OMA Ontario Medical Association

Ontario

Physician Payment Committee Report

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

Draft #2

Proposal Comments as of September 17, 2024

New Comments and Revisions highlighted

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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. Although this document references consultations with OMA constituencies, the forthcoming cost impact analysis of these proposals will be based on section or physician grouping. While some of proposals are revenue-neutral, many require funding, which is dependent on the available allocation determined by the PSA. Details on allocations for both Year 3 of the 2021-2024 PSA, and Year 1 of the 2024-2028 PSA are expected in December 2024. The PPC will engage with OMA constituency leaders once details on allocation are known.

The PPC continues to deliberate and the comments in this report are preliminary. This report is the second report, as part of a cycle of feedback and engagement that culminates with the PPC's final recommendations in October 2025. OMA constituency leaders are encouraged to provide feedback, corrections, and additional information that would aid with the PPC's continued deliberations into the fall of 2025.

The PPC chose to prioritize its deliberations on new fee codes, fee code revisions, and deletions. Proposals supported by the committee in principle are all subject to the constraints of available allocation. Given the recent release of information on physician specialty group allocations, deliberations on fee code value changes can now begin and will be completed in advance of final recommendations to PSC. 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
- Molly Thangaroopan, MD, cardiology
- Neshmi Zaman, MD, family practice

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 regarding the April 1, 2026 permanent fee adjustments to the PSC in 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). The PPC sent several reminders on key dates to OMA constituencies, in June, July, September and October. 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 on April 1, 2026. These new timelines will allow constituencies a new opportunity to submit proposals to the PPC for consideration, and additional opportunities for feedback throughout much of 2025. The PFAF portal is now open.

To support this work, the PPC hosted information/education 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)

The PPC anticipates additional information sessions given the change in timelines. More details are forthcoming.

OMA Constituencies received an Orientation Package including 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. 2023 Professional fee assessment form (PFAF)

All of this information is available on the OMA webpages:.

- PPC resource page
- Implementation agreement and arbitration process

The PPC kept members updated on the PPC fee allocation process via OMA News.

Summary of Submissions

The committee received 555 new fee proposals and 95 requests to pursue deferred items from 48 OMA constituencies (sections, MIGs, and fora). In December 2023, 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.

In the event that 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, with a deadline of January 31, 2024. 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). The PPC received a total of 11 member group submissions. Five proposals met the necessary submission criteria and are under consideration 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	18
OMA Constituencies with Submissions	48
Delete fee code	46
New fee code	152
Revision	97
Value change	317
Value Change and Revision	38
TOTAL	**650**

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	0	0	1	0	**2**
Allergy & Clinical Immunology	0	1	1	4	0	**6**
Anaesthesiology	0	2	2	2	0	**6**
Cannabinoid Medicine	0	5	0	16	0	**21**
Cardiac Surgery	0	0	4	0	0	**4**
Cardiology	0	1	0	0	0	**1**
CHC and AHAC	0	0	0	0	0	**0**
Chronic Pain	0	0	0	2	0	**2**
Clinic Endoscopists	0	0	0	0	0	**0**

OMA Constituency	Delete fee code	New fee code	Revision	Value change	Value Change and Revision	TOTAL
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	8	1	0	0	**9**
Dermatology	0	1	1	0	0	**2**
Diagnostic Imaging	0	1	0	34	1	**36**
Emergency Medicine	0	10	5	30	0	**45**
Endocrinology & Metabolism	0	0	0	8	1	**9**
Fee-for-Service Family Physician	0	5	0	16	0	**21**
Gastroenterology	1	2	1	7	1	**12**
General & Family Practice	0	3	1	50	0	**54**
General Internal Medicine	0	3	2	3	2	**10**
General Surgery	2	4	2	1	1	**10**
General Thoracic Surgery	10	1	4	7	5	**27**
Genetics	4	1	0	0	0	**5**
Geriatric Medicine	0	0	0	0	0	**0**
Green is Health	0	0	0	0	0	**0**
Haematology & Medical Oncology	0	1	2	1	2	**6**
Hospital Medicine	0	3	1	0	0	**4**
Hyperbaric Medicine	0	1	0	0	0	**1**
Infectious Diseases	0	2	0	8	0	**10**
Laboratory Medicine	17	0	7	5	0	**29**
Long Term Care & Care of the Elderly	0	1	3	3	0	**7**
Medical Students	0	0	0	0	0	**0**
Nephrology	0	1	0	1	0	**2**
Neurodevelopmental Disorders	0	0	0	0	0	**0**
Neurology	1	12	2	0	2	**17**
Neuroradiology	0	0	0	0	0	**0**
Neurosurgery	0	2	0	0	0	**2**
Nuclear Medicine	0	8	10	9	4	**31**
Obstetrics & Gynaecology	1	10	3	13	4	**31**
Occupational & Environmental Medicine	0	0	0	0	0	**0**
Ontario Psychiatric Hospitals	0	0	0	0	0	**0**
Ophthalmology	5	23	15	34	10	**87**
Orthopaedic Surgery	0	4	0	0	0	**4**
Otolaryngology	0	4	2	1	0	**7**
Pediatrics	0	3	4	1	0	**8**
Palliative Medicine	0	0	0	1	0	**1**

OMA Constituency	Delete fee code	New fee code	Revision	Value change	Value Change and Revision	TOTAL
Physical Medicine & Rehab	0	0	0	0	0	**0**
Plastic Surgery	0	0	10	2	0	**12**
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	3	3	0	0	**6**
Public Health Physicians	0	0	0	6	0	**6**
Radiation Oncology	0	0	0	0	0	**0**
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	10	5	**18**
Rural Expert Panel	0	0	0	0	0	**0**
Sleep Medicine	0	0	0	7	0	**7**
Sport and Exercise Medicine	0	2	0	2	0	**4**
Surgical Assistants	4	12	2	8	0	**26**
Urology	0	0	1	7	0	**8**
Vascular Surgery	0	2	2	4	0	**8**
Total	**46**	**152**	**97**	**317**	**38**	**650**

PPC Initiatives and Assignments from PSC/OWG

In addition to those proposals submitted by OMA constituency leaders and member groups, the PPC received direction from the Physician Services Committee (PSC) and the Operations Working Group (OWG) to implement a number of schedule of benefits changes. The PPC also developed proposals internally that involved changes to schedule definitions and revisions to preamble sections of the schedule of benefits. The PPC's proposals are meant to support the shared aim of schedule of benefits modernization. Details on these proposals can be found in the last two sections of this 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 current 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, 2025) 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 PPC's mandate includes recommending how to implement each OMA section or physician grouping's compensation increases to the Schedule of Benefits. The PPC is obligated to make

recommendations regarding the April 1, 2026 fee adjustments to the PSC (and OMA board) no later than October 2025.

The final recommendations of the PPC in October 2025must 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 to make informed recommendations related to the priority of their proposals.

The PPC will continue to engage with OMA constituencies as more information on allocation and costing becomes available. Constituencies have had opportunities to provide feedback, and this will continue following the release of this, the second draft of the PPC's report. They will also have an opportunity to submit new or revised proposals for consideration by the PPC. The most up-to-date information and current PPC timelines can be found on the OMA's PPC webpage (https://www.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 preliminary comments from the committee. This report is a followup to Report #1 that was released in June 2024. This process will continue until October 2025. OMA constituency leaders are invited to provide feedback on this draft report and further reports planned for 2025. **No decisions in this report are final**. **PPC is tasked with delivering final recommendations to PSC by October 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

In addition, the February 2024 Implementation and Procedural Agreement states the following:

"To the extent practicable, the permanent year 1 non-targeted price increases will be implemented at the same time as the April 1, 2023, price increases under Year 3 of the of the

2021-24 PSA i.e. April 1, 2025, and in any event no later than October 1, 2025. These increases will be calculated on a base of 2023-2024 expenditures as described in paragraph 1a and will be allocated to physician payments through the PPC process to each section or physician grouping. The distribution as between across the board increases and relativity increases will be determined in such manner as the parties agree or, failing agreement, as the board of arbitration awards, with the relativity portion to be based on the most current hybrid CANDI-RAANI score. These increases will also flow through to non-fee for service payments as soon as is practicable."

The bilateral PPC is empowered only to recommend changes that fall within their scope of work agreed to 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, APP working groups, and the Acuity modifier working group, to name a few. 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 year 3 & Year 1 fee setting process. New comments and revisions to the report are highlighted, and all comments herein are as of September 17th, 2024. Committee responses generally fell into one of the following categories:

- The committee supports the proposal in principle, subject to allocation, 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.
  - Deliberations will continue for fee value changes once allocation is known*

- 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 resubmitted during a future fee setting process.

- The constituency elected to withdraw this proposal.
- The committee does not support this proposal

*As details on allocation were not available as of September 17, 2024, the PPC elected to defer deliberations on fee value changes until this information became available. In this report, fee proposals for new fee codes, Schedule revisions, and fee code deletions were all evaluated on their merits.

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 take into account 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 taken into account when making adjustments to fee values.

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 submission in January and February 2024. The PPC met with 43 constituencies over 6 days; the last set of presentations took place on February 26. The process of refining recommendations will be iterative, and constituencies will have multiple opportunities 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.

