

# Physician Payment Committee Report

**Preliminary comments on proposed Schedule of  
Benefits fee changes for April 1, 2025**



**PPC Report: Preliminary comments**

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## Preface

This report from the Physician Payment Committee (PPC) outlines proposed Schedule of Benefits fee changes under consideration for implementation on April 1, 2025. 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 this fall. 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 first of three, as part of a cycle of feedback and engagement that culminates with the PPC's final recommendations in December 2024. OMA constituency leaders are encouraged to provide feedback, corrections, and additional information that would aid with the PPC's continued deliberations into the fall.

For this first draft, the PPC chose to prioritize its deliberations on new fee codes, fee code revisions, and deletions. Deliberations on fee code value changes will occur in advance of final recommendations to PSC. Proposals supported by the committee in principle are all subject to the constraints of available allocation.

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
- Miguel Cortel-LeBlanc, MD, emergency medicine
- 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, 2025 permanent fee adjustments to the PSC in November 2024 and OMA board no later than December 2024.

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.

To support this work, the PPC hosted three 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)

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 <u>without</u> Submissions | 18         |
| OMA Constituencies <u>with</u> Submissions    | 48         |
| Delete fee code                               | 46         |
| New fee code                                  | 152        |
| Revision                                      | 97         |
| Value change                                  | 317        |
| Value Change and Revision                     | 38         |
| <b>TOTAL</b>                                  | <b>650</b> |

**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     |
| Anesthesiology                         | 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     |
| 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    |

| <b>OMA Constituency</b>               | <b>Delete fee code</b> | <b>New fee code</b> | <b>Revision</b> | <b>Value change</b> | <b>Value Change and Revision</b> | <b>TOTAL</b> |
|---------------------------------------|------------------------|---------------------|-----------------|---------------------|----------------------------------|--------------|
| 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            |
| 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            |

| <b>OMA Constituency</b>     | <b>Delete fee code</b> | <b>New fee code</b> | <b>Revision</b> | <b>Value change</b> | <b>Value Change and Revision</b> | <b>TOTAL</b> |
|-----------------------------|------------------------|---------------------|-----------------|---------------------|----------------------------------|--------------|
| 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            |
| <b>Total</b>                | <b>46</b>              | <b>152</b>          | <b>97</b>       | <b>317</b>          | <b>38</b>                        | <b>650</b>   |

### 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, 2025 fee adjustments to the PSC no later than November 2024 and to the OMA Board in December 2024.

The final recommendations of the PPC in November 2024 must fit within the allocation assigned to each physician group in the PSA and the Board of Arbitration Award. Proposals will be costed in the coming months so that OMA constituencies 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 will have multiple opportunities to provide feedback between the release of this preliminary draft report, and the final recommendations in November.



**Figure 3** provides an overview of the PPC funding allocation process timelines

|      | Item   | Timeline   | Status      |
|------|--|--|-------------|
| 2023 | Initiation of process  | June   | Complete    |
|      | Information sessions   | June/July/Sept.  | Complete    |
|      | OMA constituencies consult with membership and prepare proposals | June - October   | Complete    |
|      | Proposal submissions from constituencies                         | November 1   | Complete    |
|      | Review proposals by the committee                                | November – December  | Complete    |
| 2024 | Member group submissions   | January  | Complete    |
|      | Meeting with constituencies                                      | January – February   | Complete    |
|      | Draft report #1  | April – October<br>(Iterative process with OMA Constituencies) | Complete    |
|      | Follow up with constituencies                                    |  | In Progress |
|      | Draft report #2  |  | In Progress |
|      | Follow up with constituencies                                    |  | In Progress |
|      | Draft final report   |  | In Progress |
|      | PPC recommendations to PSC                                       | November   | In Progress |

### 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 the starting point in an iterative process that started in April and will continue until October. OMA constituency leaders are invited to provide feedback on this draft report and the subsequent draft report planned later in 2024. **No decisions in this report are final. PPC is tasked with delivering final recommendations to PSC by November 2024.**

### 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 fee setting process. 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 revisited during a future fee setting process.
- The constituency elected to withdraw this proposal.
- The committee does not support this proposal

\*As details on allocation are not yet available, the PPC elected to defer deliberations on fee value changes until this information becomes 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).
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.

