon	$95.75	$102.45	$6.70	7.0%
S541	Diverticulectomy - male or female	$260.85	$279.11	$18.26	7.0%

S542	Posterior urethral valve	$331.70	$354.92	$23.22	7.0%
S543	Prolapse urethra	$118.80	$127.12	$8.32	7.0%
S544	Urethrectomy – radical	$296.95	$317.74	$20.79	7.0%
S546	Urethra/Vagina - Retropubic Urethropexy - Repeat procedure for failed retropubic or vaginal surgery for stress incontinence (See Schedule for additional details)	$496.25	$530.99	$34.74	7.0%
S547	Urethroscopy - Removal of foreign body or calculus	$170.65	$182.60	$11.95	7.0%
S548	Urethral sling	$381.60	$408.31	$26.71	7.0%
S549	Urethra/Vagina - Retropubic Urethropexy for stress incontinence - Primary procedure (See Schedule for additional details)	$391.55	$418.96	$27.41	7.0%
S551	Rupture, anterior urethra (diversion of urine extra)	$170.65	$182.60	$11.95	7.0%
S552	Posterior urethra - immediate repair	$437.20	$467.80	$30.60	7.0%
S553	Posterior urethra - late repair	$643.35	$1125.00	$481.65	74.9%
S557	Urethrovesicolysis - when sole operative procedure	$215.80	$230.91	$15.11	7.0%
S564	Transurethral incision or resection of external sphincter - when sole operative procedure	$325.95	$348.77	$22.82	7.0%
S654	Transurethral resection of prostate - for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon	$411.20	$439.98	$28.78	7.0%
S655	Transurethral resection of prostate - and may include Cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy	$450.60	$482.14	$31.54	7.0%
S656	Transurethral resection of prostate - Transurethral drainage of abscess	$85.30	$91.27	$5.97	7.0%

S815	Urethra/Vagina - Retropubic Urethropexy - Tension free vaginal tape mid-urethral sling by any method/approach (See Schedule for additional details)	$393.30	$420.83	$27.53	7.0%
Z604	Urethrotomy - Meatotomy and plastic repair	$39.60	$42.37	$2.77	7.0%
Z609	Urethrotomy - Periurethral abscess	$31.60	$33.81	$2.21	7.0%
Z615	Urethra - Dilatation of stricture - Filiform and follower urethral dilation and may include bladder catheterization	$59.75	$63.93	$4.18	7.0%
Z616	Biopsy of urethra (without Endoscopy)	$23.55	$25.20	$1.65	7.0%
Z617	Urethroscopy - diagnostic	$35.50	$37.99	$2.49	7.0%
Z618	Urethroscopy with Biopsy	$77.70	$83.14	$5.44	7.0%
Z619	Urethra - Dilatation of stricture - male, general anaesthetic	$52.70	$56.39	$3.69	7.0%
Z620	Dilatation of urethra - female, general anaesthetic	$41.65	$44.57	$2.92	7.0%
Z621	Urethra - Dilatation of stricture - male, local anaesthetic	$19.20	$20.54	$1.34	7.0%
Z622	Dilatation of urethra - female	$9.90	$10.59	$0.69	7.0%
Urology – Vasectomy fee codes (PFAF 25-333)					
E545	Vasectomy - when performed outside hospital, add	$11.55	$12.36	$0.81	7.0%
S626	Vasectomy - uni - or bilateral - by any technique	$107.40	$114.92	$7.52	7.0%

Committee Comments

- The committee supports the proposed fee value changes, subject to fitting and relativity, except for: E819, Z628, Z627 (note: a 7% increase to Z627 is supported).
- Committee analysis indicates that for E819, Z628 and Z627, the proposed fee value changes are not consistent with intrasectional relativity

58.29 Multiple fee codes – Deletion of various fee codes associated with urology (PFAF 25-304, 25-306 to 25-311, 25-313 to 25-315, 25-321, 25-322, 25-324, 25-326, 25-334, 25-335)

Constituency Proposal

- The constituency proposed the deletion of the following urology associated fee codes:
- The constituency stated the proposed fee codes for deletion are to simplify and modernize the Schedule of Benefits.

Fee Code	Descriptor	Current value	PFAF ID	Stated Rational for Deletion in PFAF or Response	Code to be used instead
S403	Exploration of renal and peri-renal tissues (with or without Biopsy or unroofing of cyst)	$356.70	25-304	Procedure is rarely done as an isolated procedure	Not provided
S430	Removal of staghorn calculus filling renal pelvis and calyces -open, with or without x-ray control and/or anatrophic nephrolithotomy	$657.75	25-306	Three codes were amalgated and we did request the E792 code to allow for laparoscopy. It is rarely done. Most stones are managed endoscopically.	S405
S410	Calycectomy with diversion of urine	$512.00	25-307	Modernization of SOB	Not provided
S423	Partial or heminephrectomy with total ureterectomy	$757.85	25-308	Modernization of SOB	Not provided only stated “we are not changing the wording of S411”
S412	Nephrectomy - ectopic kidney	$467.00	25-309	Modernization of SOB	Not provided
S413	Nephrectomy lumbar	$467.00	25-310	Modernization of SOB	Not provided