Given the new timelines, constituency leaders will be invited to meet with the PPC again in early 2025. Meeting invitations will be shared with constituency leaders shortly.

1 Addiction Medicine

1.1 Opioid Agonist Maintenance Program (OAMP) monthly management fee – intensive and maintenance (K682 and K683) (PFAF 45)

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 xx)

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.

2 Allergy and Clinical Immunology

2.1 A625 Consultation (PFAF 177)

Constituency Proposal

- The constituency requested a fee increase to A625 from $159.00 to $165.00, by 3.8 per cent.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

2.2 A623 Medical specific assessment (PFAF 179)

Constituency Proposal

- The constituency requested a fee increase to A623 from $80.90 to $82.00, by 1.4 per cent.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

2.3 G197 Skin testing - professional component (PFAF 184)

Constituency Proposal

- The constituency requested a fee increase to G197 from $0.37 to $2.00, by 440.5 per cent.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

2.4 G208 Provocation testing (PFAF 185)

Constituency Proposal

- The constituency requested a fee increase to G208 from $21.25 to $50.00, by 135.3 per cent.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

2.5 Exxx Allergy procedure stabilization premium (PFAF 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 D3)

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 awaits feedback from the constituency to aid in its deliberations.

3 Anesthesiology

3.1 A/Cxxx - Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service) (PFAF D4)

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 99)

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 100)

Constituency Proposal

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

Committee Comments

- Analysis has demonstrated that the impact of this change is negligible.
- The committee does not support this proposal.

3.4 Anaesthesiologist Unit fee (PFAF 101)

Constituency Proposal

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

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

3.5 Z438A Insertion of Swan-Ganz catheter (PFAF 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.
- The constituency indicated they may defer or drop this proposal pending additional information including funding allocation, costing, etc.

Committee Comments

- The committee acknowledges the section's choice to continue with PFAF 102.
- Deliberations will continue for fee value changes once allocation is known.

3.6 Anaesthesia basic unit relativity adjustment (PFAF 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 supports the proposal in principle.
- Deliberations will continue once allocation is known.

4 Cannabinoid Medicine MIG

4.1 General & Family Practice time-based "K" prefix fee codes relativity adjustment (various, excluding K023) (PFAF 30)

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

- Deliberations will continue for fee value changes once allocation is known.

4.2 Kxxx Monthly Management Fee for Focused Practice Family Doctors (exception of Addiction Medicine) (PFAF 32)

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)
- The Fee-for-Service Family Physician (MIG) made the same request. See Fee-for-Service Family Physician (MIG) for more information.

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.

4.3 Community-based infrastructure premium-for office-based practices (out of hospital) and in-basket (PFAF 33)

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.
- The Fee-for-Service Family Physician (MIG) made the same request. Please see Fee-for-Service Family Physician (MIG) for more information.

Committee Comments

- The proposal represents a large system-wide issue that involves the entire profession and is 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.

4.4 Exxx Unattached patient premium (PFAF 34)

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.
- The Fee-for-Service Family Physician (MIG) made the same request. Please see Fee-for-Service Family Physician (MIG) for more information.

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.

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 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 allocation, and awaits feedback from the constituency regarding the appropriate list of codes.

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

5.3 E646 Coronary artery repair - vein patch angioplasty of coronary artery, add (PFAF 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 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 allocation.

5.5 Zxxx Removal of temporary epicardial wires (PFAF 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 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 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 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 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 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 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 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.

6 Cardiology

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

7 Chronic Pain

7.1 G384 Infiltration of tissues for trigger point (PFAF 105)

7.2 G385 For each additional site (to a maximum of 2) (PFAF 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

- 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 Critical Care Medicine

8.1 Critical Care Per Diem Menu of Fees (PFAF 247, 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

- Further deliberations will occur once allocation is known.

8.2 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 249)

8.3 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 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, further deliberations will occur once allocation is known.

8.4 Special Visit Premiums – Evening & Weekend (PFAF D6)

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 relevant.
- The committee views the proposal as withdrawn.

9 Dermatology

9.1 Complex Skin Cancer Specific Assessment (PFAF 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 A020/A021 and understands that the section supports this approach (see comments on PFAF 156 below).
- Deliberations will continue once allocation is known.

9.2 A020 Complex dermatology assessment – revision (PFAF 156)

9.3 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 awaits feedback from the constituency to aid in its deliberations on wording for E.v.

10 Diagnostic Imaging

10.1 Interventional Radiology procedures except angioplasty and stenting codes (PFAF 24)

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%
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	$60.15	$75.19	$15.04	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%

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
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%
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	$331.90	$414.88	$82.98	25.0%

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
	or more abscesses within the same abdominal quadrant or the pelvis				
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

- Deliberations will continue for fee value changes once allocation is known.

10.2 J182 Diagnostic Ultrasound - Extremities - per limb (excluding vascular studies) (PFAF D7)

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.

10.3 J1xx Ultrasound - biophysical profile (BPP) (PFAF D8)

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 believes that J160 adequately compensates when a biophysical profile is performed.
- The committee does not support this proposal.

11 Emergency Medicine

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

Constituency Proposal

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

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
Z101	Abscess or haematoma - Local anaesthetic - subcutaneous - one	$25.75	$30.90	$5.15	20.0%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
Z102	Abscess or haematoma - General anaesthetic - subcutaneous - one	$44.35	$53.20	$8.85	20.0%
Z104	Abscess or haematoma - Local anaesthetic - subcutaneous - perianal	$20.10	$44.35	$24.25	120.6%
Z173	Abscess or haematoma - Local anaesthetic - subcutaneous - two	$30.35	$36.40	$6.05	19.9%
Z174	Abscess or haematoma - Local anaesthetic - subcutaneous - three or more	$40.80	$48.95	$8.15	20.0%
Z154	Repair of lacerations - up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers	$35.90	$43.10	$7.20	20.1%
Z175	Repair of lacerations - 5.1 to 10 cm	$35.90	$43.10	$7.20	20.1%
Z176	Repair of lacerations - up to 5 cm	$20.00	$24.00	$4.00	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	$85.55	$14.25	20.0%
Z179	Repair of lacerations - 10.1 to 15 cm	$50.40	$60.50	$10.10	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	$121.75	$20.30	20.0%
Z191	Repair of lacerations - more than 15.1 cm - other than face	$77.30	$92.75	$15.45	20.0%

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

11.2 Axxx Emergency Medicine Specialist Consultation (PFAF 141)

11.3 Axxx Extended Emergency Medicine Specialist Consultation (PFAF 142)

11.4 Axxx Comprehensive Emergency Medicine Specialist Consultation (PFAF 143)

11.5 Various new Consultation and Assessment codes (PFAF 188-193)

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-

PFAF	Fee code	Descriptor	Proposed fee value	Note
				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
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 disagrees with establishing new fee codes for Emergency Medicine specialists for services rendered outside of an emergency department.
- The committee does not support this proposal.

11.6 H055 Consultation - Emergency Department Physician on Duty (PFAF 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.

11.7 H065 Consultation in Emergency Medicine (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

11.8 Relativity fee value changes to Emergency Medicine Assessment H-fee codes (PFAF 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%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
H154	Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h) - Re-assessment	$26.35	$26.60	$0.25	0.9%
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

- Deliberations will continue for fee value changes once allocation is known.

11.9 H100 Emergency department investigative ultrasound (PFAF 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.
- At this point in time, the committee considers POCUS to be an element of the patient assessment already bundled with the assessment fee, similar to other point-of-care diagnostic tools.
- 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.
- 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

11.10 Hxxx Emergency Department Point-of-Care Ultrasound for static or dynamic guidance (PFAF 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.

11.11 D015 Dislocations - Glenohumeral joint - closed reduction without anaesthetic (PFAF 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.

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

11.13 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 D9)

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 the proposal in principle. Deliberations will continue once allocation is known.

11.14 Gxxx - Emergency department pelvic exam with speculum (PFAF 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 the proposal in principle, subject to schedule of benefits language and allocation.

12 Endocrinology & Metabolism

12.1 Endocrinology & Metabolism Consultation and Assessment fee increases (PFAF 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%
A156	Endocrinology - Repeat consultation	$105.25	$115.80	$10.55	10.02%

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

12.2 K046 Diabetes team management (PFAF 038)

Constituency Proposal

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

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

12.3 K045 Diabetes management by a specialist (PFAF 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.
- Deliberations will continue for fee value changes once allocation is known.

13 Fee-for-Service Family Physician (MIG)

13.1 Exxx Unattached patient premium (PFAF 46)

Constituency Proposal

- The constituency requested a new 15% premium for family doctors who cares 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.

13.2 Community-based infrastructure premium-for office-based practices (out of hospital) and in-basket (PFAF 47)

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.

13.3 Exxx Chronic Disease Assessment Premium (PFAF 48)

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.

13.4 General & Family Practice time-based "K" prefix fee codes relativity adjustment (various, excluding K023) (PFAF 49)

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%
K037	Fibromyalgia/chronic fatigue syndrome care, per unit	$70.10	$74.70	$4.60	7.0%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
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

- Deliberations will continue for fee value changes once allocation is known.

13.5 Kxxx Monthly Management Fee for Focused Practice Family Doctors (exception of Addiction and Palliative Medicine) – Initial and follow-up (PFAF 50)

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.