The committee recognizes the significant time and effort OMA constituencies put into canvassing constituency groups, developing and refining proposals from the PPC. OMA constituencies' deferred proposals may continue to be carried forward to future fee setting processes to ensure no work is lost, and to avoid duplication. Proposals the PPC declines to support in principle will not be carried forward. The PPC will also be reviewing their processes to look at opportunities for improvement for future allocations. The committee hopes to consider Schedule changes on a more regular and iterative basis going forward.

### Committee meetings and constituency leader engagement

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

OMA constituencies were invited to present to the PPC on their submission in January and February. 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 in October.

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

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

## 1 Addiction Medicine

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

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

## 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 fee 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 constituency declined to pursue this proposal as part of the year three allocation process. The proposal may be revisited during a future fee setting process.

# 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 manually 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 is awaiting information from the constituency to aid in its deliberations.

#### 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**

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

#### 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 are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once AWG has concluded its 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**

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

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:
  - Evening ICU/NICU admission assessment fee at \$96.40 (equivalent to K994 + K962).
  - Weekend/Holiday ICU/NICU admission assessment fee at \$111.40 (equivalent to K998 + K963).

**Committee Comments**

- The committee notes that the constituency would support a code being created as a premium rather than assessment codes.
- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

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.
- 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 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 has engaged with the constituency on the proposed revisions and continues to deliberate on this proposal.

## 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%      |

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

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

#### Committee Comments

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

#### 10.2 J182 Diagnostic Ultrasound J182 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 is awaiting information from the constituency to aid in its deliberations.

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 requires additional evidence to justify the creation of a new fee in terms of time, intensity, and work effort.
- The committee is awaiting information from the constituency to aid in its deliberations.

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%      |
| 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%      |

| Fee Code | Descriptor   | Current Value | Proposed Value | \$ Increase | % Increase |
|----------|--|---------------|----------------|-------------|------------|
| Z190     | Repair of lacerations - 10.1 to 15 cm if on face and/or requires tying of bleedersand/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-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%       |

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

- The committee’s analysis of physician billings suggests that expanding H100 billing will worsen intra-sectional relativity.
- The committee does not support this proposal.

**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.

**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.

### 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 ~~striketrough~~)

### Committee Comments

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

11.14 G365 - Papanicolaou Smear – periodic (PFAF D10)

### Constituency Proposal

- During the last fee allocation process, the constituency requested a descriptor revision to G365 Periodic Papanicolaou Smear to include an emergency department speculum exam as follows:

Papanicolaou smear - periodic or emergency department pelvic exam with speculum

(Revisions underlined, deletions ~~striketrough~~)

- The OMA MSPC did not support the revision and had proposed creating a new fee code for gynaecological exam with use of speculum, which the PPC did not have sufficient time to fully consider.

- As such, the constituency requested the creation of a new fee code with a fee value equal to G365 (\$12.00) as follows:

Gxxx Emergency department pelvic exam with speculum

**Committee Comments**

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

## 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.

## 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%       |

| Fee Code | Descriptor   | Current Value | Proposed Value | \$ Increase | % Increase |
|----------|--|---------------|----------------|-------------|------------|
| 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%       |
| 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):
  - Same rules as K682 and K683
  - 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 the 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 in principle the creation of this fee code.
- 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 is awaiting information from the constituency to aid in its deliberations.

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.

14.10E749: 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,
  - Fee value increase from \$22.35 to \$24.50, by 9.6 per cent, and
  - 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%      |

| <b>Fee Code</b> | <b>Descriptor</b>  | <b>Current Value</b> | <b>Proposed Value</b> | <b>\$ Increase</b> | <b>% Increase</b> |
|-----------------|--|----------------------|-----------------------|--------------------|-------------------|
| 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%            |
| 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%             |

| <b>Fee Code</b> | <b>Descriptor</b>   | <b>Current Value</b> | <b>Proposed Value</b> | <b>\$ Increase</b> | <b>% Increase</b> |
|-----------------|---|----------------------|-----------------------|--------------------|-------------------|
| 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 catastrophically or terminally ill patient - 1 or more persons per unit   | \$70.10              | \$74.70               | \$4.60             | 6.56%             |
| 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%             |

| Fee Code | Descriptor   | Current Value | Proposed Value | \$ Increase | % Increase |
|----------|--|---------------|----------------|-------------|------------|
| 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, Arrhythmia 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**

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

#### 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%       |
| 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%       |

| Fee Code | Descriptor                          | Current Value | Proposed Value | \$ Increase | % Increase |
|----------|-------------------------------------|---------------|----------------|-------------|------------|
| 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 ~~striketrough~~)

- 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-writing 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 defer consideration of these proposals until after details of the new APP can be evaluated, as the revisions may no longer be necessary.
- The committee will re-engage the section once more information is available.
- Deliberations will continue for fee value changes once allocation is known.

