

# INFOBulletin

Keeping health care providers informed of payment, policy or program changes

**To: Physicians**

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**Bulletin #: 4726**

**Re: Kaplan Board of Arbitration Award - Appropriateness Working Group (AWG): Changes to the Schedule of Benefits for Physician Services (Schedule) effective October 1, 2019.**

**Additional Schedule Changes for Medical Trainees and the application of Rubidium 82 with Positron Emission Tomography(PET).**

## **A. Background**

### **1. Appropriateness Working Group (AWG) – Kaplan Board of Arbitration Award**

As directed by the February 2019 Kaplan Board of Arbitration Award, the ministry and the Ontario Medical Association (OMA) formed the Appropriateness Working Group (AWG) with a mandate to use evidence, best practices and expert opinion to identify and update payment for the delivery of certain services to help ensure the most effective care for Ontario patients.

The Appropriateness Working Group considered the evidence including current standards of care, best practices and the latest technology to identify the following changes to services insured under the Ontario Health Insurance Plan:

- Use more accurate diagnostic imaging for sinus problems
- Refer patients to specialized clinics for chronic hip and knee pain to improve arthritic care
- Update the use of ambulatory cardiac monitoring devices (Loop and Holter Monitors)
- Improve access to primary and specialty care by simplifying referrals to specialists

**Ontario** 

- Use more effective testing to diagnose infertility
- Perform procedure to remove ear wax only when medically necessary
- Conduct larynx examinations during stomach examinations only when medically necessary
- Ensure Continued Access to Urine Pregnancy Tests when Medically Necessary
- Improve primary care access by streamlining pre-operative assessments
- Improve access to knee arthroscopies for patients with non-degenerative knee disease
- Fund physician premiums for house calls only for frail elderly and housebound patients

In order to implement these changes, amendments have been made to the Schedule as described below.

## 2. Other Schedule Changes

Prior to the Appropriateness Working Group (AWG) work, the ministry and the Ontario Medical Association (OMA) collaborated on other appropriateness initiatives to identify changes to clarify and modernize physician fee for service (FFS) payments in the Schedule:

- The ministry and the Ontario Medical Association (OMA) established a working group in 2017, to review the **Team Care in Teaching Units** section of the Schedule. The working group recommended modernizing this section to specify the current types of trainees and clarifying when the supervising physician can submit a claim for the care trainees render. These revisions will strengthen the quality of supervision of medical trainees. The revised section has been renamed **Supervision of Postgraduate Medical Trainees**.
- The province's PET Steering Committee recommended that the ministry insure the use of Rubidium for cardiac perfusion PET and a corresponding code was created.

## B. Overview of Specific Schedule Changes

**Please Note:** Updated Schedule pages reflecting the AWG changes will be posted closer to the effective date of October 1, 2019.

### 1. Changes to the Schedule

This bulletin outlines all of the changes to the Schedule and provides references to more detailed information. The changes involve new fee codes, revised fee codes/descriptions and removed fee codes.

#### **New fee codes effective October 1, 2019\***

New codes have been added to the Schedule effective October 1, 2019 for:

- Level 2 Continuous Cardiac Monitoring, 14 or more days recording (e.g., Holter Monitors) - G694, G695, G696;
- Laryngoscopy - Z292, Z293;

- Knee Arthroscopy - R699 (for **non-degenerative** disorders or acutely locked knee);
- Knee Debridement - E498 (debridement of focal, symptomatic post-traumatic cartilage flap); and
- Application of Rubidium PET for cardiac perfusion - J900, J901.

\*These changes will be implemented over the next couple of months. Further information regarding implementation of these changes will be forthcoming.

### Revised Fee Codes/Descriptions

Revisions to descriptions and/or payment requirements have been made to the following services effective October 1, 2019\*:

- G005 - Urine Pregnancy Test;
- G420 - Ear Wax Removal;
- A900 - Complex House Call Assessment;
- Continuous Cardiac Monitoring services (e.g., Holter Monitors) – descriptions and medical record requirements;
- Specialist Consultations (for most specialties);
- Special Visit Premiums for Home Visits;
- Laryngoscopy Commentary;
- Magnetic Resonance Imaging Commentary;
- R687 - Knee Arthroscopy (now for **degenerative** disease of the knee only);
- E494 - Knee Debridement (now for **degenerative** cartilage);
- Supervision of Postgraduate Medical Trainees (formerly Team Care in Teaching Units); and
- J866, J809 – Myocardial Perfusion Scintigraphy with Single-Photon Emission Computerized Tomography (SPECT).