14 Gastroenterology

14.1 E098 Chronic Disease Assessment Premium (PFAF 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 supports this change, subject to allocation and fee code relativity considerations.
- Deliberations will continue once allocation is known.

14.2 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 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 supports this proposal in principle. Deliberations will continue once allocation is known.

14.3 Exxx Radiofrequency Ablation for Barrett's Esophagus (PFAF 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 continues to deliberate on an appropriate fee value for this code. However, the committee supports the creation of this fee code in principle.
- Deliberations will continue once allocation is known.

14.4 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 202)

Constituency Proposal

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

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

  (Revisions underlined, 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 supports this proposal in principle, subject to allocation.

14.5 Oesophageal Studies: Proposed revisions and fee increases (PFAF 203, 208, 211)
14.6 G350 Gastroenterology - Oesophageal motility study(ies) with manometry
14.7 G251 Oesophageal Studies - Oesophageal pH study for reflux, with installation of acid
14.8 G351 Oesophageal Studies - Oesophageal pH study for reflux, with installation of acid, with 24 hour monitoring
14.9 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 is awaiting information from the constituency to aid in its deliberations.

- Deliberations will continue for fee value changes once allocation is known.

14.10 E749: when Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z512, Z555 or Z580 rendered in private office, add (PFAF 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

- A review of billing data failed to demonstrate that this change would address an intrasectional relativity issue.
- The committee does not support this proposal.

14.11 Consultation and Assessment Fees (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

15 General & Family Practice

15.1 Relativity fee value changes to various visit codes (PFAF 23)

Constituency Proposal

- The constituency requested several increases ranging from 1 to 20 per cent to the following fee codes:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
A001	GP/FP - Minor assessment	$23.75	$24.45	$0.70	2.95%
A002	GP/FP - Enhanced 18 month well baby visit	$62.20	$65.30	$3.10	4.98%
A003	GP/FP - General assessment	$87.35	$89.10	$1.75	2.00%
A007	GP/FP - Intermediate assessment/well baby care	$37.95	$40.05	$2.10	5.53%
A/C/W777	GP/FP - Intermediate assessment - Pronouncement of death	$37.95	$40.05	$2.10	5.53%
A888	GP/FP - ED equivalent - Partial assessment	$37.95	$40.05	$2.10	5.53%
A900	GP/FP - Complex house call assessment	$54.50	$57.25	$2.75	5.05%
A917	GP/FP - Focused Practice Assessment (FPA)- Sport medicine FPA	$37.95	$40.05	$2.10	5.53%
A927	GP/FP - Focused Practice Assessment (FPA) - Allergy FPA	$37.95	$40.05	$2.10	5.53%
A937	GP/FP - Focused Practice Assessment (FPA) - Pain management FPA	$37.95	$40.05	$2.10	5.53%
A947	GP/FP - Focused Practice Assessment (FPA) - Sleep medicine FPA	$37.95	$40.05	$2.10	5.53%
A957	GP/FP - Focused Practice Assessment (FPA) - Addiction medicine FPA	$37.95	$40.05	$2.10	5.53%
A967	GP/FP - Care of the elderly FPA	$37.95	$40.05	$2.10	5.53%
G538	Injections and Infusions - Immunization - Other immunizing agents not listed above	$5.80	$6.50	$0.70	12.07%
G700	Basic fee- Per- Visit premium for procedures marked (+)	$5.60	$5.65	$0.05	0.89%
G840	Injections and Infusions - Immunization - Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP/IPV) - Paediatric	$5.40	$6.50	$1.10	20.37%
G841	Injections and Infusions - Immunization - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP- IPV- Hib) - Paediatric	$6.35	$6.50	$0.15	2.36%
G842	Injections and Infusions - Immunization - Hepatitis B (HB)	$5.40	$6.50	$1.10	20.37%
G843	Injections and Infusions - Immunization - Human Papillomavirus (HPV)	$5.40	$6.50	$1.10	20.37%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
G844	Injections and Infusions - Immunization - Meningococcal C Conjugate (Men-C)	$5.40	$6.50	$1.10	20.37%
G845	Injections and Infusions - Immunization - Measles, mumps, rubella (MMR)	$5.40	$6.50	$1.10	20.37%
G846	Injections and Infusions - Immunization - Pneumococcal conjugate	$5.40	$6.50	$1.10	20.37%
G847	Injections and Infusions - Immunization -Diphtheria, Tetanus, acellular Pertussis (Tdap) - Adult	$5.40	$6.50	$1.10	20.37%
G848	Injections and Infusions - Immunization - Varicella (VAR)	$5.40	$6.50	$1.10	20.37%
K002	GP/FP - Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act per unit	$70.10	$74.70	$4.60	6.56%
K003	GP/FP - 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	6.56%
K005	GP/FP - Primary mental health care - Individual care per unit	$70.10	$74.70	$4.60	6.56%
K006	GP/FP - Hypnotherapy - Individual care per unit	$70.10	$74.70	$4.60	6.56%
K007	GP/FP - Psychotherapy - Individual care per unit	$70.10	$74.70	$4.60	6.56%
K008	GP/FP - Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities per unit	$70.10	$74.70	$4.60	6.56%
K013	GP/FP - 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	6.56%
K014	GP/FP - Group Counselling - Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons per unit	$70.10	$74.70	$4.60	6.56%
K015	GP/FP - Group Counselling - Counselling of relatives - On behalf of	$70.10	$74.70	$4.60	6.56%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
	catastrophically or terminally ill patient - 1 or more persons per unit				
K022	GP/FP - HIV primary care per unit	$70.10	$74.70	$4.60	6.56%
K028	GP/FP - Sexually transmitted disease (STD) or potential blood- Borne pathogen management - STD management per unit	$70.10	$74.70	$4.60	6.56%
K029	GP/FP - Insulin Therapy Support (ITS) per unit	$70.10	$74.70	$4.60	6.56%
K030	GP/FP - Diabetic Management Assessment	$40.55	$43.20	$2.65	6.54%
K032	GP/FP - Specific neurocognitive assessment	$70.10	$74.70	$4.60	6.56%
K033	GP/FP - Counselling - Individual care - Additional units per patient per provider per 12-month period per unit	$49.35	$51.80	$2.45	4.96%
K037	GP/FP - Fibromyalgia/myalgic encephalomyelitis care	$70.10	$74.70	$4.60	6.56%
K040	GP/FP - Group Counselling - 2 or more persons - Where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12-month period per unit	$70.10	$74.70	$4.60	6.56%
K130	GP/FP - Periodic health visit - Adolescent	$77.20	$80.30	$3.10	4.02%
K131	GP/FP - Periodic health visit - Adult age 18 to 64 inclusive	$56.95	$59.25	$2.30	4.04%
K132	GP/FP - Periodic health visit - Adult 65 years of age and older	$80.95	$84.20	$3.25	4.01%
K680	GP/FP - Substance abuse - Extended assessment per unit	$70.10	$74.70	$4.60	6.56%
P003	Obstetrics - Prenatal care - General assessment (major prenatal visit)	$80.35	$84.35	$4.00	4.98%
P004	Obstetrics - Prenatal care - Minor prenatal assessment	$38.15	$40.05	$1.90	4.98%
P005	Obstetrics - Prenatal care - Antenatal Preventative Health Assessment	$47.70	$50.10	$2.40	5.03%

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

15.2 Exxx Complexity Modifier for Comprehensive Family Practice (PFAF 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.

15.3 Exxx - Complexity Add on Fee to A007 (PFAF 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

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

15.4 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 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 allocation and drafting schedule language.

15.5 Services provided after hours in small rural hospitals (PFAF 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.

16 General & Family Practice (Member Group)

16.1 Exxx Community based infrastructure premium for office-based practice (PFAF 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.

16.2 Administrative support time-based code (PFAF 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.

16.3 Multiple GP/FP visit fee relativity changes (PFAF 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%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
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

- Deliberations will continue for fee value changes once allocation is known.

16.4 Exxx Additional medical issue add-on (PFAF 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.

17 General Internal Medicine

17.1 A/C135 Consultation (PFAF 19)

Constituency Proposal

- The constituency requested a fee value change to A/C135 Consultation, from $164.90 to $175.00, by 6.1 per cent.
- Request to increase the consultation fee value to be in line with similarly trained medicine subspecialists. Additionally, to recognize the added time it takes to do an internal medicine consultation in the context of an aging population with more acute presentations and comorbid disease.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

17.2 A/C130 Comprehensive internal medicine consultation (PFAF 20)

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~~ rendering the consultation, including time spent before, during and after patient contact, exclusive of time spent rendering any other separately billable intervention to the patient.
>
> (Revisions underlined, 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.

17.3 Most Responsible Physician (MRP) Premiums (E082, E083 and E084) (PFAF D36)

17.4 Hospitalist Premium (PFAF D29)

17.5 Cxxx - Inpatient transfer of care (PFAF D30)

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

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

17.8 Wxx2 - MRP day of discharge, medically complex patient, long term care or chronic care facility (PFAF 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. As such, the committee's position is to decline consideration of these proposals during this allocation.
- The section may bring these items back to the committee at a future allocation, after the new APP is established.