**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 Rxxx Minimal fee for procedure performed in an operating room under a general anesthetic (PFAF 269)

#### Constituency Proposal

- The constituency 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.
- This was partially addressed with a 100% premium for perianal abscesses done under a GA. However, this left many codes unattended in a similar vein, and addressing each with a premium is cumbersome.
- Other provinces have either add-on amounts or higher fees if performed under GA.
- The fee value of \$200.00 is based on anesthesia units of 6-7 base, plus time units, plus age, BMI, ASA units which brings their respective “value for time” at around \$200.

#### Committee Comments

- The committee continues to deliberate on the constituency’s counter-proposal to modify 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 is awaiting information from the constituency to aid in its deliberations.

### **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

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

#### 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

- The proposal represents a large system-wide change that involves the entire profession and potentially a significant re-write to the Schedule as it would require redefining partial and specific assessments.
- The committee does not support this proposal.

## 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. Deliberations will continue once allocation is known. The committee notes that this would need to be defined as sole procedure code.

## 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

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

### 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 supports in principle the creation of a fee for open or VATS drainage of pericardial effusion for Cardiac Tamponade
- The committee proposes an all-inclusive time-based fee billed on 15-minute increments that is restricted to emergency cases, similar to the time base critical care fees (G521, G523, G522, G395 and G391).
- Deliberations will continue once allocation is known.

20.6 E683 when performed thoroscopically, 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”. This is consistent with the section’s feedback that this code is used exclusively within the context of oncology.
- Deliberations on the descriptor change is ongoing and the committee is awaiting information from the constituency to aid in its deliberations.
- 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

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



## 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 continues to deliberate on this proposal as deliberations for M105 and Z354 are also ongoing.

## 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 for diagnosis or therapeutic drainage ~~with therapeutic drainage with or without diagnostic sample~~

(Revisions underlined, 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, chemotherapy or sclerosing agent via thoracostomy tube (chest tube).

(Revisions underlined)

- With this revision, the constituency also requested the deletion of Z349 -intrapleural administration of chemotherapy or sclerosing agent - by any method.

### Committee Comments

- As this is a new fee code, the committee recommends a moratorium on further changes until accurate utilization data becomes available. The proposal may be revisited during a future fee setting process.
- The committee does not support this proposal at this time.

## 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 is awaiting engagement between thoracic surgery and general surgery to aid in its deliberations.

## 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**

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

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 a fee increase to Z788 from \$366.50 to \$549.75 (50 per cent).

**Committee Comments**

- The committee is awaiting information from the constituency to aid in its deliberations.

- Please consult cardiac surgery regarding your proposal to separate ECMO for respiratory indications and ECMO for cardiac indications.

## 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

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

## 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

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

## 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 ~~striketrough~~)

- 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 continues to deliberate on the proposed rule change.
- 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) First infusion of bispecific antibodies (such as glofitamab)  
Chemotherapy for infusion of CAR T cells”

(Revisions underlined)

- Given the intensive monitoring, the Hematology Oncology section is requesting addition of the first bispecific antibody therapy and CART infusion under the G390 code.
- Subsequent bispecific antibody infusion should be billed under the code G359 because of severe immunosuppression and other associated side effects.

#### **Committee Comments**

- The committee 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 aspiration 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