\*These changes will be implemented over the next couple of months. Further information regarding implementation of these changes will be forthcoming.

### Fee Codes Removed

The Appropriateness Working Group (AWG) considered evidence, changes in standards of care, best practices and the latest technology to recommend the following fee codes to be removed from the Schedule effective October 1, 2019:

- G364 – Post Coital Mucous Test;
- X008 – Sinus X-Ray;
- A901 – House Call Assessment;
  - Note: Physicians visiting patients in their home who are not complex patients (i.e. frail, elderly or housebound as defined under fee code A900) may use the appropriate assessment fee code listed in the Schedule for the service provided.
- A903, A904 – Pre-Dental/Pre-Operative Assessment;
  - Note: When a **medically necessary** assessment is required to be performed by the family physician or a specialist prior to an in-hospital dental or other surgical procedure, that service remains eligible for payment under the appropriate existing assessment fee codes.

- G660, G661, G690, G692 – Cardiac Monitoring – Cardiac Loop Recording; and
- Z321 – Laryngoscopy – with or without biopsy.

Please refer to the Appendix for more information.

## 2. Detailed Summary of Fee Code Changes

The chart below summarizes the fee codes and Schedule provisions impacted by this change:

<b>Fee Code and Schedule provisions</b>	<b>Type of Change</b>	<b>Additional Reference</b>
X008	Removed	N/A
Hip and Knee Imaging Commentary	Revised	Appendix
G694, G695, G696	New	Appendix
Cardiac Monitoring	Revised	Appendix
G660, G661, G690, G692	Removed	N/A
Specialist Consultations	Revised	Appendix
G364	Removed	N/A
G420	Revised	Appendix
Z292, Z293	New/Revised	Appendix
Z321	Removed	N/A
Laryngoscopy Commentary	Revised	Appendix
G005	Revised	Appendix
A903, A904	Removed	N/A
R699	New	Appendix
E498	New	Appendix
R687	Revised	Appendix
E494	Revised	Appendix
A900	Revised	Appendix
A901	Removed	N/A
Home Special Visit Premiums (Table VI)	Revised	Appendix

<b>Fee Code and Schedule provisions</b>	<b>Type of Change</b>	<b>Additional Reference</b>
Supervision of Postgraduate Medical Trainees	Revised	Appendix
J900, J901	New	Appendix
J866, J809	Revised	Appendix

This bulletin is a general summary provided for information purposes only. Physicians, hospitals, and other health care providers are directed to review the *Health Insurance Act*, Regulation 552, and the Schedules under that regulation, for the complete text of the provisions. You can access this information at [www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca) . In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.

## **Appendix: Effective October 1, 2019\***

\*These changes will be implemented over the next couple of months. Further information regarding implementation of these changes will be forthcoming.

### **Refer Patients to Specialized Clinics for Chronic Hip and Knee Pain to Improve Arthritic Care**

#### **Commentary – Magnetic Resonance Imaging (MRI)**

The Canadian Orthopaedic Association, the Canadian Arthroplasty Society and the Arthroscopy Association of Canada do not recommend the use of knee or hip MRI scans when weight-bearing X-rays demonstrate osteoarthritis. As such, Commentary in the 'Extremity or joint(s)' paragraph of the MRI Section of the Schedule, has been added to align with [Choosing Wisely Canada's recommendations](#) as found at their website.

### **Update the Use of Ambulatory Cardiac Monitoring Devices (e.g., Holter Monitor)**

#### **New Fee Codes**

The following fee codes have been added to the Schedule for Level 2 cardiac monitoring that extend beyond 13 days of recording:

- G694 (\$107.02) – technical component – 14 or more days of recording;
- G695 (\$78.72) – technical component – 14 or more days of scanning; and
- G696 (\$86.80) – professional component – 14 or more days of recording.
- Additional important changes that impact Level 1 and Level 2 cardiac monitoring– Revised Fee Schedule Codes/Descriptions', including a change to the descriptor for Level 1 and Level 2 monitors as well as changes to limits, medical record requirements and payment rules.

#### **Fee Code Revisions (Descriptions and/or Payment Requirements)**

The description/definition of a Level 1 cardiac monitor has been modified. A Level 1 monitor requires a device capable of:

- recording three or more simultaneous channels;
- acquiring a continuous ambulatory electrocardiographic recording of all beats using three or more skin electrodes;
- analyzing all parts of the recording;
- allowing manual review of all parts of the recording; and
- producing graphical and quantitative reports of relevant parameters and diagnostic quality tracings for visual review (including post-hoc review of any portion) to enable diagnostic rhythm analysis.