17.9 MRP Subsequent visits (C122, C142) (PFAF D33, D34)

Constituency Proposal

- The Constituency requested fee increases to C122 and C142 from $61.15 to $71.35, by 16.7 per cent

Committee Comments

- The items pertaining to value changes are deferred pending allocation.
- Changing the value of C122, C142 would require consultation with all affected sections.

17.10 Kxxx - Interprofessional Rounds (PFAF 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 require cost utilizations 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.

18 General Surgery

18.1 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 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 counter-proposal, 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, Z574, subject to allocation and rewriting of schedule language for E515.

18.2 Exxx Suffix modifier for selected codes for a second general surgeon assisting another general surgeon (PFAF 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 plans to deliberate further on this proposal when allocation is known and reach out to the constituency as required.

18.3 Rxxx Same as R226 but for soft tissue sarcoma for general surgeons (PFAF 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 the proposal in principle. Deliberations will continue once allocation is known.

18.4 E673 Lysis of extensive intra-abdominal adhesions, add (PFAF 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

- Deliberations will continue for fee value changes once allocation is known

18.5 S332 Herniotomy - Umbilical - adolescent or adult (PFAF 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 allocation, and notes that the paediatric code (S333) should be changed in the same manner.

18.6 A034 - Partial assessment (PFAF D14)

18.7 A033 - Specific assessment (PFAF D15)

18.8 A0xx - Assessments of greater than 30 minutes (PFAF 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

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

19 General Surgery (Member Group)

19.1 Sxxx Temporary abdominal closure with or without abdominal washout (PFAF 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 allocation.

20 General Thoracic Surgery

20.1 E618 Lungs and pleura - with decortication of remaining lobe(s), add (PFAF 41)

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 allocation and schedule language approval.

20.2 M143 Lobectomy, may include radical mediastinal node dissection or sampling (PFAF 51)

20.3 M144 Segmental resection, including segmental bronchus and artery (PFAF 52)

20.4 M145 Wedge resection of lung (PFAF 133)

Constituency Proposal

- The constituency proposed the following fee increases:

Fee code	Descriptor	Current value	Proposed value	$ Increase	% Increase
M143	Lobectomy, may include radical mediastinal node dissection or sampling	$1402.60	$1500.78	$98.18	7.0%
M144	Segmental resection, including segmental bronchus and artery	$1441.75	$1542.67	$100.92	7.0%
M145	Wedge resection of lung	$843.40	$902.45	$59.05	7.0%

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

20.5 Rxxx Open or VATS drainage of pericardial effusion for Cardiac Tamponade (PFAF 53)

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 notes that when discussing this code with the section, the rationale for the creation of the code related to the acuity of the patient. When preoperative resuscitation is required, the physician should bill appropriate critical care codes for that care. The committee notes that compensation for that acuity could be sought through the use of critical care codes, as appropriate.
- Given that the section did not provide evidence that the surgical procedure was significantly different in this clinical scenario, the committee does not support the creation of a new fee code.
- The committee supports allowing E683 to be added to R750 when drainage pericardial affusion is performed using a VATS approach.
- The committee continues to deliberate schedule of benefits language.

20.6 E683 when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach (PFAF 54)

20.7 M138 Hilar lymph node or lung biopsy with full thoracotomy (PFAF 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 that this E-code applies to.
- The committee does not support this proposal.

20.8 M117 Chest wall - pleura - Sternal fixation for trauma (PFAF 55)

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.

20.9 M105 Chest and Mediastinum - Chest wall tumour, resection of 2 or 3 ribs or cartilages (PFAF 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 allocation and schedule language approval.
- Deliberations will continue for fee value changes once allocation is known.

20.10 M111 Surgical collapse - Thoracoplasty - One stage (PFAF 56)

20.11 E605 Surgical collapse - Thoracoplasty – for each additional rib (max 3 additional) (PFAF 56)

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 notes that there remain indications for this procedure.
- The committee does not support this proposal.

20.12 Z353 Chest and Mediastinum - Incision - Incisional biopsy of chest wall tumour (PFAF 57)

20.13 Z354 Chest and Mediastinum - Incision - Excisional biopsy of rib for tumour (PFAF 57)

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.

20.14 Z337 Rib resection for drainage (PFAF 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 to be re-written as, "Z354 Excisional biopsy of rib, or rib resection for drainage."

20.15 Z332 Aspiration with therapeutic drainage with or without diagnostic sample (PFAF 60)

20.16 Z331 Aspiration for diagnostic sample (PFAF 59)

Constituency Proposal

- The constituency proposed a revision to Z332 as follows:

> Z332 Thoracentesis - Aspiration <u>for diagnosis or 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. Deliberations will continue once allocation is known.

20.17 Z333 Endoscopy - with transbronchial biopsy under image intensification (including bronchoscopy) (PFAF 58)

Constituency Proposal

- The constituency proposed the deletion of Z333.

Committee Comments

- The committee supports the proposal and would implement with the next revision of the fee Schedule.

20.18 Z352 Intrapleural administration of thrombolytic or fibrinolytic agent via thoracostomy tube (chest tube) (PFAF 62)

20.19 Z349 Intrapleural administration of chemotherapy or sclerosing agent - by any method (PFAF 61)

Constituency Proposal

- The constituency proposed a revision to Z352 as follows:

  Intrapleural administration of thrombolytic agent, fibrinolytic agent<u>, chemotherapy or sclerosing agent</u> via thoracostomy tube (chest tube).

  (Revisions <u>underlined</u>)

- 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 resubmitted during a future fee setting process.
- The committee does not support this proposal at this time.

20.20 Z338 Biopsy of pleura or lung - with limited thoracotomy (PFAF 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 continues to deliberate, and will engage constituencies as required.

20.21 R940 Mesenteric or celiac artery repair - Pulmonary thromboendarterectomy (PTE) – includes circulatory arrest with hypothermia (PFAF 97)

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

- Deliberations will continue for fee value changes once allocation is known.

20.22 M106 Chest wall reconstruction - Mediastinal tumour (PFAF 98)

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

- There is no evidence that M106 as currently billed is undervalued relative to other surgical codes used by this section.
- The committee does not support this proposal.

20.23 N284 Chest wall reconstruction - Excision of first rib and/or cervical rib to include scalenotomy when required (PFAF 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.
- Deliberations will continue for fee value changes once allocation is known.

20.24 M155 Lung transplant (one lung) (PFAF 112)

Constituency Proposal

- The constituency proposed a fee increase to M155 from $2,054.25 to $2,465.09 (20 per cent).

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

20.25 Z788 Extracorporeal Membrane Oxygenator (ECMO) - includes cannulating and decannulating, by any method heart, vein and/or artery and repair of vessels if rendered (PFAF 113)

Constituency Proposal

- The constituency proposed to split the fee code based on two indications:) 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 section'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 codes.

20.26 E616 bi-lobectomy on right side, add (PFAF 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:

  bi-lobectomy on right side or segmentectomy plus lobectomy (same side).

  (Revisions underlined)

Committee Comments

- The committee supports the proposed descriptor change.

- Deliberations will continue for fee value changes once allocation is known.

20.27 E676A Morbidly obese patient, surgeon, to procedural fee(s), add (PFAF 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.

21 Genetics

21.1 Kxxx Genetic Clinical Analysis and Care Planning (PFAF 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.

21.2 K044 Genetic Family Counselling (PFAF D18)

21.3 K016 Genetic assessment, patient or family (PFAF D19)

21.4 A221 Genetic minor assessment (PFAF D20)

21.5 A/C325 Limited consultation (PFAF 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 constituency declined to pursue this proposal as part of the year three allocation process after discussion with the committee.

22 Haematology & Medical Oncology

22.1 E078 Chronic Disease Assessment Premium

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.

22.2 G388 Management of special oral chemotherapy, for malignant disease

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, subject to allocation and schedule language approval.
- Deliberations will continue for fee value changes once allocation is known.

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

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.

22.4 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)

Constituency Proposal

- The constituency requested a descriptor change to G390 as follows,

    "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) <u>First infusion of bispecific antibodies (such as glofitamab) Chemotherapy for infusion of CAR T cells</u>"

    (Revisions <u>underlined</u>)

- 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 supports the proposal in principle, and is currently engaging the section to explore appropriate Schedule modification.
- Deliberations will continue once allocation is known.

22.5 Z403 Bone marrow a spiration and/or core biopsy

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.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

22.6 Gxxx Systemic Therapy Planning (PFAF 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.

23 Hospital Medicine

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 there is a provision within the 2021 Physician Services Agreement to establish a hospitalist APP. As such, the committee's position is to decline consideration of these proposals during this allocation.
- The section may bring these items back to the committee at a future allocation, after the new APP is established.

24 Hyperbaric Medicine

24.1 Axxx Consultation in Hyperbaric Medicine (PFAF 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.

25 Infectious Diseases

25.1 Relativity fee value changes to various consult and assessment codes (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

25.2 Gxxx Supervision of Outpatient Antimicrobial Therapy (PFAF 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.

25.3 Axxx Management of Fecal Microbiota Transplant (FMT) (PFAF 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.

26 Laboratory Medicine

26.1 Deletion of fee codes (PFAF 66-75, 76-82, 88)

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

Fee code	Descriptor	Fee value
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
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.