### 23.1 Cxxx Inpatient transfer of care (PFAF D23)

### 23.2 Admission Assessment – General Requirements - Payment Rule 3 amendment (PFAF D24)

### 23.3 Cxxx Day of discharge, medically complex patient (PFAF D25)

### 23.4 Wxx2 MRP day of discharge, medically complex patient, long term care or chronic care facility (PFAF D26)

### **Constituency Proposal**

- The constituency requested:
  - A new fee for inpatient transfer of care at \$31.35 payable to the Most Responsible Physician (MRP) who is transferring care of medically complex patient to another oncoming MRP.
  - Amend the Admission Assessment – General Requirements - Payment Rule 3 (GP40), such that (1) general or specific assessments or reassessment are eligible for payment per physician per admission when care is transferred from one physician to another physician, (2) Such assessments related to transfer of care should be limited to once a week (Monday-Sunday), and (3) E083 or E084 should apply to these codes to reflect the MRP (Most Responsible Physician) providing the service.
  - Create a new medically complex patient - day of discharge fee of \$106.85 with the same service elements as C124, or a fee increase to C124 from \$61.15 to \$106.85.
  - Create new MRP day of discharge fees for inpatients in chronic care settings, similar to MRP discharge fees for hospital inpatients; Wxx1 MRP day of discharge (equal to C124 at \$61.15) and Wxx2 MRP day of discharge, medically complex patient (equal to Cxx at \$106.85)

### **Committee Comments**

- The committee notes that there is a provision within the 2021 Physician Services Agreement to establish a hospitalist APP. As such, the committee's position is to defer consideration of these proposals until after details of the new APP can be evaluated, as the revisions may no longer be necessary.
- The committee will re-engage the section once more information is available.



## 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%      |

| Fee Code | Descriptor   | Current Value | Proposed Value | \$ Increase | % Increase |
|----------|--|---------------|----------------|-------------|------------|
| 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**

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

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   |
| 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, L823, L822, L812, L837, and L844 as follows:

| Fee Code | Proposed descriptor  |
|----------|--|
| L848     | Seminal fluid analysis - quantitative kinetic studies, <del>including velocity linearity and lateral head amplitude</del>                |
| L823     | <del>-each subsequent frozen section or direct smear and/or selection of tissue for biochemical assay e.g. estrogen receptors, add</del> |
| L822     | Operative consultation, with or without frozen section <u>or direct smear</u>  |

|      |  |
|------|--|
| L812 | Cervical vaginal <u>sample, HPV testing and/or cytology specimens including all types of cellular abnormality, assessment of flora, and/or cytochemical evaluation</u>   |
| L844 | Special microscopy <u>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)</u> |
| L837 | Immunohistochemistry, <u>direct immunofluorescence, in situ hybridization, immunobead or other method</u> 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 (OCSF).
- For L848 and L819, the committee continues to deliberate on this proposal and is working with the section to draft appropriate wording for the codes.
- 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).

### 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     | Special Procedures and Interpretation - Histology or Cytology - 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%      |
| 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:

- A maximum of two (2) units of Wxxx are eligible for payment per patient per day.
- A maximum of eight (8) Wxxx units are eligible for payment per patient per 12-month period.
- Wxxx is only eligible for payment where:
  - there is a minimum of 10 minutes of patient-related discussion; and
  - 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)

#### Committee Comments

- 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

- 

### 27.4 The committee continues to deliberate on the best way to revise the code so that it can be used by all physicians with the requisite skills.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)  $\geq$  10%
  - b) eGFR <15mL/min/1.73m<sup>2</sup>

**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 in principle. Deliberations 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 is exploring schedule language and payment rules, including the prospect of changing A113 to a complex neurological assessment for both complex neuromuscular conditions and complex headaches.

The committee will continue to engage with the Section.



## 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

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

## 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 is exploring schedule language and payment rules, including the prospect of changing A113 to include chronic CNS disorders, along with a minimum time requirement.
- The committee will continue to engage with the Section.

## 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 is exploring schedule language and payment rules, including the prospect of changing A113 to include complex neuro-oncology assessment, along with a minimum time requirement.
- The committee will continue to engage with the Section.

### **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 applicable 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**

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

### 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**

- This proposal is related to an item under consideration by the AWG and will not be considered at this time
- Deliberations will continue on this proposal once AWG has concluded its work.

### 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**

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

## 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 ~~23~~ per examination), to J807 or J808.

(Revisions underlined, deletions ~~strikethrough~~)

- J866 is used for both cardiac and non-cardiac SPECT, while J809 is also used for cardiac SPECT. Separating the codes so J809 is used only for cardiac SPECT and J866 only for non-cardiac SPECT is proposed. As J809 and J866 currently pay the same amount this change will be cost-neutral.

#### Committee Comments

- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.
- The committee will continue to engage with the Section to discuss isolation of cardiac SPECT imaging.