Fee Code	Descriptor	Current value	PFAF ID	Stated Rational for Deletion in PFAF or Response	Code to be used instead
S415	Nephrectomy transperitoneal	$522.50	25-311	Modernization of SOB	Not provided
S437	Renal autotransplantation	$1,161.60	25-313	Modernization of SOB	it will be billed as a transplant
S428	Symphysiotomy for horseshoe kidney with or without nephropexy and associated procedures	$494.90	25-314	Modernization of SOB	Not provided
S433	Sacrococcygeal teratoma	$437.20	25-315	Modernization of SOB	Not provided
Z625	Selective catheterization of calyces (one or more)	$52.70	25-321	We are creating a new code to replace this code in order to reflect current technology	Not provided
E780	Endoscopy - Cystoscopy - with needle Biopsy of prostate, add	$32.60	25-322	We are creating a new code to replace this one so as to modernize the schedule	Not provided only stated “It is not done via cystoscopy; It is an antiquated practice. It is a separate procedure from cystoscopy
S567	Penis - Slit of prepuce (complete care) newborn	$61.35	25-324	These codes are antiquated as "complete care"	It is rarely done as an isolated procedure.
S568	Penis - Slit of prepuce (complete care) infant	$62.45	25-324	These codes are antiquated	It is rarely done as an

Fee Code	Descriptor	Current value	PFAF ID	Stated Rational for Deletion in PFAF or Response	Code to be used instead
				as "complete care"	isolated procedure .
S569	Penis - Slit of prepuce (complete care) - adult or child	$65.30	25-324	These codes are antiquated as "complete care"	It is rarely done as an isolated procedure .
Z605	Bladder Aspiration	$12.50	25-326	Modernization of SOB	It is rarely done as an isolated procedure
S645	Prostatectomy Perineal	$574.60	25-334	Not a current surgical technique	Not provided
S646	Prostatectomy - Perineal with vesiculectomy	$875.00	25-335	Not a form of surgery being performed and does not require a unique descriptor.	Not provided

Committee Comments

- The committee recommends that the descriptions of S567, S568, and S569 be modified to remove references to “complete care” rather than these codes being deleted. This will allow consultations and assessments to be billed at the time these procedures are performed.
- The committee does not support the deletion of S433, as other constituencies utilize this fee code.

59 Vascular Surgery

59.1 E078 - Chronic disease assessment premium (PFAF 23-205)

Constituency Proposal

- The constituency proposed a revision to E078 that would allow vascular surgery physicians to bill the code.

Committee Comments

- Given this code would apply to all vascular surgeons as well as the majority of their patients, the proposed change does not address intra-sectional relativity.
- Thus, the committee does not support this proposal and would recommend increasing consultation and assessment fees instead.

59.2 A/C175 - Consultation (PFAF 23-206)

59.3 A/C935 - Special surgical consultation (PFAF 23-207)

59.4 A173 - Specific assessment (PFAF 23-273)

59.5 A174 - Partial assessment (PFAF 23-274)

Constituency Proposal

- The constituency proposed the following fee increases:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
A175	Consultation	$107.45	$160.00	$52.55	48.9%
C175	Consultation	$107.45	$160.00	$52.55	48.9%
W175	Consultation	$107.45	$107.45	$0.00	0.0%
A935	Special surgical consultation	$163.20	$300.00	$136.80	83.8%
C935	Special surgical consultation	$163.20	$300.00	$136.80	83.8%
A176	Repeat consultation	$60.00	$60.00	$0.00	0.0%
C176	Repeat consultation	$60.00	$60.00	$0.00	0.0%
W176	Repeat consultation	$60.00	$60.00	$0.00	0.0%
A173	Specific assessment	$44.40	$80.00	$35.60	80.2%
A174	Partial assessment	$24.10	$60.00	$35.90	149.0%
C173	Specific assessment	$44.40	$44.40	$0.00	0.0%
C174	Specific re-assessment	$25.95	$25.95	$0.00	0.0%

- When a comprehensive special vascular surgical consultation (A/C935)) is performed, significant time commitment is required for patient investigation, preparation, consent, surgical planning, multidisciplinary discussions, and ensuring the availability of necessary materials. Such comprehensive consultations should be compensated at a rate aligned with specialties that have comprehensive consultation codes, typically associated with approximately 75 minutes of care, and reimbursed at $300 or more.

Committee Comments

- The increases proposed by this PFAF exceed the allocation available to this constituency. The committee would support increasing these codes within the allocation available, in a manner that maintains relativity between these codes.
- The committee notes that A/C935 is billed by all surgical specialities and any change to that code needs to take into account relativity between consultations and assessments in each section.