26.2 Fee code revisions (PFAF 83-87, 89, 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/orselection 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, phasecontrast, 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 modifications are pending relating to changes in 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 allocation.

26.3 Fee code Increases (PFAF 90, 92, 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

- Deliberations will continue for fee value changes once allocation is known.

26.4 A/C586 Repeat Consultation (PFAF 93, 110)

Constituency Proposal

- The constituency proposed fee increases for A/C586 from $71.20 to $108.95 (53%).

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

27 Long Term Care & Care of the Elderly

27.1 Nursing Home or Home for the Aged Fees (PFAF 173-175)

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%

Fee Code	Descriptor	Current Fee	Proposed Fee	$ Increase	% Increase
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

- Deliberations will continue for fee value changes once allocation is known.

27.2 Wxxx LTC telephone support (PFAF 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:

  1. A maximum of two (2) units of Wxxx are eligible for payment per patient per day.
  2. A maximum of eight (8) Wxxx units are eligible for payment per patient per 12-month period.
  3. 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.

27.3 K042 Extended specific neurocognitive assessment (PFAF 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.

27.4 A075 & A775 Consultations (PFAFs 180, 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.

28 Nephrology

28.1 Exxx Complex Chronic Kidney Disease Assessment Premium (PFAF 63)

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.

28.2 E060 Post Renal Transplant Assessment Premium (PFAF 64)

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 supports the proposal, subject to allocation.
- Deliberations on fee value changes will continue once allocation is known.

29 Neurology

29.1 G874 Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral) (PFAF 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~~)

- Given the section's response that this procedure takes approximately 15 minutes, the proposed increase in this code would result in the procedure becoming out of relativity with other similar services.
- Deliberations will continue for fee value changes once allocation is known.

29.2 Kxxx Neurologist to allied health professional outpatient consultation (PFAF 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.

29.3 Axxx Complex headache assessment (PFAF 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. Deliberations on fee value changes await allocation.

29.4 E150, CritiCall review of complex neurosurgical imaging, to K733 (PFAF 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 allocation.

29.5 Kxxx Neurology Assessment Extension (PFAF 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.

29.6 Exxx Chronic CNS disorders premium (PFAF 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. Deliberations on fee value changes awaits allocation.

29.7 Axxx Complex neuro-oncology assessment (PFAF 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. Deliberations on fee value changes awaits allocation.

29.8 G419 Tensilon test (PFAF 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.

29.9 Exxx After Hours Acute Stroke Premium (50%) (PFAF D37)

29.10 Exxx After Hours Acute Stroke Premium (75%) (PFAF 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.

29.11 Kxx1 Epilepsy Surgery Multidisciplinary Rounds (PFAF D39)

29.12 Kxx2 Epilepsy Surgery Rounds Planning and Preparation (PFAF 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, the proposal for Epilepsy Surgery Multidisciplinary Case Conferences, subject to allocation and drafting of appropriate schedule language.
- 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.

29.13 G456 Needle Electromyography and Nerve Conduction Studies - professional component (PFAF D41)

Constituency Proposal

- The constituency requested an increase to G456 from $99.90 to $120.00.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

29.14 Gxxx Neuromuscular Ultrasound (PFAF 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.

29.15 Gxx1 Transcranial Doppler Ultrasound – Complete Study (60 minutes) (PFAF D43)

29.16 Gxx3 Transcranial Doppler Ultrasound – Limited Study (30 minutes) (PFAF 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.

29.17 G545 Prolonged EEG monitoring (PFAF 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, subject to allocation, 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 this service has both a technical fee and professional fee associated. The committee continues to explore the best approach to implement the change given that technical fees are outside of the PPC's mandate.

30 Neurosurgery

30.1 Nxxx Endovascular mechanical thrombectomy for embolic stroke (PFAF 124)

Constituency Proposal

- The constituency proposed a new fee for endovascular mechanical thrombectomy for embolic stroke, valued at $2,500.00.

Committee Comments

- The committee continues to deliberate on this proposal and awaits a joint proposal from Radiology and Neurosurgery. That joint proposal should identify all possible fee code combinations which are currently being claimed for this.

30.2 Exxx BMI premium (PFAF 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.

31 Nuclear Medicine

31.1 J809 Myocardial Perfusion Scintigraphy - application of SPECT (maximum two per examination), to J808 (PFAF 95)

Constituency Proposal

- The constituency proposed a revision to J809 as follows:

> - Application of SPECT (maximum ~~2~~3 per examination), to <u>J807 or</u> J808.
>
> (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.

31.2 J866 Application of (SPECT), maximum one per examination, to J807 (PFAF 96)

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.

31.3 A735 Diagnostic Consultation (PFAF 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 negligible.
- The committee does not support this proposal.

31.4 Cardiac codes J807, J808, J809, J900, J901, J811, J812, J813, J814 (PFAF 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.

31.5 Jxxx Brain scintigraphy - cerebral perfusion (PFAF 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 the proposal and will deliberate on the value of the two codes once allocation is known.

31.6 Jxxx1, Jxx2, Jxx4 - hybrid tomographic (SPECT/CT) imaging and multiple tomographic sequences (PFAF 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.
- Deliberations on fee value changes will continue once allocation is known.

31.7 Cost neutral modernization of the OHIP Schedule: application of SPECT and hybrid SPECT/CT, cardiac nuclear medicine studies and miscellaneous nuclear medicine studies (PFAF D52, D53, D65-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

- Deliberations continue. The committee will engage with the constituency, as required.

31.8 Modernization of the OHIP Schedule, PET and PET/CT studies (PFAF D54-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.

32 Obstetrics & Gynaecology

32.1 Pxxx Management of labour (PFAF 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.

32.2 S760 Abdominal approach to vaginal vault prolapse - vaginal sacropexy (PFAF 197)

32.3 S813 Abdominal approach to vaginal vault prolapse - repeat - vaginal sacropexy (PFAF 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.
- Deliberations regarding the first rule change and fee value are deferred until allocation is known.
- The committee notes that E862 can already be billed if these procedures are done laparoscopically and therefore no change to the payment rules is required.

32.4 Exxx female genital procedures - vagina - repair - anterior or posterior repair - when implant is used (PFAF 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

- Committee analysis indicates this fee changes will likely worsen intra-sectional relativity.
- The committee does not support this proposal.

32.5 Sxxx Pelvic mesh excision (PFAF 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 continues to deliberate and will reach out to the constituency as required.

32.6 S725 Colpocleisis (PFAF 212)

Constituency Proposal

- The constituency proposed a fee increase to S725, from $300.35 to $515.05, and a revision as follows:

  Colpocleisis <u>or vaginectomy</u>

  (Revisions <u>underlined</u>)

- 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.
- Deliberations on fee value will continue once allocation is known.

32.7 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 (PFAF 215)

32.8 Sxx1 Stripping bladder peritoneum with cancer (PFAF 215)

32.9 Sxx2 Stripping large/ small bowel mesentery with cancer (PFAF 215)

32.10 Sxx3 Resection of diaphragmatic disease from cancer (PFAF 215)

32.11 Sxx4 Resection of omental cake from cancer (PFAF 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 S727 was recently modified. 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.
- The committee believes a time-based fee code is the best solution for complex surgeries which may have variable procedural lengths.
- The committee continues to deliberate and will reach out to the constituency as required.

32.12 Zxxx Transvaginal injection into pelvic floor muscle trigger point for chronic pain (PFAF 220)

32.13 Exxx Each additional injections to a maximum of 6 additional (PFAF 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.

32.14 S745 Oophorectomy - and/or oophorocystectomy (PFAF 219/222)

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.

32.15 P020 Operative delivery, i.e. mid-cavity extraction or assisted breech delivery (PFAF 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 or greater than 1 minute in duration or urgent referral to an obstetrician from a non-obstetrician on call for assistance."

32.16 Zxxx Insertion of hormonal implant or rod for contraception, menstrual cycle control or menopausal hormone therapy (PFAF 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 has drafted schedule language which addresses this proposal and awaits feedback from the relevant constituencies to aid in its deliberations.

32.17 Z463 Removal of Norplant (PFAF 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.

32.18 E090 Oophorectomy - removal of contralateral ovary with moderate or severe endometriosis, to S745, add (PFAF 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 supports the proposed rule change, subject to allocation.

32.19 Various fee increases (PFAF 260, 264-267, 270, 284, 294, 296, 297)

Constituency Proposal

- The constituency proposed the following fee increases:

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
S784	Ectopic pregnancy any technique	$382.10	$458.60	$76.50	20.0%
S738	Salpingectomy or Salpingoophorectomy (Uni-bilateral)	$366.20	$458.60	$92.40	25.2%
S745	Oophororectomy and/or oophorocystectomy	$366.20	$458.60	$92.40	25.2%
Z552	Laparoscopy without biopsy	$149.65	$160.00	$10.35	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	$28.35	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	$44.95	6.9%

Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
Z715	Abscess of vulva, Bartholin or Skene's gland - general anaesthetic	$56.70	$100.00	$43.30	76.4%
Z716	Abscess of vulva, Bartholin or Skene's gland - Marsupialization of Bartholin's cyst or abscess	$89.80	$110.00	$20.20	22.5%
Z475	Biopsy(ies) - when sole procedure - general anaesthetic	$56.70	$100.00	$43.30	76.4%
S707	Biopsy(ies) - when sole procedure - Hymenectomy (with or without perineotomy) or hymenotomy	$97.20	$120.00	$22.80	23.5%
S706	Biopsy(ies) - when sole procedure - Cyst of Bartholin's gland	$129.85	$160.00	$30.15	23.2%
Z737	Laparoscopy - Laser treatment of extensive pelvic disease	$215.80	$260.00	$44.20	20.5%

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

33 Ophthalmology / Eye Physicians and Surgeons of Ontario

33.1 Various fee value changes to consult and assessment fee codes (PFAF 147, 148, 171, 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

- Deliberations will continue for fee value changes once allocation is known.