### 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 J807, J808, or J852 - maximum one per Nuclear Medicine examination

(Revisions underlined, deletions ~~strikethrough~~)

- J866 is used for both cardiac and non-cardiac SPECT, while J809 is also used for cardiac SPECT. Separating the codes so J809 is used only for cardiac SPECT and J866 only for non-cardiac SPECT is proposed. As J809 and J866 currently pay the same amount this change will be cost-neutral.

#### Committee Comments

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

- The committee will continue to engage with the Section to discuss isolation of cardiac SPECT imaging.

### 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

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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 <sup>1</sup> | 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 <sup>2</sup> | Myocardial wall motion - studies  | \$43.25       | \$38.93        | -\$4.32     | -10.0%     |
| J812 <sup>2</sup> | Myocardial wall motion - repeat same day (to a maximum of three repeats)                      | \$20.90       | \$18.81        | -\$2.09     | -10.0%     |
| J813 <sup>2</sup> | Myocardial wall motion - studies with ejection fraction                                       | \$62.50       | \$56.25        | -\$6.25     | -10.0%     |
| J814 <sup>2</sup> | 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 is awaiting information from the constituency to aid in its deliberations.

### **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 is awaiting information from the constituency to aid in its deliberations.

### **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 is awaiting information from the constituency to aid in its deliberations.

### **31.7 Cost neutral modernization of the OHIP Schedule: application of SPECT and hybrid SPECT/CT, cardiac nuclear medicine studies, PET and miscellaneous nuclear medicine studies (PFAF D52, D54-D57, D63-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
  - PET fee codes
  - Descriptor revisions of the following fee codes to reflect modern day practice: J820, J857, J858, J860, J865, J869, J830 and J878



## Committee Comments

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

## 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**

- The committee is awaiting information from the constituency to aid in its deliberations.

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 <del>apical</del> prolapse - vaginal sacropexy          | \$432.45      | \$800.00       | \$367.55    | 85.0%      |
| S813     | Abdominal approach to vaginal vault <del>apical</del> prolapse - repeat - vaginal sacropexy | \$515.05      | \$1200.00      | \$684.95    | 133.0%     |

(Revisions underlined, deletions ~~striketrough~~)

- Proposed payment rules:
  - Can be billed concurrently with S757, S816, S758, S759.
  - Can be billed along with # E862 if done laparoscopically.

**Committee Comments**

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

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

### 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 is awaiting information from the constituency to aid in its deliberations.

### 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 or vaginectomy

(Revisions underlined)

- Proposed payment rule: Involves closure of the vaginal vault.

### Committee Comments

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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 invites the section to meet with PPC to explore options for time-based payments for complex gynaecologic surgeries.

### [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 AWG has concluded its 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 ~~striketrough~~)

#### **Committee Comments**

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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**

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

### 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 ~~striketrough~~)

- 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 insertion of Norplant code was removed from the Schedule, the removal of Norplant code Z463 is due to be deleted.
- 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 ~~striketrough~~)

- 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 is awaiting information from the constituency to aid in its deliberations.

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     | Oophorectomy 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 enterocele and/or vault prolapse repair when rendered | \$655.05      | \$700.00       | \$44.95     | 6.9%       |
| 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%      |

| Fee Code | Descriptor  | Current Value | Proposed Value | \$ Increase | % Increase |
|----------|---|---------------|----------------|-------------|------------|
| 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%      |
| S738     | Ectopic pregnancy - Salpingectomy or salpingo-oophorectomy (uni- or bilateral)              | \$366.20      | \$450.00       | \$83.80     | 22.9%      |
| 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, or to strabismus procedure performed for patients with post traumatic strabismus, Thyroid eye disease, post placement of a retinal buckle, or external ophthalmoplegia.

(Revisions underlined)

- Strabismus surgery when performed on patients with post traumatic strabismus, Thyroid eye disease or external ophthalmoplegia is extremely complex due to the disruption of normal anatomy, and extreme restriction of eye movements. Therefore, there should be an additional premium applied to compensate for this complexity.



### **Committee Comments**

- Preliminary data regarding E877 indicates that cases for which it is billed do not take longer than for cases for which it is not billed.
- The committee does not support this proposal to expand indications.
- The proposal may be revisited 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 Paediatric cataract extraction age 0 to 7 years (PFAF 12)

### 33.8 Exx2 Paediatric 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 its 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

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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**

- The committee is awaiting information from the constituency to aid in its deliberations.

**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**

- The committee is awaiting information from the constituency to aid in its deliberations.