- The committee notes that PFAFs 23-206, 23-273, and 23-274 were withdrawn when the constituency submitted PFAF 25-093 and 25-201.

59.6 Payment issues (PFAF 23-216)

Constituency Proposal

- The constituency highlighted several payment issues, including:
  - Payment rejections stemming from a lack of understanding of the nature of multi-step surgical procedures.
  - Geographic and individual disparities in reimbursement with some centres/members encountering rejections.
  - A lack of clarity around reasons for rejection and the adjudication process for disputed claims.
- The constituency proposes:
  - Establishing a feedback mechanism to facilitate direct communication between the medical section and the Ministry.
  - Developing clear guidelines around fee code utilization and transparency in claims adjudication.
  - Instituting uniform claims reimbursement policies to rectify geographic and individual disparities, ensuring consistent criteria for payment across providers and regions.

Committee Comments

- This proposal does not contain any proposed changes to the Schedule of Benefits. The issues described fall outside of the PPC's mandate. OMA staff will help the constituency to identify where to better direct this proposal.

59.7 Exxx - Diagnostic imaging assessment premium (PFAF 23-233)

Constituency Proposal

- The constituency proposed a new premium be added to consultation and assessment fees when completing a dedicated review of source imaging as part of the service, valued at 30%.

Committee Comments

- The section indicated that this would be broadly billed. The committee therefore recommends that funds be directed to all consultations and assessments rather than the creation of a new "E" Code.
- The committee does not support this proposal.

59.8 Rxxx - Second Surgeon - Aorto-iliac and Visceral Vascular Surgery (PFAF 23-278)

Constituency Proposal

- The constituency proposed a new fee for a second surgeon when aorto-iliac and visceral vascular surgery is performed and the second surgeon's presence at the case is recorded in the medical record, valued at 75% of the procedural fee.
- Aorto-iliac and visceral abdominal vascular surgery often requires two surgeons to achieve optimal results. A second surgeon is frequently involved in these cases across the province, yet

they cannot be appropriately reimbursed outside of assistant fees that undervalue their contribution to the procedure.

Committee Comments

- The committee notes the constituency's support for a team based surgical code.
- The committee, in consultation with the section, supports the creation of a team fee for the following codes: R799, R800, R801, R802, R803, R817, R877, and R875, subject to fitting and relativity.
- The committee notes that this team fee will be created in a manner consistent with existing team fees (e.g., R804, R766, and R767), in terms of physician compensation.

59.9 R792 - Carotid - Endarterectomy, with or without bypass graft (PFAF 25-076)

Constituency Proposal

- The constituency proposed an increase to the R792 fee code, from $841.00 to $1,100.00 (30.8%).

Committee Comments

- The committee notes that this proposal is a duplicate of PFAF 25-201.

59.10 R936 - Mesenteric or celiac artery repair - endarterectomy or graft (PFAF 25-077)

Constituency Proposal

- The constituency proposed an increase to the R936 fee code, from $954.10 to $1,775.80 (86.1%).

Committee Comments

- The committee supports this proposal, subject to fitting and relativity.

59.11 R813 - Embolectomy - artery or graft - as sole procedure (PFAF 25-079)

Constituency Proposal

- The constituency proposed an increase to the R813 fee code, from $490.00 to $1,000.00 (104.1%).

Committee Comments

- The committee notes that this proposal is a duplicate of PFAF 25-201.

59.12 R796 - Carotid - carotid body tumour (PFAF 25-080)

59.13 R798 - Carotid - aneurysm - reconstruction or excision with graft (PFAF 25-081)

Constituency Proposal

- The constituency proposed an increase to the R796 fee code, from $769.85 to $1,100.00 (42.9%).
- The constituency proposed the deletion of the R798 fee code. The constituency stated physician will alternatively bill the proposed revised R796 fee code found in PFAF 25-080.

- The constituency proposed a complete revision to the R796 and R798 fee code descriptors and payment rules. The constituency stated that this will result in one single R796 fee code that will incorporate the definitions of both services.
- The constituency stated the purpose of the proposal is to modernize the Schedule of Benefits since the repair for both these diseases is identical.
- The constituency stated 25-081 is contingent on the PPC supporting 25-080.

Committee Comments

- The committee supports the proposed deletion of R798 and changes to the descriptor of R796.
- The committee notes that the requested value change is a duplicate request from PFAF 25-201.