33.2 Axxx Optometrist-Requested Assessment for Uveitis and Ocular Inflammatory Diseases (PFAF 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.
- Deliberations will continue once allocation is known.

33.3 Axxx Optometrist-Requested Assessment for Neuro-ophthalmic Disorders (PFAF 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.
- Deliberations will continue once allocation is known.

33.4 E877 Strabismus procedures - repeat strabismus procedure(s), to E185, E184, E183, or E182 (PFAF 4)

Constituency Proposal

- The constituency requested a revision to E877 as follows:

  Repeat strabismus procedures. additive to E185, E184, E183, E182, <u>or to strabismus procedure performed for patients with post traumatic strabismus, Thyroid eye disease, post placement of a retinal buckle, or external ophthalmoplegia</u>.

  (Revisions <u>underlined</u>)

- 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.
- The proposal may be resubmitted during a future fee setting process as additional data would be available at that time.

33.5 Exxx Laser retinopexy for retinoblastoma (PFAF 7)

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 Laser retinopexy for retinoblastoma be added as an indication to code E125 - Laser retinopexy for Retinopathy of Prematurity – one eye and E126 – both eyes.

33.6 Exxx Cryopexy for retinoblastoma (PFAF 8)

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.

33.7 Exx1 Pediatric cataract extraction age 0 to 7 years (PFAF 12)

33.8 Exx2 Pediatric cataract extraction age years (PFAF 13)

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.
- E214 cataract surgery with glaucoma filtering procedure surgery $729 still does not adequately compensate for this procedure for patients in this age range. British Columbia has more recently assess this procedure and adjusted the code accordingly.

Committee Comments

- Based on an analysis service time, and taking into account the age premium that already applies, the committee supports creating a single paediatric cataract extraction code (age 0-16 years).
- Deliberations will continue once allocation is known.

33.9 G428 Hess screen examination - professional component (PFAF 2)

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

- Deliberations on fee value changes will continue once allocation is known.

33.10 G436 Visual fields - kinetic (with permanent record) - professional component (PFAF 3)

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

- Deliberations on fee value changes will continue once allocation is known.

33.11 G432 Ophthalmology - Visual fields - Static - professional component (PFAF 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

- Deliberations on fee value changes will continue once allocation is known.

33.12 G453 Contact lens fitting - Electro-oculogram - interpretation fee (PFAF 5)

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

- Deliberations on fee value changes will continue once allocation is known.

33.13 G150 Visual evoked response - threshold - professional component (PFAF 6)

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

- Deliberations on fee value changes will continue once allocation is known.

33.14 G147 Visual evoked response - simple - professional component (PFAF 9)

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

- Deliberations on fee value changes will continue once allocation is known.

33.15 G438 Colour vision detailed assessment - professional component (PFAF 10)

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

- Deliberations on fee value changes will continue once allocation is known.

33.16 G870 Botulinum toxin injection(s) of extraocular muscle(s), (unilateral) (PFAF 11)

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.

33.17 E140 Cataract - all types of, by any procedure, includes insertion of intraocular lens (PFAF 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.

33.18 Various fee value changes to oculoplastics fee codes (PFAF 118, 119, 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%

Type	Fee Code	Descriptor	Current Value	Proposed Value	$ Increase	% Increase
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%
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

- Deliberations on fee value changes will continue once allocation is known.

33.19 Z901 Irrigation of nasolacrimal system - unilateral or bilateral (PFAF 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

- Deliberations on the proposed rule change will continue once allocation is known.

33.20 E194 Distichiasis – unilateral (PFAF 119)

33.21 E195 Trichiasis, repair by tarsal transplantation (PFAF 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.
- Deliberations on fee value changes will continue once allocation is known.

33.22 Z857 Epilation -by hyfrecator, electrolysis (PFAF 119)

33.23 Z858 Epilation -by cryopexy (PFAF 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

- Deliberations on fee value change and combining Z857 and Z858 will continue once allocation is known.

33.24 E196 Entropion, other than Zeigler puncture (PFAF 119)

33.25 E197 Ectropion, other than Zeigler puncture (PFAF 119)

33.26 E945 - repeat by second surgeon, add (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.
- 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".

33.27 E948 Ocular and Aural Surgical Procedures - with mucous membrane graft, add (PFAF 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

- Deliberations on fee value changes will continue once allocation is known.
- The committee continues to deliberate on the proposed descriptor change.

33.28 E210 Excision of conjunctival lesion (PFAF 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 underlined)

Committee Comments

- The committee notes the constituency has withdrawn their request to change the descriptor.
- Deliberations on fee value changes will continue once allocation is known.

33.29 E169 Decompression - two walls (PFAF 120)

33.30 E170 Decompression - three walls (PFAF 120)

Constituency Proposal

- The constituency requested the E196 fee be increased from $542.00 to $1,749.25 (22.7 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

- Deliberations will continue for fee value changes once allocation is known.
- The committee continues to deliberate on the proposed descriptor change.

33.31 E157 Placement and suturing of iris prosthetic device with or without suturing of iris/pupillary defect (PFAF 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 the proposal in principle.

33.32 E138 Fixation of intraocular lens and/or capsular tension device by suturing (PFAF 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 awaits the constituency's response to the draft schedule language the committee sent to the constituency.

33.33 Exxx Pneumatic Retinopexy (PFAF 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 the proposal in principle. Deliberations will continue once allocation is known.

33.34 E151 Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure (PFAF 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 committee is awaiting information from the constituency to aid in its deliberations.

33.35 E154 Photocoagulation (xenon, argon laser, etc.) - one eye (PFAF 154)

Constituency Proposal

- The constituency requested a revision to E154 as follows:

  Retinal laser photocoagulation of retinal lesion or for panretinal photocoagulation or 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 committee is awaiting information from the constituency to aid in its deliberations.

33.36 E940 Anterior vitrectomy - when done in conjunction with another intraocular procedure, add (PFAF 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 awaits the constituency's review of the draft schedule language, which was sent by the committee to the constituency.

33.37 E148 Anterior vitrectomy - Vitrectomy by infusion suction cutter technique (PFAF 157)
33.38 E936 Vitreous exchange - to vitrectomy (PFAF 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 awaits the constituency's review of the draft schedule language, which was sent by the committee to the constituency.

33.39 Various proposals to the Ocular and Aural Surgical Procedures – Vitreous – Anterior vitrectomy section in the Schedule (PFAF 157, 158, 160-167)

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	$1,318.26	New E148 + E141 + E950

PFAF #	Type	Fee Code	Proposed Descriptor	Proposed Value	Notes
			the posterior segment by fragmatome, with intraocular lens insertion		
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 awaits the constituency's review of the draft schedule language, which was sent by the committee to the constituency.

33.40 Gxxx Pattern electroretinogram (PFAF 14)

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.

33.41 Gxxx Colour vision screening with permanent record (PFAF 15)

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.

33.42 Gxxx Full field stimulus threshold testing (FST) (PFAF 16)

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.

33.43 Gxxx Visual Evoked Response pattern reversal (PFAF 17)

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.
-

33.44 Gxxx Pupillometry (PFAF 18)

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.
-

33.45 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 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.

33.46 G822 OCT unilateral or bilateral - active management with laser or intravitreal injections for neovascularization associated with…: (PFAF 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.

33.47 G813 Corneal pachymetry, professional component (PFAF 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 is awaiting information from the constituency to aid in its deliberations.
- Deliberations will continue for fee value changes once allocation is known.

33.48 E132 Glaucoma filtering procedures (PFAF 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.

33.49 E983 Glaucoma filtering procedures - following previous glaucoma filtering procedure, to E132, add (PFAF 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.

33.50 E214 Glaucoma filtering procedure and cataract extraction (same eye) (PFAF 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.

33.51 E984 Glaucoma filtering procedure and cataract extraction (same eye) - following previous glaucoma filtering procedure, to E214, add (PFAF 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.

33.52 Exxx Retinal imaging including peripheral retinal imaging by ultra-widefield or widefield fundus cameras (PFAF 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.