**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**

- The committee is awaiting information from the constituency to aid in its deliberations.

**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**

- The committee is awaiting information from the constituency to aid in its deliberations.

**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**

- The committee is awaiting information from the constituency to aid in its deliberations.

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

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%      |
| 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 -  | \$100.00      | \$250.00       | \$150.00    | 150.0%     |

| Type  | Fee Code | Descriptor  | Current Value | Proposed Value | \$ Increase | % Increase |
|-------|----------|---|---------------|----------------|-------------|------------|
|       |          | with autogenous conjunctival Transplant, add  |               |                |             |            |
| Orbit | E169     | Decompression – two walls   | \$542.00      | \$1,749.25     | \$1207.25   | 222.7%     |
| Orbit | E170     | Decompression – three walls   | \$575.85      | \$1,749.25     | \$1173.40   | 203.8%     |
| Orbit | E167     | Tumour or foreign body - posterior exposure   | \$640.00      | \$1,421.00     | \$781.00    | 122.0%     |
| Orbit | E166     | Tumour or foreign body - anterior route   | \$450.00      | \$994.85       | \$544.85    | 121.1%     |
| Orbit | E165     | Tumour or foreign body - Lateral orbitotomy (Kronlein)                                      | \$590.00      | \$1,691.50     | \$1,101.50  | 186.7%     |
| Orbit | E164     | Drainage of abscess   | \$350.00      | \$796.00       | \$446.00    | 127.4%     |
| Orbit | E109     | Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles. | \$677.50      | \$894.95       | \$217.45    | 32.1%      |
| Orbit | E103     | Evisceration, with or without primary implant   | \$542.00      | \$795.50       | \$253.50    | 46.8%      |
| Orbit | E102     | Enucleation, with or without primary implant  | \$542.00      | \$795.50       | \$253.50    | 46.8%      |

- Significantly undercompensated, given how complex these procedures are and the high levels of knowledge and judgement involved, as well as increased risk, high stress, and several years of subspecialty training.

#### Committee Comments

- The committee is awaiting information from the constituency to aid in its deliberations.

#### 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 - per eye ~~unilateral or bilateral~~

(Revisions underlined, deletions ~~strikethrough~~)

#### Committee Comments

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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 is awaiting information from the constituency to aid in its deliberations.

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

### 33.23 Z858 Epilation -by cryopexy (PFAF 119)

#### Constituency Proposal

- The constituency requested a revision and fee value change for Z857 from \$26.60 to \$175.00, by 557.9 per cent. The proposed descriptor revision is as follows:

Epilation -by hyfrecator, electrolysis, per eye

(Revisions underlined)

- With the value change, the constituency also proposed the deletion of Z858 and to combine it with Z857, instead.

#### Committee Comments

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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 or amniotic membrane or spacer graft.

(Revisions underlined, deletions ~~striketrough~~)

### Committee Comments

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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 presumed malignant

(Revisions underlined)

### Committee Comments

- The committee is awaiting information from the constituency to aid in its deliberations.

### 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 ~~striketrough~~)

- 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**

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

### **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 ~~striketrough~~)

- 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**

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

[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 infusion suction cutter technique~~

(Revisions underlined, deletions ~~striketrough~~)

- 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**

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

[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.

| <b>PFAF #</b> | <b>Type</b>  | <b>Fee Code</b> | <b>Proposed Descriptor</b>   | <b>Proposed Value</b> | <b>Notes</b>           |
|---------------|--------------|-----------------|--|-----------------------|------------------------|
| 157           | Revision     | New E148        | Vitrectomy, complete and by posterior approach, with vitreous exchange (air, gas, or artificial vitreous substance)  | \$810.00              | Combined E148 + E936   |
| 158           | New fee code | Exx1            | Vitrectomy, complete and by posterior approach, with cataract extraction, by phacoemulsification including insertion of intraocular lens   | \$1,148.09            | New E148 + E140        |
| 160           | Deletion     | E142            | Anterior vitrectomy - Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation  | \$0.00                | Combined E142 + E936   |
| 161           | New fee code | Exx2            | Vitrectomy, complete and by posterior approach, with preretinal membrane peeling or segmentation, and vitreous exchange (air, gas, or artificial vitreous substance)   | \$920.00              | Combined E142 + E936   |
| 162           | New fee code | Exx3            | Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, without intraocular lens insertion patient left aphakic   | \$1,239.63            | New E148 + E141        |
| 163           | New fee code | Exx4            | Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, with intraocular lens insertion   | \$1,318.26            | New E148 + E141 + E950 |
| 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**

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

### **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 G821 is 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 ~~striketrough~~)

- 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 ~~striketrough~~)

#### 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 section’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 engage with the section to explore this further.