Level 1 monitoring must include a patient diary and event marker capability to enable symptom-rhythm correlation.

The description/definition for a Level 2 cardiac monitor has also been clarified to describe the device as:

- one with fewer than three skin electrodes; or
- one that records only portions of the monitoring period or does not provide trend analysis.

Additional notes have been added to clarify that:

- cardiac monitoring using an external cardiac loop recording device that relies solely on patient activation to record electrocardiographic data and no real-time rhythm analysis is not insured; and
- in a 30 day period, only one 14 day or more test for a patient (whether Level 1 or Level 2), is eligible for payment.

As before, all cardiac monitoring (Level 1 and Level 2) must record for a minimum of 12 hours to be eligible for payment.

The patient's medical records for all levels of cardiac monitoring must include:

- the test report(s) with the number of channels recorded;
- whether the recording was continuous; and
- whether it was analyzed in real time, post-hoc or both and other information, such as, the name of the manufacturer and model of the device(s) used in the performance of the test.

## **Improve Access to Primary and Specialty Care by Simplifying Referrals to Specialists**

### **Fee Code Revisions (Descriptions and/or Payment Requirements)**

Revisions to the payment rules for successive Specialist Consultations have been added.

Consultations rendered by the same consultant to the same patient for the same diagnosis are now only eligible for payment once every 24 months when provided in the office.

An additional consultation rendered by the same consultant to the same patient with the same diagnosis is eligible for payment once every 12 months but only if it is provided to the patient who has been admitted to hospital or seen in the Emergency Department.

Any additional consultations rendered by the same consultant to the same patient for the same diagnosis are payable using the appropriate assessment code.

As is currently the case, one additional consultation rendered by the same consultant to the same patient is eligible for payment once every 12 month period if rendered for a clearly defined unrelated diagnosis.

All consultations (including time-based and age-specific) that exceed these limits, may be eligible for payment as an appropriate general, medical specific or specific assessment (depending on the specialty).

A repeat consultation remains eligible for payment in the circumstances defined by the fee code, namely following a consultation where the referring physician renders interval care but refers the patient back to the consultant for additional advice.

Note that consultations are not eligible for payment if requested by a Medical Trainee. However, they are eligible for payment at the appropriate assessment fee code amount dependent on specialty.

As before, a consultation prior to a low risk elective surgical procedure under local anaesthesia and/or I.V. sedation (cataract surgery, colonoscopy, cystoscopy, carpal tunnel or arthroscopic surgery) would be uncommon; however, such consultation is eligible for payment where the medical record demonstrates the medical necessity of the consultation and all other payment requirements are met (including consultation limits).

## **Perform Procedure to Remove Ear Wax Only When Medically Necessary**

### **Fee Code Revisions (Descriptions and/or Payment Requirements)**

G420 is only insured and eligible for payment when ear wax is impacted resulting in hearing loss and the application of topical cerumenolytics has been unsuccessful, or when immediately removing the wax is necessary for diagnosis and/or therapy.

G420 remains ineligible for payment when rendered in conjunction with the services already listed in the Schedule (Z906, Z907, Z908 and Z913).

## **Conduct Larynx Examinations During Stomach Examinations Only When Medically Necessary**

### **New Fee Codes**

Two new fee codes for the primary surgeon and the anaesthetist have been created to replace Z321 (\$61.30) – for Laryngoscopy to differentiate between a service with and without a biopsy:

- Z292 (\$61.30) – without biopsy; and
- Z293 (\$61.30) – with biopsy.

Where no biopsy is taken, Z292 is not eligible for payment with a gastroscopy, oesophagoscopy, oesophagoscopy-gastroscopy, duodenoscopy or a small bowel push

enteroscopy **unless** the laryngoscopy is performed due to suspicion of disease of the larynx. Claims for Z292 in conjunction with upper gastrointestinal tract endoscopy must include a written explanation. Submit the claim with a manual review indicator and provide the supporting documentation as per the usual process.

### **Commentary**

Commentary has been added to clarify that manual review by a ministry medical advisor is not required for Z293 (with biopsy), Z322 (removal of a foreign body) or Z323 (removal of lesion(s)) when rendered in association with gastroscopy, oesophagoscopy, oesophagoscopy-gastroscopy, duodenoscopy and small bowel push enteroscopy services.