33.53 E202 Corneal cross-linking (PFAF 257)

Constituency Proposal

- The constituency requested a fee value change to E202 Corneal cross-linking from $200.00 to $400.
- 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. We were never given an explanation to any of our questions or concerns. We are now hearing that separate conversations have taken place to restore funding to certain academic centres, but only to those centres. We have concerns regarding patient access and the precedent this sets for other procedures now and in the future. As a result, we would like to have more time to investigate what the Ministry's plans are for this procedure, and hopefully have an inclusive conversation regarding the final code and associated fee.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

33.54 E123 Division of iris to cornea (PFAF 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.

33.55 Extraction cataract all types of, by any procedure, bilateral and simultaneous, includes insertion of intraocular lens (PFAF 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

33.56 Exxx - cyclo-photocoagulation/ablation/destruction (laser to the ciliary body) - either trans-scleral or endoscopic (PFAF 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. If there would be no change in the value of E134 and no change in utilization, then this change may be implemented independent of allocation.
- The committee notes the section's support for expanding E134 to include this procedure.

33.57 U235 Initial e-assessment (PFAF D76)
33.58 U236 Follow-up e-assessment (PFAF 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.

34 Orthopedic Surgery

34.1 Flatfoot Correction (PFAF D78)
34.2 Cavovarus Foot Reconstruction (PFAF D79)
34.3 Multi ligament knee reconstruction– Acute (PFAF 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.

34.4 Exxx Obesity add-on code - total knee replacement (PFAF 1)

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.

35 Otolaryngology

35.1 Axxx Audiologist-requested assessment (PFAF D81)

35.2 Axxx Special Audiologist-requested assessment (PFAF D82)

35.3 Axxx Dentist-requested assessment (PFAF D83)

35.4 Axxx Special dentist-requested assessment (PFAF 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.

35.5 M090 Laryngoplasty (PFAF 136)

35.6 M080 Teflon augmentation larynx (PFAF 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.

35.7 S063 Tonsillectomy and may include adenoidectomy (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

36 Pediatrics

36.1 E082 - Admission assessment by the MRP (PFAF 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

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

36.2 K704 Paediatric outpatient case conference (PFAF 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.

36.3 Axx1 Consultation (minimum 45 minutes) (PFAF D87)

36.4 Axx2 Consultation (minimum 60 minutes) (PFAF 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

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

36.5 A/C815 Midwife requested special assessment (PFAF 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 allocation and fee code relativity considerations.
- This change would also apply to A817.
- Deliberations will continue once allocation is known.

36.6 A661 Paediatrics Complex Medical Specific reassessment (PFAF 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 continues to deliberate the creation of a new code to address the issues raised by this proposal. The committee will reach out to the constituency as required.

36.7 Exxx - Paediatrics Office Stabilization Premium (PFAF 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. OMA staff will help the constituency to identify where to better direct this proposal.
- Therefore, the committee does not support this proposal.

36.8 A262 Level 2 - Paediatric assessment (PFAF 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

- Deliberations will continue for fee value changes once allocation is known

37 Palliative Medicine

37.1 A/C945 Special Palliative Care Consultation (PFAF D92)

Constituency Proposal

- The constituency requested a fee increase from $159.20 to $203.30, by 27.7 per cent.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

38 Plastic Surgery

38.1 Z142 Removal of breast prosthesis (PFAF 21)

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 is working on draft schedule language to share with the constituency as per this PFAF's request. The committee will reach out to the constituency as required.

38.2 Multiple skin cancer excisions/reconstructions for same patient/day (PFAF 65)

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.

38.3 R110B Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral (PFAF 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 287)

38.4 R110 Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral (PFAF 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 a response from the constituency to aid in its deliberations.

38.5 R118 Post Mastectomy Breast Reconstruction - Breast skin reconstruction by local flaps or grafts (PFAF 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

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

38.6 Free Island Flaps (PFAF 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%. <u>This fee reduction does not apply to free island flap breast reconstruction following post-mastectomy or post-lumpectomy.</u>

  (Revisions <u>underlined</u>)

Committee comments

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

38.7 Cosmetic Surgery (PFAF D93)

38.8 Contralateral balancing mastopexy or reduction (PFAF D95)

38.9 Septorhinoplasty (PFAF 99)

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.

38.10 E832 - Excision of fascia for Dupuytrens, one or more additional rays, to R551 (PFAF D98)

Constituency Proposal

- The constituency requested a revision to E832 to allow payment for each additional ray.

Committee comments

- The committee supports unbundling additional rays with an appropriate price adjustment to ensure no change in cost.

38.11 Surgical Assistant base units (PFAF 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.

39 Primary Care Mental Health

39.1 Value change to select K-codes (PFAF 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%

Fee Code	Descriptor	Current value	Proposed value	$ Increase	% Increase
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

- Deliberations will continue for fee value changes once allocation is known.

39.2 K701 - Mental Health Out-Patient Case Conference (PFAF 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.

39.3 Focused Practice Psychotherapy Premium (PFAF D102)

Constituency Proposal

- The constituency proposed that the Focused Practice Psychotherapy premium be increased by 3 percentage points - from 17% to 20%.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

39.4 Psychotherapy Services (PFAF D103)

Constituency Proposal

- The constituency requested a revision to virtual care payment rules to allow psychotherapy services, delivered in any format (in-person, virtual (video or by phone) and in any platform (OTN or other PHIPA protected platforms)) to be able to bill K007, K004, K025, K019, K012, K024, K025, K005, K020, K006, K623, K624 and K629. (K082 will no longer be necessary for psychotherapy.)

Committee comments

- Given the recent negotiation and implementation of the new virtual care model, there are insufficient billing data to conduct meaningful deliberation regarding changes at this time.
- The committee does not support this proposal.

40 Public Health Physicians

40.1 Various fee value changes to consultations & assessment fee codes (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

41 Primary Care Solo Doctors MIG

41.1 Kxxx Cancer patient comprehensive care (PFAF 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.

41.2 Kxxx Same day urgent follow-up (PFAF 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.

42.3 Axxx Non-Patient-Facing Care Code (PFAF 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.

42 Psychiatry

42.1 Gxxx Repetitive Transcranial Magnetic Stimulation (rTMS) (PFAF 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.
- Deliberations on the value of the fee code await allocation.

42.2 Kxxx Level I modifier

42.3 Kxxx Level II modifier (PFAF 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 the proposal, subject to allocation and appropriate payments rules.

42.4 K198, K199, K197, K190 Psychiatric Care and Psychotherapy (PFAF 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.

42.5 K701 Mental health out-patient case conference, per unit (PFAF 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.

42.6 K300A and K301A Identifiers for video & telephone claim submissions (PFAF 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 Indivicual 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.

43 Reproductive Biology

43.1 S745 Oophorectomy - and/or oophorocystectomy (PFAFs 218 & 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 item #31.14 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.

43.2 Gxxx Ovarian tissue processing and cryptopreservation (PFAF 226)

43.3 Gxxx Ovarian tissue thawing and preparation for transplantation (PFAF 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.

44 Respiratory Diseases

44.1 G412 Nephrological component of renal transplantation-1st day following transplantation (PFAF D105)

44.2 G408 Nephrological component of renal transplantation, 2nd to 10th day, inclusive per diem (PFAF D106)

44.3 G409 Nephrological component of renal transplantation, 11th to 21st day, inclusive per diem (PFAF 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:
  1. 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 is awaiting a response from the constituency to aid in its deliberations.

44.4 Kxxx - Multidisciplinary Respiratory Case Conference (PFAF 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 supports the proposal in principle. Deliberations will continue once allocation is known.

45 Rheumatology

45.1 Consultation, Assessment, and Counselling Fee Value Changes (PFAF 25-29, 35, 37, 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

- Deliberations will continue for fee value changes once allocation is known.

45.2 Management Fees and Complex Assessment (PFAF 40, 121)

Constituency Proposal

4. 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

- Deliberations will continue for fee value changes once allocation is known.

45.3 A480 Complex Rheumatology Assessment (PFAF 36)

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.
- For the payment rule change to add E078, the committee does not support this as A480 was designed to compensate for the complexity of the patients to which it applies. If the section's

goal is to increase compensation for patient encounters billed as A480, then the fee value of A480 could be increased.
- Deliberations will continue for fee value changes once allocation is known.

45.4 Exxx Geriatric Age Premium (PFAF 125 & 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.

45.5 Kxxx Psoriatic arthritis management by a specialist-annual (PFAF 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.

45.6 G370 Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath (PFAF 42)

45.7 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 43)

45.8 G328 Aspiration of bursa or complex joint, with or without injection (PFAF 114)

45.9 G329 Aspiration of bursa or complex joint, with or without injection - each additional bursa or complex joint, to a maximum of 2 (PFAF 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.

Committee Comments

- Deliberations will continue on this proposal once PSC provides direction to the PPC regarding AWG's work.

45.10 Gxxx Initiating or switching of biologic or small molecule advanced therapeutic (PFAF 44)

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 allocation.
- 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.