59.14 Multiple fee codes - Increases to aortic procedure fee code values (PFAF 25-093 & 25-201)

Constituency Proposal

- The constituency stated the current fee values for aortic procedures does not reflect the complexity to perform these procedures.
- The constituency proposed the following value changes:

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
A173	Specific assessment	$44.40	$79.90	$35.50	80.0%
A174	Partial assessment	$24.10	$28.90	$4.80	19.9%
A175	Consultation	$107.45	$139.70	$32.25	30.0%
A176	Repeat consultation	$60.00	$72.00	$12.00	20.0%
C173	Specific assessment	$44.40	$79.90	$35.50	80.0%
C174	Specific re-assessment	$25.95	$31.15	$5.20	20.0%
C175	Consultation	$107.45	$128.95	$21.50	20.0%
C176	Repeat consultation	$60.00	$72.00	$12.00	20.0%
E510	Arteries - for branched or fenestrated devices, to R875, add	$838.15	$1,000.00	$161.85	19.3%
E627	Arteries - ruptured aneurysm, to R802, R803, R817 or R877, R875, add	$400.00	$800.00	$400.00	100.0%
R792	Carotid - endarterectomy, with or without bypass graft	$841.00	$1,100.00	$259.00	30.8%
R796	Carotid - carotid body tumour	$769.85	$1,100.00	$330.15	42.9%
R802	Abdominal aorta - repair or excision with graft - aneurysm repair alone or including unilateral common femoral repair	$1,585.50	$2,400.00	$814.50	51.4%
R803	Thoracic aorta aneurysm - repair or excision with graft - Thoraco-abdominal aneurysm	$2,859.30	$4,315.50	$1,456.20	50.9%
R813	Femoro-anterior/posterial tibial/peroneal bypass graft -	$490.00	$1,000.00	$510.00	104.1%

	Embolectomy - artery or graft - as sole procedure				
R817	Abdominal aorta - repair or excision with graft - aneurysm repair and bilateral common femoral repair	$2,327.50	$3,416.00	$1,088.50	46.8%
R858	Aorto-Iliac repair - Total removal of infected aortic graft (stem and limbs)	$918.35	$1,218.00	$299.65	32.6%
R875	Endovascular aneurysm repair using stent grafting	$1,396.90	$1,700.00	$303.10	21.7%

Committee Comments

- The committee notes that across the Schedule of Benefits, there is a proportionality between consultations and different levels of assessment. This proposal would disrupt that proportionality and thus has broad implications across the Schedule of Benefits.
- The committee supports an increase in the value of consultations and assessments, which maintains the current proportionality, subject to fitting and relativity.
- The committee supports the proposed fee value changes to: E510, E627, R792, R796, R802, and R813.
- The committee does not support the proposed fee value changes to: R803, R817, R875, and R858, as our analysis indicates that the proposed changes are not consistent with maintain intrasectional relativity.

59.15 R802 & R817 - Repair of aorta – iliac disease (PFAF 25-096)

59.16 Multiple fee codes - Deletion of various aorto-iliac repair fee codes (PFAF 25-094)

Constituency Proposal

- The constituency proposed a revision to the R802 and R817 fee code descriptors and an increase in fee code values.
- The constituency proposed the R802 fee code value should increase from $1,585.50 to $2,400.00 (51.4%) and the R817 fee code value should increase from $2,327.50 to $3,416.00 (46.8%).
- The constituency proposes the following descriptor revisions:

  R802 - <u>Open abdominal aortic repair (tube graft or endarterectomy).</u> ~~aneurysm repair alone or including unilateral common femoral repair~~

  R817 - <u>Open abdominal aortic repair including iliac and/or femoral arteries (unilateral or bilateral).</u> ~~aneurysm repair and bilateral common femoral repair~~

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

- The constituency proposed the deletion of the following fee codes as part of their larger aortic section revision (PFAF 25-096):
  - R877 - Abdominal aorta - repair or excision with graft - aneurysm with repair of iliac artery aneurysm (unilateral or bilateral)
  - R783 - Aorto-Iliac repair - including common iliac repair (uni- or bilateral)
  - R784 - Aorto-Iliac repair - plus unilateral common femoral repair

    - R785 - Aorto-Iliac repair - plus bilateral common femoral repair
- The constituency stated physician will alternatively bill the new proposed R802 and R817 revised fee codes (PFAF 25-096) once the codes are deleted.
- The constituency stated the revision of the R802 and R817 fee codes will simplify the aortic section of the Schedule of Benefits so that aortic repair procedures can be billed under only 2 codes opposed to 6.
- The constituency only wishes to proceed with the deletion if 25-096 is able to proceed.

Committee Comments

- The committee notes that the requested value change to R802 and R817 are a duplicate request from PFAF 25-201.
- The committee supports these proposed fee code modifications, subject to fitting, relativity, and drafting appropriate schedule language.

59.17 R875 & R858 - Removal of infected aortic graft and Endovascular aneurysm repair using stent grafting (PFAF 25-102)

59.18 R859 - Aorto-Iliac repair - Partial removal of infected aortic graft (one limb only) (PFAF 25-100)

Constituency Proposal

- The constituency proposed a revision to the R858 fee code descriptor and an increase in fee code values to the R875 and R858 fee codes.
- The constituency proposed the R875 fee code value should increase from $1,396.90 to $ 1,700.00 (21.7%) and the R858 fee code value should increase from $918.35 to $1,218.00 (32.6%).
- The constituency proposes the following descriptor revision:

  R585 – ~~Total~~ Removal of infected aortic graft (stem and/or limbs, unilateral or bilateral).