### **Ensure Continued Access to Urine Pregnancy Tests when Medically Necessary**

#### **Fee Code Revisions (Descriptions and/or Payment Requirements)**

G005 is only insured and eligible for payment when an immediate determination of pregnancy is required (e.g., a woman presents to the office with abdominal pain and the physician wants to rule out ectopic pregnancy).

Quantitative pregnancy tests performed in the office (G021) and pregnancy tests ordered through laboratories remain insured.

### **Improve Access to Knee Arthroscopies for Patients with Non-Degenerative Knee Disease**

#### **New Fee Codes**

Two new fee codes have been added to the Schedule for knee arthroscopy:

- R699 (\$97.35) – Non-Degenerative Disorders of the Knee or Acutely Locked Knee - Knee arthroscopy set-up, non-degenerative disorders of the knee or acutely locked knee. Includes when rendered synovial biopsy and/or resection or trimming of plica. This service is eligible for payment to a surgical assistant (6 base units) and an anaesthetist (7 base units) as well.
- E498 (\$299.00) – Debridement (trauma) – substantial debridement of 1 or more focal flaps of unstable post-traumatic articular cartilage causing mechanical symptoms, includes when rendered synovectomy, meniscal trimming and/or chondroplasty.
- A knee procedure in the Knee section of the Schedule is eligible for payment with R699 or R687 if that procedure is not described as a component of R699 or described by an E add-on code to R699. The descriptor for debridement add-on codes E494 and E498 include specific language defining medically necessary debridement.
- There are also a number of new and revised Payment Rules and Commentary applicable to R687 and R699.

## Fee Code Revisions (Descriptions and/or Payment Requirements)

The descriptor for R687 has been changed to specify that the service is for **degenerative** disease of the knee only.

Three E-codes have additional Payment Rules in order to be eligible for payment with R687:

- E476 (Removal of symptomatic loose body(ies) and/or screw) is not eligible for payment with R687 unless there is evidence prior to surgery of an intra-articular loose body causing mechanical symptoms or a symptomatic loose screw.
- E494 (Debridement) and E495 (meniscectomy) are eligible for payment with R687 only with prior approval by a ministry medical consultant (contact your Claims Services Branch office for assistance), or, when there exists:
  - a. Kellgren-Lawrence knee osteoarthritis grade of less than 3 as documented on standing knee x-rays performed within the last 12 months; and
  - b. Unstable chondral pathology or a meniscal tear causing mechanical symptoms which have not responded to a minimum of six months active non-surgical treatment.

R687 is also eligible for payment in all patients with degenerative disease when a diagnostic arthroscopy is required prior to or in conjunction with reconstructive proximal tibial or distal femoral osteotomy.

### Commentary

Commentary has been added to note that:

- R687 is an uninsured service when performed for lavage only, when the payment criteria are not met or when pre-approval is denied by the medical consultant.
- Prior approval should be obtained for Kellgren-Lawrence grade 3 or 4 knee osteoarthritis based on the documentation of significant functional impairment and ineligibility for more extensive reconstructive surgery.

R699 is subject to the same restriction as R687 regarding claims with codes from the Knee section and additional arthroscopic knee codes not being a component of the procedure itself or of E-codes associated with R699. For greater specificity, the descriptor for E494 (debridement –degenerative cartilage) was revised to specify the criteria for substantial debridement.

The descriptor for E494 has changed. This add on code is only for debridement of **degenerative cartilage** (for substantial debridement of 1 or more focal flaps of unstable degenerative articular cartilage causing mechanical symptoms).

Lastly, additional Payment Rules were created to specify that:

- E492 (Synovectomy) may not be claimed with E494 or E498 (Debridement – trauma);
- E498 may not be claimed with codes for degenerative disease R687 and E494; and
- E494 and E498 may not be claimed for the purpose of surgical visualization alone.

## Fund Physician Premiums for House Calls Only for Frail Elderly and Housebound Patients

### Fee Code Revisions (Descriptions and/or Payment Requirements)

Payment rules for A900, the complex house call assessment, have been made to the Schedule to clarify that the service is only eligible for payment for a **frail elderly** patient or a **housebound** patient. The current definitions for these patients listed in the Schedule have been revised as follows:

A frail elderly patient is:

- 65 years of age or older; and
- has one or more of the following:
  - complex medical management needs that may include polypharmacy;
  - cognitive impairment (such as dementia or delirium);
  - age-related reduced mobility or falls; or
  - unexplained functional decline (not otherwise described above).