46 Sleep Medicine

46.1 J896, J897, J895, J890, J889, J893, J894 Diagnostic and Therapeutic Sleep Studies Fee Value Changes (PFAF 231, PFAF 234)

Constituency Proposal

- The constituency requested fee value changes to the following fee codes:

PFAF	Fee Code	Descriptor	Current	Proposed	$ Increase	% Increase
231	J896	Initial Diagnostic Study - Level 1	$97.50	$104.33	$6.83	7.0%
231	J897	Repeat Diagnostic Study – Level 1	$97.50	$104.33	$6.83	7.0%
231	J895	Therapeutic study for sleep related breathing disorders - Level 1	$97.50	$104.33	$6.83	7.0%
231	J890	Specialized facility diagnostic study	$97.50	$104.33	$6.83	7.0%
231	J889	Specialized facility therapeutic study	$97.50	$104.33	$6.83	7.0%
234	J893	Multiple sleep latency test	$49.90	$53.39	$3.49	7.0%
234	J894	Maintenance of wakefulness test	$49.90	$53.39	$3.49	7.0%

- 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.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

47 Sports and Exercise Medicine

47.1 A917 Sports medicine focused practice assessment (PFAF 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.
- With respect to the proposal to remove A917 from basket, such a change to modify PEM agreements exceeds the scope of the PPC. OMA staff will help the constituency to identify where to better direct this proposal.
- Deliberations will continue for fee value changes once allocation is known.

47.2 A005 Consultation (PFAF 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 believes that the workload associated with A005 and A003 are comparable in terms of time and intensity, and the current relative value of the fee codes should remain unchanged.
- Therefore, the committee does not support this proposal.

47.3 Kxxx Sports medicine counselling (PFAF 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.

47.4 Kxxx Concussion neurocognitive assessment (PFAF 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

48 Surgical Assistants MIG

48.1 Special visit premiums (PFAF 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
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

Committee Comments

- The committee is of the opinion that the current model (GP88, GP89) for compensating travel for unscheduled surgical assist is appropriate. Therefore, the committee does not support this proposal.
- If the constituency believes that the individual codes are undervalued, they could propose increasing the fee values if allocation permits.

48.2 C988B - Special visit premium to assist at non-elective surgery with sacrifice of office – first patient seen

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 allocation.

48.3 Surgical assistant unit fee (PFAF 291)

Constituency Proposal

- The constituency requested that all of their remaining allocation be directed towards increasing the surgical assistant unit fee.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

48.4 Time units – GP86 (PFAF 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

- Deliberations on this revision are deferred until allocation is known.

48.5 S738B, S758B, S745B, S757B, P018B, S816B, R110B (PFAF 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	Descriptor	Current	Proposed fee value	% Increase
S738B	Fallopian Tube - Excision, suture or Repair - Ectopic Pregnancy - Salpingectomy or salpingo- Oophorectomy (uni- or bilateral)	6 units	8 units	33.34%
S758B	Corpus Uteri - Incision or excision - Hysterectomy - With or without adnexa (unless otherwise specified) - With anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	6 units	8 units	33.34%
S745B	Ovary - Excision (Unilateral Or Bilateral) - Oophorectomy - And/or oophorocystectomy	6 units	8 units	33.34%
S757B	Corpus Uteri - Incision or excision - Hysterectomy - With or without adnexa (unless otherwise specified) - Abdominal - Total or subtotal	6 units	8 units	33.34%
P018B	Obstetrics - Labour - Delivery - Caesarean section	6 units	8 units	33.34%
S816B	Corpus Uteri - Incision or excision - Hysterectomy - With or without adnexa (unless otherwise specified) - Vaginal	6 units	8 units	33.34%
R110B	Operations of the Breast - Repair - Reduction mammoplasty and augmentation mammoplasty (other than post- Mastectomy breast reconstruction) -Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) – unilateral	6 units	8 units	33.34%

Committee Comments

- Increases in base units represents a change in overall value for a procedure and thus deliberations are deferred until allocation is known.

48.6 S757B Hysterectomy - with or without adnexa (unless otherwise specified) - abdominal - total or subtotal (PFAF 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 in principle.
- Deliberations will continue once allocation is known.

49 Urology

49.1 Consultation and assessment fees (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

49.2 Z606 Endoscopy - Cystoscopy - diagnostic with or without urethroscopy (PFAF 280)

Constituency Proposal

- The constituency proposed a minimum 5% increase to Z606, or an evenly distributed percentage increase based on available funds.

Committee Comments

- Deliberations will continue for fee value changes once allocation is known.

49.3 Slit of prepuce codes S567, S568, S569 (PFAF 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 the rationale provided by the section for making this change will be addressed by surgical unbundling.
- The committee does not support this proposal.

50 Vascular Surgery

50.1 E078 Chronic disease assessment premium (PFAF 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.

50.2 A/C175 Consultation (PFAF 206)

50.3 A/C935 Special surgical consultation (PFAF 207)

50.4 A173 Specific assessment (PFAF 273)

50.5 A174 Partial assessment (PFAF 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

- Deliberations will continue for fee value changes once allocation is known.

50.6 Payment issues (PFAF 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.

50.7 Exxx Diagnostic imaging assessment premium (PFAF 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.

50.8 Rxxx Second Surgeon - Aorto-iliac and Visceral Vascular Surgery (PFAF 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 constituency's support for a team based surgical code is noted.
- 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 allocation.

51 PPC Initiatives

51.1 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.

51.2 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.
- **Appendix A** contains preliminary costing estimates for the proposal.

51.3 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.

51.4 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/
- After consulting with the relevant constituencies, the PPC has recommended proceeding with these changes to the PSC.

51.5 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.

51.6 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.
- PPC proposes to modernize the Schedule requirements related to X235 Cardio-thoracic Computed Tomography to align with the Ontario guidelines.
- 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]

51.7 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."

51.8 Time based surgical fee codes

Proposal

- The committee continues to explore the creation of time-based surgical fee codes for a limited number of surgical services.
- The PPC will reach out to constituencies as required.
- More details will be made available in a subsequent draft of this report.

51.9 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.

52 Assignments from PSC/OWG

52.1 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 insured 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.

52.2 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.
- Prices listed above are subject to adjustment, allocation and intrasectional relativity considerations.

52.3 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).
- Internal Medicine Office Assessment Premium: The PPC will deliberate on the application of the premium once allocation is known.
- 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.

Appendix A: Preliminary Cost Estimates for Surgical Unbundling of Pre- and Post- Operative Care

Network	OHIP Specialty	Post-Op Care estimated cost	Pre-Op Care estimated cost	Total Estimated cost (Pre & Post-Op Care)
Surgical	01-Anaesthesiology	$1,120	$5,921	$7,041
	03-General Surgery	$3,830,532	$980,879	$4,811,411
	04-Neurosurgery	$1,426,662	$212,050	$1,638,712
	06-Orthopaedic Surgery	$5,919,344	$973,616	$6,892,961
	08-Plastic Surgery	$364,956	$86,580	$451,536
	09-Cardiac Surgery	$1,545,520	$217,551	$1,763,071
	17-Vascular Surgery	$829,735	$129,850	$959,585
	20-Obstetrics & Gynaecology	$99,757	$46,935	$146,692
	23-Ophthalmology	$17,852	$131,317	$149,169
	24-Otolaryngology	$292,044	$38,350	$330,394
	35-Urology	$499,391	$79,011	$578,401
	64-General Thoracic Surgery	$457,232	$47,569	$504,801
Total Surgical		**$15,284,146**	**$2,949,628**	**$18,233,774**
Diagnostic	28-Laboratory Medicine	$0	$0	$0
	33-Diagnostic Radiology	$403,178	$121,014	$524,192
	63-Nuclear Medicine	$0	$0	$0
Total Diagnostic		**$403,178**	**$121,014**	**$524,192**
GP/FP	GP-1 Family: Capitation	$23,361	$5,227	$28,588
	GP-2 Family: FFS	$32,289	$91,461	$123,750
	GP-3 Family: Salary and Contracts	$546	$173	$719
	12-Emergency Medicine	$223,417	$6,134	$229,551
Total GP/FP		**$279,613**	**$102,995**	**$382,607**
Medical	02-Dermatology	$5,174	$8,388	$13,562
	05-Community Medicine	$0	$0	$0
	07-Geriatrics	$0	$0	$0
	11-Critical Care Medicine	$64,208	$11,554	$75,762
	13-Internal and Occupational Medicine	$11,531	$6,323	$17,854
	15-Endocrinology & Metabolism	$0	$0	$0
	16-Nephrology	$709	$38	$746
	18-Neurology	$64,123	$6,453	$70,576
	19-Psychiatry	$0	$0	$0
	22-Genetics	$0	$0	$0
	26-Paediatrics	$3,587	$899	$4,486
	31-Physical Medicine & Rehabilitation	$688	$73	$762
	34-Radiation Oncology	$40	$112	$151

Network	OHIP Specialty	Post-Op Care estimated cost	Pre-Op Care estimated cost	Total Estimated cost (Pre & Post-Op Care)
	41-Gastroenterology	$104,927	$41,022	$145,949
	44-Medical Oncology	$0	$0	$0
	46-Infectious Diseases	$0	$110	$110
	47-Respiratory Disease	$30,475	$10,323	$40,798
	48-Rheumatology	$0	$0	$0
	60-Cardiology	$171,255	$156,228	$327,482
	61-Haematology	$0	$0	$0
	62-Clinical Immunology	$0	$40	$40
Total Medical		**$456,716**	**$241,562**	**$698,278**
Grand Total		**$16,423,653**	**$3,415,199**	**$19,838,852**

Note:
[1] See item 51.2 in report for details on the PPC's proposal for unbundling pre- and post-operative care.
[2] Cost estimates are preliminary and subject to change.
[3] Source: FY2023 OHIP Claims Data