  (Revisions underlined, deletions ~~strikethrough~~)

- The constituency states the proposed descriptor revision to the R858 fee code is to capture the R859 procedure so that the R859 fee code can be deleted (PFAF 25-100) to modernize and simplify the Schedule of Benefits.
- The constituency proposed a deletion of the R859 fee code and stated the deletion of this fee code will modernize the aortic section of the Schedule of Benefits; physicians will alternatively bill the new proposed R858 revised fee code. The constituency only wishes to proceed with the deletion only if 25-102 is able to proceed.

Committee Comments

- The supports the proposed deletion of R859 and descriptor change for R858.
- The committee notes that the value change proposed for R875 is a duplicate of PFAF 25-102.

59.19 N282 - Brachial Plexus (excluding thoracic outlet syndrome or cervical rib) (PFAF 25-226)

Constituency Proposal

- The constituency proposed a revision to the N282 payment rules, to delete the exclusion criteria from the N282 fee code.
- The constituency proposed a revision to the N282 fee code payment rules so that N282 can be billed with the N283 fee code.
- The constituency stated the purpose of this proposal is to modernize the Schedule of Benefits to recognize the updated standard of care by the Society of Vascular Surgery.
- The constituency stated at the time that the exception ruling was made for N282, data was ambiguous, but this is no longer the case. Surgeons who manage this rare disease should have the ability to bill both procedures, if treating the neurogenic subset of thoracic outlet syndrome.

Committee Comments

- The committee acknowledges the confusion that this proposal is attempting to address.
- The committee continues to deliberate on appropriate schedule language to clarify the combined use of these two fee codes and will reach out to the constituency, as required.

60 PPC Initiatives

60.1 A765 - Consultation, patient 16 years of age and under

Proposal

- The Committee proposes deleting A/C/W765 from the Schedule.
- This is a code that exists across sections and is therefore difficult to modify for an individual specialty. For some sections, this code has fallen out of relativity with their other consults and assessments.
- With the introduction of age-based premiums (see pg. GP64), the purpose of this code is now obsolete. Any savings generated by elimination of the code will be reinvested by the relevant section.
- All constituencies which chose to provide feedback approve of this proposal, provided there was no decrease in what consultations for patients under 16 years of age would pay.

60.2 Surgical Unbundling of Pre- and Post- Operative Care

Proposal

- The surgical preamble currently bundles pre- and post-operative care and visits as an element of many surgical services.
- During the last fee setting allocation process a number of surgical sections proposed and supported revising the surgical preamble to allow for pre- and post-operative care to be billed with surgical cases, to better capture time and complexities in the attendance of patients before and after surgical procedures, and during patient recovery in a hospital setting. The PPC had deferred its decision until cost estimates could be examined and affected Sections had an opportunity to provide feedback.
- The committee proposes revising the surgical preamble to allow for pre- and post-operative care to be billed with surgical cases, to better capture time and complexities in the attendance of patients before and after surgical procedures, and during patient recovery in a hospital setting.

~~SURGICAL SERVICES WHICH ARE NOT LISTED AS A "Z" CODE~~
~~In addition to the above, the fee for this service includes the following:~~
~~1. Pre-operative Care and Visits Pre-operative hospital visits which take place 1 or 2 days prior to surgery.~~
~~2. Post-operative Care and Visits Post-operative care and visits associated with the procedure for up to two weeks postoperatively, and making arrangements for discharge, to a hospital in-patient except for: a. the first and second post-operative visits in hospital (payable at the specialty specific subsequent visit fee); and~~
~~b. subsequent visit by the Most Responsible Physician (MRP) - day of discharge (C124).~~
~~The specific elements for pre- and post-operative visits are those for assessments.~~
(~~deletions~~)

- This does not provide for any change to assessments on the day of surgery.
- The committee notes that this proposal is currently at the negotiations table for arbitration. If the proposal proceeds at that table, this proposal is unnecessary. If the proposal does not proceed at that table, it will be deliberated further by PPC.

60.3 Bone Mineral Density Measurement Modernization

Proposal

- The Canadian Medical Association Journal (CMAJ) released the clinical practice guideline for management of osteoporosis and fracture prevention in Canada: 2023 update. The Schedule of Benefits (Schedule) refers to the 2002 guidelines.
- PPC proposes to modernize the Schedule requirements for BMD measurement to align with the 2023 guidelines.
- The committee notes that no concerns have been raised by the relevant constituencies.