### 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.
- 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

- Typically, when a surgical assistant bills for a surgical procedure that does not have an accompanying surgical assist basic unit, a M400B claim is associated with the procedure in the OHIP claims database. According to that data, an M400B is rarely requested for M080 and M090. When requested, it is almost always paid. It would therefore appear that requiring an assist is an unusual situation which can be appropriately managed by submitting an M400B request with the appropriate supporting documentation.
- The committee does not support this proposal.

#### 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 is awaiting information from the constituency to aid in its deliberations.

## **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**

- More time is required for the committee to complete deliberations. The PPC 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

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

#### 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%. This fee reduction does not apply to free island flap breast reconstruction following post-mastectomy or post-lumpectomy.



(Revisions underlined)

**Committee comments**

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

**38.7 Operations of the Breast – Z142, Z135 and Z182 (PFAF D94)**

**Constituency Proposal**

- The constituency requested clarifications be added to the Schedule of Benefits to clarify how to appropriately bill Z142, Z135 and Z182 and when to charge for cosmetic surgery (e.g., bill to OHIP or the patient)

**Committee comments**

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

**38.8 Cosmetic Surgery (PFAF D93)**

**38.9 Contralateral balancing mastopexy or reduction (PFAF D95)**

**38.10 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.

**38.11 E832 - Excision of fascia for Dupuytren's, 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.

**38.12 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 is awaiting information from the constituency to aid in its deliberations.

## 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%      |
| 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%      |

| Fee Code | Descriptor  | Current value | Proposed value | \$ Increase | % Increase |
|----------|---|---------------|----------------|-------------|------------|
| 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 did not receive sufficient evidence to expand K701 to include GP focus practice psychotherapists.
- 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 current virtual care codes, the committee has insufficient information to conduct meaningful deliberation regarding changes.
- 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.

#### 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

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

### 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 is awaiting information from the constituency to aid in its deliberations.

**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

- Changing the case conference definitions would have implications across multiple sections.
- 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:
  - K196 (out-patient family psychiatric care),
  - K195 (out-patient family psychotherapy),
  - K199 (in-patient psychiatric care),
  - K191 (in-patient family psychiatric care),
  - K190 (in-patient 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 crytopreservation (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 crytopreservation, 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 ~~striketrough~~)

### Committee comments

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

### 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**

- Deliberations will continue for fee value changes once allocation is known.
- For the request to change the limits/payment rule 3, 4 visits is the standard limitation for complex medical re-assessments and this code already exceeds that at 6 visits. Changing the limit requires consultation across medical sections. 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 already compensates for the complexity of the patients to which it applies.

**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

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

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

- Topics related to this proposal are under review by the Appropriateness Working Group (AWG).
- Deliberations will continue on this proposal once AWG has concluded its 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. The committee lacks evidence of care provision which is not already compensated.
- 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            |

| Revision | Fee code | Descriptor  | Current | Proposed fee value |
|----------|----------|---|---------|--------------------|
| 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**

- SVPs are not designed to compensate for unscheduled surgical work; this is compensated through E400B/E401B after hours premiums.
- The committee is of the opinion that the current model for compensating travel for unscheduled surgical assist is appropriate.
- The committee does not support extending SVPs to surgical work at this time.

**48.2 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.

**48.3 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.

**48.4 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%.

| <b>Fee code</b> | <b>Descriptor</b>   | <b>Current</b> | <b>Proposed fee value</b> | <b>% Increase</b> |
|-----------------|---|----------------|---------------------------|-------------------|
| 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 enterocele 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.

## 48.5 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 is awaiting information from the constituency to aid in its deliberations.

## 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%       |

| Fee Code | Descriptor             | Current value | Proposed value | \$ Increase | % Increase |
|----------|------------------------|---------------|----------------|-------------|------------|
| 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.
- More time is required for the committee to complete deliberations. The PPC will reach out to the constituency, as required.

## 51 PPC Proposals

### 51.1 A765 Consultation, patient 16 years of age and under

#### Proposal

- The Committee proposes deleting A765 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.