A housebound patient is a person:

- that has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
- for whom transportation is not available or not appropriate in the person's circumstances;
- for whom other strategies to address the access challenges have been considered but are not available or not appropriate in the person's circumstances; and
- for whom the care and support requirements can be effectively and appropriately delivered at home.

Special Visit Premiums for Home Visits (Special Visit Premium Table VI):

- The travel premiums (B960-B964) and special visit premiums (B990, B992, B993, B994 and B996) are not eligible for payment with a minor assessment (A001) or an intermediate assessment (A007) rendered in a patient's home (as defined on page GP3 of the Schedule).

### Commentary

Commentary has been added to clarify that A900 is not eligible for payment when rendered in a long-term care home. The service is only eligible for payment when rendered to a patient in their home (as defined on page GP3 of the Schedule).

Home-based assessments for patients who are not frail elderly or housebound are no longer insured with a specific fee code as A901 (\$45.15) been deleted.

Patients may still be able to receive care in their homes but the physician may only claim an appropriate assessment (A001 or A007) and may not claim the Special Visit premiums for Travel and First Person Seen listed in SVP Table VI as these are included as common

elements in the assessment. Note that there has been no change to fee codes associated with home-based Palliative Care visits.

## **Changes to Supervision of Postgraduate Medical Trainees (formerly Team Care in Teaching Units)**

### **Fee Code Revisions (Descriptions and/or Payment Requirements)**

The ministry and the Ontario Medical Association (OMA) have revised this section (pages GP54 to GP57) by defining terms, clarifying payment rules, establishing limits and outlining medical record requirements.

Definitions are listed on page GP54 and include: Supervision, Supervising Physician, Medical Trainee, Resident, Clinical Fellow, Procedure, Non-Procedure and Time-Based Services.

Services are now specifically defined as:

- Procedures: an insured service with anaesthesia base units and includes anaesthesia services
- Non-Procedure: an insured service that is not a 'Procedure' or a 'Time-Based Service'
- Time-Based Service: an insured service listed on pages GP37-42 (psychotherapy, counselling, interviews, hypnotherapy, psychiatric care and primary mental health care).
- A service rendered by a Medical Trainee is not eligible for payment to the Supervising Physician:
  - where a Medical Trainee has an OHIP Billing Number, and is providing services **outside** of the training program;
  - for Special Visit Premiums associated with the Trainee's service (unless the Supervising Physician personally meets the payment requirements for the Special Visit Premium);
  - for Case Conferences, Multidisciplinary Cancer Conferences, Telephone Consultations, E-Consultations or E-Assessments; or,
  - for Procedures:
    - where the patient is not aware the Medical Trainee is rendering the service;
    - unless the Supervising Physician is physically present in the clinical facility at the time a Resident is rendering the service or is immediately available to personally attend the patient when requested by the Resident or another health care professional; or
    - unless the Supervising Physician is available to personally attend the patient when requested by the Clinical Fellow or another health care professional in a timely manner consistent with the acuity of the clinical scenario (unless the service is procurement of organs or tissues to be used in transplantation).

Note: A Clinical Fellow with an OHIP billing number rendering a procedure under supervision, may claim fees for the assistant service if the procedure has basic units listed under the 'Asst' column (suffix 'B'). The supervising physician is eligible for payment as the operating surgeon (suffix 'A').

## **Myocardial Perfusion Scintigraphy with Rubidium Positron Emission Tomography (PET)**

### **New Fee Codes**

Two new fee codes have been added for Myocardial Perfusion Scintigraphy:

- J900 (\$43.50 Technical, \$23.65 Professional) - application of Rubidium PET for cardiac perfusion (resting, immediate post stress); and
- J901 (\$43.50 Technical, \$23.65 Professional) - application of Rubidium PET for cardiac perfusion (delayed).

These are new add on fee codes only eligible for payment in patients with:

- known coronary artery disease; or
- suspected coronary artery disease and who are at intermediate risk (10%-90%) of significant ischemia where the need for intervention is uncertain.

## **Myocardial Perfusion Scintigraphy with Single-Photon Emission Computerized Tomography (SPECT)**

### **Fee Code Revisions (Descriptions and/or Payment Requirements)**

The Schedule was revised to clarify that:

- J866 – application of SPECT (maximum of 1 per examination) is an add on to J807 - resting, immediate post stress; and
- J809 – application of SPECT (maximum of 2 per examination) is an add on to J808 - delayed.