60.4 Modernizing Cervical Screening (G365, G394, E430, E431)

Proposal

- The Ontario Cervical Screening Program (OCSP) is a province-wide screening program that provides people with a cervix (women, transmasculine and nonbinary people) with access to comprehensive, coordinated, high-quality cervical screening. The program's goal is to reduce the risk of developing or dying from cervical cancer by increasing the percentage of eligible people who get screened regularly and who have timely and appropriate follow-up of abnormal results. The OCSP is planning changes to their guidelines for cervical cancer screening in 2025.
- PPC proposes to modernize the Schedule requirements for cervical cancer screening.
- The committee proposes modifying the descriptor for G365 Papanicolaou smear, periodic to "Cervical screening Collection of cervical screening specimen(s) as defined by the Ontario Cervical Screening Program (OCSP)"
- The committee proposed modifying the descriptor E430 and E431 to, "when collection of cervical screening specimen is performed outside of hospital or ICHSC"
- The committee proposes the following revisions to modifying the descriptor for G394 Papanicolaou smear, additional to "Collection of additional cervical screening specimen(s)"

- The committee proposes payment rules to align with Ontario Cervical Screening Program (OCSP). OSCP Guidelines for cervical screening can be found at https://www.cancercare.on.ca/
- The committee notes that these changes were implemented in March of 2025.

60.5 Bariatric Surgery

Proposal

- Eligibility conditions for OHIP-insured bariatric surgery are currently based on clinical guidelines published in 1991.
- In 2022, the American Society for Metabolic and Bariatric Surgery (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) released updated guidelines that have since been adopted by the Canadian Association of Bariatric Physicians and Surgeons and other international health authorities.
- PPC proposes to modernize the Schedule of Benefits (Schedule) requirements related to bariatric surgery to align with ASMBS and IFSO bariatric guidelines.
- The committee notes that no concerns have been raised by the relevant constituencies.

60.6 X235 - Cardiac CT angiogram

Proposal

- Coronary Computed Tomography Angiography (CCTA) is an important testing modality for the detection and risk assessment of coronary artery disease. CCTA is a non-invasive 3D imaging test that identifies plaque and blockages or narrowing (stenosis) of the coronary arteries. It can detect abnormalities in how blood flows through the heart and can diagnose cardiovascular disease, such as coronary artery disease (CAD).
- CCTA has been endorsed as a first-line test for the diagnosis of CAD in stable patients by numerous international medical societies.
- Ontario Clinical Guidance on Patient Selection and Prioritization for Coronary Computed Tomography Angiography were published in May 2024.
- Ontario Clinical Guidance on Patient Selection and Prioritization for Coronary Computed Tomography Angiography can be found at https://www.corhealthontario.ca/Provincial-Clinical-Guidance-on-CCTA_Final.pdf
- PPC proposes to modernize the Schedule requirements related to X235 Cardio-thoracic Computed Tomography to align with the Ontario guidelines.
- The committee notes that no concerns have been raised by the relevant constituencies.

60.7 K042 - Extended specific neurocognitive assessment

Proposal

- As part of its work to modernize the OHIP Schedule of Benefits, PPC proposes revisions to the commentary section of K042.
- The new proposed commentary is,

> *"Examples of extended neurocognitive assessment batteries which would be acceptable, where the minimum time requirement has been met, are the Toronto Cognitive Assessment (TorCA) or the Behavioral Neurology Assessment-short form in addition to the Montreal Cognitive Assessment (BNA-SF + MOCA) or the Behavioral Neurology*

Assessment-short form in addition to the Frontal Assessment battery (BNA-SF + FAB). Note that for K042, MOCA, BNA-SF or FAB alone are not sufficient neurocognitive assessment batteries for payment purposes."

- The committee notes that no concerns have been raised by the relevant constituencies.

60.8 Time based surgical fee codes

Proposal

- The committee is exploring the creation of time-based surgical fee codes for Gynecological Surgery and for Mastectomy.
- The committee notes Obstetrics and Gynecology's support for gynecological surgery.
- The committee notes that General Surgery is awaiting a decision regarding unbundling pre- and post- operative care before deliberating further on the Mastectomy proposal and that Plastic Surgery deferred to General Surgery's opinion.
- The committee continues to deliberate on schedule language and final fee values, subject to fitting and relativity.
- The committee continues to explore time-based surgical fee codes with other constituencies; these deliberations continue.

60.9 Modernization of G877-G880

Proposal

- The committee proposes combining G877 with G879 and combining G878 with G880.
- The committee proposes the following descriptor changes to the following:

  EMG and/or ultrasound guidance for Botulinum toxin injections

  G877 - with EMG guidance and/or ultrasound guidance (when required to determine the injection site), for one injection, to G870, G873, G874, or G875

  G878 - with EMG guidance and/or ultrasound guidance (when required to determine the injection site), for two or more injections, to G870, G873, G874 or G876.

  (Revisions underline)

- The committee proposes that G879 and G880 be deleted.
- The committee notes that no concerns have been raised by the relevant constituencies.

