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Bulletin 230604 — Appropriateness Working Group Recommendations

Appropriateness Working Group (AWG) Changes Effective July 1, 2023

To: All Physicians

Category: Physician Services

Written by: Provider Services Branch; Physician and Provider Services Division

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Background

The 2021–24 Physician Services Agreement (PSA) included the continuation of the Appropriateness Working Group (AWG) to satisfy any outstanding AWG requirements as part of the Kaplan Arbitration Award.

The Ministry of Health and the Ontario Medical Association (OMA) formed the AWG with a mandate to use evidence, best practices and expert opinion to identify and update the delivery of certain services to help ensure the most effective care for Ontario patients.

The AWG 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 effective July 1, 2023:

- Trial conservative treatment before proceeding with a hemorrhoidectomy
- Initiate a 3-month period of watchful waiting before treating chronic ear infections by inserting tubes in otherwise healthy children
- Hysterectomy for heavy menstrual bleeding or fibroids should only be performed if medical management or less invasive alternatives have been offered and either declined or found unsuccessful
- Do not claim cast/brace codes when a prefabricated cast or splint is used
- Unless earlier screening is clinically indicated based on findings or advised/recommended by the specialist rendering an initial colonoscopy, do not claim Fecal Immunochemical Testing (FIT) screening fees for 10 years following a negative colonoscopy consistent with Ontario Health (Cancer Care Ontario) Guidance
- Colonoscopy in patients under 50 years of age exclusively for constipation should not be performed
- Perform surgical intervention for treatment of Dupuytren's contracture only when significant flexion deformity is demonstrated
- Intravitreal injection of medication for the treatment of wet macular degeneration should not be performed more than 12 times per eye per year unless in exceptional circumstances where clinical conditions warrant the procedure

Overview of Specific Schedule Changes

Amendments have been made to the Schedule as described below.

Effective July 1, 2023:

Trial conservative treatment before proceeding with a hemorrhoidectomy

A payment rule and commentary have been added to clarify that hemorrhoidectomy (S247 and Z565) is only insured when the patient has failed a

trial of non-surgical therapy, grade III or IV haemorrhoids or haemorrhoids with substantial concomitant skin tags.

Initiate a 3-month period of watchful waiting before treating chronic ear infections by inserting tubes in otherwise healthy children

A payment rule has been added to note that surgical ear tube insertion (Z912 or Z914) performed on an otherwise healthy child is only eligible for payment for the treatment of symptomatic chronic otitis media with effusion that has persisted beyond 3 months or recurrent episodes of acute otitis media with effusion.

Hysterectomy for heavy menstrual bleeding or fibroids should only be performed if medical management or less invasive alternatives have been offered and either declined or found unsuccessful

Commentary has been added to indicate that hysterectomy (S757, S816) for benign conditions should only be performed when less invasive treatments have been found to be unsuccessful or are declined by the patient.

Do not claim cast/brace codes when a prefabricated cast or splint is used

A payment rule has been added to clarify that the cast-brace fee codes (E544, Z201, Z198, and Z873) are not eligible for payment for application of a prefabricated device (for example, a pre-fabricated hinged knee splint). This supplements existing Schedule language that specifies that corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or metal finger splint following soft tissue injury.

Unless earlier screening is clinically indicated based on findings or advised/recommended by the specialist rendering an initial colonoscopy, do not claim Fecal Immunochemical Testing (FIT) screening fees for 10 years following a negative colonoscopy consistent with Ontario Health (Cancer Care Ontario) Guidance

Description of fee codes Q150A and Q152A has been modified to indicate that they are only payable once per patient every 2 years, unless a patient has a negative colonoscopy (i.e., revealing either no polyps or only hyperplastic polyps in the sigmoid or rectum) – then only after 10 years unless earlier screening is

clinically indicated based on findings, advice and/or recommendations of the specialist who rendered the colonoscopy.

The description of fee codes Q150A, Q152A and Q043A have been changed as follows:

- Q150A: Colorectal Cancer Screening Fee
- Q152A: Colorectal Cancer Screening Test Completion Fee
- Q043A: New Patient Fee Abnormal Colorectal Cancer (CRC)/Increased Risk

Please see INFOBulletin 4723 (<https://wayback.archive-it.org/16312/20220506031940/https://health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4723.aspx>) for minimum requirements to claim fee codes Q150A, Q152A and Q043A.

Colonoscopy in patients under 50 years of age exclusively for constipation should not be performed

A payment rule and commentary have been added to clarify that colonoscopy to investigate constipation is only insured when patients are aged 50 years or older, have family history associated with an increased risk of malignancy (e.g. first degree relative or at least two second degree relatives with colorectal cancer or a premalignant lesion) or to exclude organic disease for patients with alarm features, such as bleeding, abdominal pain and new onset symptom.

Perform surgical intervention for treatment of Dupuytren's contracture only when significant flexion deformity is demonstrated

A payment rule has been added to note that excision of fascia for Dupuytren's (R551, E832) is only insured for patients who demonstrate at least one of the following physical signs:

- Metacarpophalangeal (MCP) joint flexion contractures of 30 degrees or more.
- Interphalangeal (IP) joint flexion contracture of any degree.
- Adduction contractures of the interdigital web spaces with significant functional impairment.
- Recurrence of Dupuytren's disease, defined as any recurrent flexion contracture of the MCP or IP joints following prior interventional treatment

(e.g., fasciotomy/fasciectomy).

- Significant functional impairment with any degree of contracture at the MCP or IP joints.

Intravitreal injection of medication for the treatment of wet macular degeneration should not be performed more than 12 times per eye per year unless in exceptional circumstances where clinical conditions warrant the procedure

Current fee code for intravitreal injection of medication for the treatment of wet macular degeneration (E147) has been replaced with two new codes: E186 for the left eye and E187 for the right eye.

A payment rule has been added to note that the new intravitreal injection codes (E186, E187) are each limited to 12 per patient per year and that services in excess of this limit are only eligible for payment in exceptional circumstances where clinical conditions warrant the procedure.

Schedule of Benefits for Physician Services

The Schedule of Benefits for Physician Services can be found at OHIP - Schedule of Benefits and Fees - Health Care Professionals - MOHLTC ([gov.on.ca](https://www.health.gov.on.ca)) (<https://www.health.gov.on.ca/en/pro/programs/ohip/sob/>)

Keywords/Tags

OHIP; Physicians; Appropriateness Working group (AWG); E147; E186; E187; E544; E832; Q043A; Q150A; Q152A; R551; S247; S757; S816; Z198; Z201; Z565; Z873; Z912; Z914.