60.10 Hospital & LTC Subsequent Visits

Proposal

- The committee notes that several proposals have been made to modify Hospital Subsequent visit codes:
  - Several constituencies requested fee increase to their Hospital In-patient Subsequent Visits Fees.

    - Section on Long Term Care & Care of the Elderly proposed fee increases to LTC subsequent visit fees.
- PPC previously agreed LTC subsequent visit (Wxxx) fees should not exceed Hospital subsequent visit (Cxxx) fees.
- The committee recommends value increases to these fees. Final fee increases are subject to fitting and relativity.

60.11 Deletion of Low-Birth-Weight Codes

Proposal

- In addition to the deletion of low-birth-weight codes proposed in PFAF 25-071, the PPC also recommends deleting other low birth weight codes from the Schedule of Benefits. This is the totality of the proposed deletions:

Fee code	Description
H002	Low birth weight baby care (uncomplicated) - initial visit (per baby)
H003	Low birth weight baby care (uncomplicated) - subsequent visit
H262	Low birth weight newborn uncomplicated care - initial
H263	Low birth weight newborn uncomplicated care – thereafter

- PPC proposes deleting language defining “low birth weight” on GP33.
- The proposed change is cost neutral as cost savings will be reallocated to other fee codes billed by the affected constituencies.
- The committee notes that SGFP and Paediatrics support this proposal.

60.12 Incorporation of internal medicine premium into the fee code values

Proposal

- Currently, physicians who are practicing solely as a general internist and who have submitted all claims using the specialty designation of Internal Medicine (13) in the qualifying year are eligible for a premium of 12% of the approved fee amount on the following qualifying services:
    - A133A-Medical specific assessment
    - A134A-Medical specific re-assessment
    - A131A-Complex medical specific re-assessment
    - A138A-Partial assessment
- The committee proposes to incorporate the 12% Internal Medicine Office Assessment Premium into the applicable Internal Medicine assessment fees. This re-investment is revenue neutral, and care is taken to ensure Internal medicine recovers all funds from the premium.
- The committee notes that the premium was created to facilitate large differentials in available allocations, rather than for policy reasons. This premium is no longer needed.
- The committee notes that this code benefits internists working in ambulatory care centres with and without overhead and therefore is not specific to covering office overhead.

- The committee notes that this proposed change works to simplify and modernize the Schedule of Benefits.
- The committee continues to engage with Internal Medicine.

61 Assignments from PSC/OWG

61.1 Gxxx - Intravenous high-dose ketamine infusion for chronic pain

Proposal

- The Operations Working Group (OWG) requested the PPC to develop recommendations for insured ketamine infusion used in the treatment of chronic pain, including, if deemed necessary, the creation of applicable fee codes and evidence-based payment rules.
- The committee proposes to add ketamine infusion for chronic pain services to the Schedule of Benefits for Physician Services (the Schedule) to make it an insured service under the Ontario Health Insurance Plan (OHIP) for clinical conditions where the use of this treatment is supported by medical evidence.
- Proposed price of $125.00 for IV ketamine infusion is equivalent to both G387 - Intravenous local anaesthetic infusion for central neuropathic pain and G359 – Special single agent or multi-agent therapy – chemotherapy and/or biologic agents with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician.
- The physician must be physically present at the bedside for the initiation of the infusion. The fee includes administration of the IV infusion supervised by the physician, including venipuncture, establishment of any vascular access line and administration of agent(s). The physician must be physically available in the clinical facility to intervene in a timely fashion for the duration of the prescribed therapy to manage adverse reactions.
- The services will only be eligible for payment for patients with persistent, life-altering chronic pain, defined as average daily pain intensity ≥ 6/10 over a period of a least six consecutive months due to one of the listed conditions:
    - upper or lower limb chronic pain that meets Budapest criteria for complex regional pain syndrome (CRPS),
    - post-spinal cord injury pain,
    - phantom limb pain, or
    - peripheral neuropathy.
- The service would only be eligible for payment where standard conventional pharmacological (trials of at least 4 classes of medication considered to be generally accepted medical therapy for chronic pain such as gabapentinoids, TCAs, SNRIs and NSAIDs) and non-pharmacologic pain therapies (e.g. physical therapy, massage therapy) have been unsuccessful or are contra-indicated.
- The service would only be eligible for payment where ketamine is infused at a minimum dose of 0.5 mg/kg/hour for a minimum of 2 hours for patients who meet the above eligibility criteria.
- The service would be limited to a maximum of 6 infusions per patient per 12-month period, and a maximum of 6 of any combination of this service and G387 claims would be payable per patient per 12-month period.
- G387 would not be eligible for payment with this service.

- The medical record for the service would need to reflect the information above.
- The PPC proposes deleting Z811 Intravenous drug test for pain. Z811 is an historic fee code for the purpose of performing an IV drug test of lidocaine to predict mexiletine response. The listing has become outdated and no longer relevant. Billing of the professional service has decreased significantly, <5 services billed in FY 2022.
- The PPC will reach out to relevant constituencies as required.

61.2 Medical Assistance in Dying (MAiD)

Proposal

- Physicians rendering Medical Assistance in Dying (MAiD) services are currently remunerated through palliative care fee codes including K023 *(palliative care support)* and A945 *(special palliative care consultation)*. A request has been received to develop MAID-specific fee codes that differentiate between MAiD services and palliative care services.
- The committee proposes defining MAiD in the Schedule of Benefits and to create new fee schedule codes specific to MAiD services:
    - Axxx Special Medical Assistance in Dying consultation, valued at 159.20
    - Kxxx Medical Assistance in Dying support, per unit, valued at 74.70
- The committee expects the proposal to be cost neutral.
- The fee values are subject to fitting and relativity.

61.3 Fee Schedule Listing for Occupational Medicine

Proposal

- The Section on Occupational Medicine has submitted an application to the Operations Working Group for an OHIP specialty designation, distinct from Internal Medicine (13). At a meeting on February 6, 2024, the OWG approved this application in principle.
- The PPC proposes establishing a new Consultations & Assessments section in the Schedule for Occupation Medicine (OMA) physicians (e.g. create new fee codes and mirror established rates for 13's – maintain Internal & OM fees for OM physicians).
- PPC proposes that fee values for the new occupational medicine consults and visit codes be set equal to current Internal medicine fee codes (along with applicable increases to those codes planned for April 1, 2026).
- A120, K045 and K046: The PPC proposes not to include A120, K045 and K046 in the OM Consultations and Assessments section and would continue to restrict to the specialties listed in the Schedule. Since many OM physicians are dually qualified as OM and IM, they could continue to bill using their IM/13 OHIP billing specialty.
- The PPC supports the creation of a new fee listing for occupational medicine to mirror the following codes from Internal Medicine:

IM Fee Code	Action
A/C/135	new equivalent code(s) needed
W235	new equivalent code(s) needed
A/C765	Code to be deleted
W765	Code to be deleted

A/C/W130	new equivalent code(s) needed
A/C/W435	new equivalent code(s) needed
A/C/136	new equivalent code(s) needed
W236	new equivalent code(s) needed
A/C133	new equivalent code(s) needed
A/C134	new equivalent code(s) needed
A/C131	new equivalent code(s) needed
A138	new equivalent code(s) needed
C132	new equivalent code(s) needed
C137	new equivalent code(s) needed
C139	new equivalent code(s) needed
C122	fee code is shared, include in OM C&V section of Schedule and allow OM to claim
C123	fee code is shared, include in OM C&V section of Schedule and allow OM to claim
C124	fee code is shared, include in OM C&V section of Schedule and allow OM to claim
C142	fee code is shared, include in OM C&V section of Schedule and allow OM to claim
C143	fee code is shared, include in OM C&V section of Schedule and allow OM to claim
C121	fee code is shared, include in OM C&V section of Schedule and allow OM to claim
C138	new equivalent code(s) needed
C982	fee code is shared, include in OM C&V section of Schedule and allow OM to claim

- The PPC acknowledges the constituency's preference to incorporate the internal medicine premium into the base values of the new fee codes and is supportive.

61.4 Food Allergy Immunotherapy (FAIT)

Proposal

- The Canadian Society of Allergy and Clinic Immunology (CSACI) published Clinical Practice Guidelines affirming Oral Immunotherapy (OIT) as a standard of care treatment in the management of IgE mediated food allergy.
- The PPC recognizes that in certain circumstances, delivery of OIT may be associated with relatively higher work intensity than other clinical immunology services.
- PPC proposes the introduction of two new fee codes specific to food allergy immunotherapy (FAIT).

1. FAIT Initiation Fee valued at $190.60 - remuneration of the initial dose setting encounter
    - minimum of 30 continuous minutes in direct personal contact with the patient
    - Includes all assessment, counselling, education, and observation components rendered during the initial FAIT encounter and all provocation tests rendered on the date of service

    - once per patient per allergen per lifetime, once per treatment protocol whether initiating monoallergen or polyallergen therapy
2. FAIT Support Fee valued at $74.05 per unit (unit means ½ hour or major part thereof)- time-based remuneration that compensates direct physician assessment, support and counselling of patients receiving FAIT, applicable to all FAIT related patient encounters rendered after the dose setting visit that meet minimum time requirements.
    - maximum of 2 units per patient per day, maximum of 12 units per patient, per physician, per year

- FAIT services will be eligible for payment to physicians with specialty designations in clinical immunology (62) for patients with history and physical consistent with suspected or proven IgE-mediated food allergy and positive skin prick test to the allergen, and/or, positive specific IgE testing, and/or, a positive oral provocation test consistent with the identified or suspected food allergy.
- The PPC will reach out to relevant constituencies as required.