OMA Section on General Surgery
c/o Ontario Association of General Surgeons
P.O. Box 192, Station Main, Peterborough ON K9J 6Y8
Phone: 705-745-5621
Fax: 705-745-0478

August 17, 2018

Attn. James Wright and Jasmin Kantarevic (Economics, Policy and Research)
Relativity Committee
Ontario Medical Association
150 Bloor St. W., Toronto, ON
Re: Out-Of-Hours Modifier

Section of General Surgery Response to Relativity Committee Re. After-Hours Work

The Section of General Surgery has multiple concerns with both RAANI and CANDI methodology with regards to measurement and attribution of work that is out-of-hours (between 5 pm and 7 am, or on weekends or holidays).

We would preface this by saying that we have marked concerns about the appeal for surveys. Self-reported data, especially when the intent is to possibly reallocate money, will give a much-distorted picture and potentially make relativity worse.

The "Better-Than-Average Effect" is a well-established and well researched social phenomenon wherein most people have an unrealistic picture of their situation relative to their peers. In most cultures, about 80% of drivers consider themselves to have above average driving skills, 90% of university professors consider themselves above average teachers and in anecdotal research 100% of my residents thought they were busier on call than their peers. This effect is part of our social makeup and a close relative of confirmation bias. As physicians and scientists, we should reject self-reported, unverified data and seek something that is independent.

That being said, if surveys are the only means by which the OMA intends to collect this data, biased or otherwise, we would not stand in the way of this and would encourage our members to participate.

Re: Impact of Block Fees for Surgery;

There appears to be an assumption by many nonsurgical physicians and those responsible for CANDI and RAANI methodologies that surgical fees just cover the operation. This is incorrect. Non-Z code procedural fee codes **are block fees that cover comprehensive care for the entire perioperative period,** including 2 days preoperatively and extending for 14 days post operatively **including nights and weekends**. Surgeons may **not** bill any subsequent visits after day 2 and no MRP premiums are allowed on post op patients, except for the day of discharge. For a 16-day stay, the difference in visit fees between a surgical patient managed with surgery or without is over $650, which essentially nullifies any operative fee code worth less than $650.

Page 2…

OMA EXECUTIVE
Dr. Chris Vinden (Chair), Dr. Alice Wei (Vice Chair), Dr. Harshad Telang (Secretary), Dr. Kevin Lefebvre (Tariff Chair),
Dr. Tim Jackson (Member-at-Large), Dr. Jennifer Macmillan (Member-at-Large), Dr. Jeff Kolbasnik (OMA Past Section Chair)

OAGS BOARD OF DIRECTORS
Dr. Harshad Telang (President), Dr. Alice Wei (Past President), Dr. Tim Jackson (Vice President),
Dr. Kevin Lefebvre (Treasurer), Dr. Jennifer Macmillan (Secretary),
Dr. Luke Bui, Dr. Peter Dauphinee, Dr. Ken Leslie, Dr. Sean McIlreath,
Dr. Husein Moloo, Dr. Ravinder Singh, Dr. Eric Touzin, Dr. Julie Ann Van Koughnett, Dr. Joel Weaver

As billing hospital visits is not allowed, no billings are submitted, and the OHIP databases, and therefore CANDI and RAANI, are basically **blind** to the activity and underestimate the work and service delivered .

This impacts surgical specialties in 2 ways with regards to CANDI and RAANI calculations…

Firstly, it significantly underestimates the number of days worked. Most surgeons round on their patients at least once per day until discharge. On weekends when they are not on call, it may be the only work that they do. So, despite working on a weekend or holiday or a post call day, it appears as a zero billing day in both CANDI and RAANI methodology.

Secondly, it impacts the amount of out-of-hours work attributed to surgeons, as routine care provided on weeknights, weekends and holidays does not appear in the OHIP database. This results in overestimation of daytime work, which inflates both CANDI and RAANI inappropriately. This contrasts with medical specialties and anesthesia, where care on weeknights, weekends and holidays is always billed and counts towards both days worked as well as out-of-hours work.

The fair and obvious solution would be for non-Z code surgery to be treated the same way as dialysis fees which are also block fees and are prorated on a weekly basis.

Although the OHIP database is blind to post op visits that are not billed, the CIHI databases can provide an estimate of the magnitude of the issue. We have requested that OMA economics analyze the CIHI discharge abstract database and based on the length of stay of surgical patients could provide some fairly robust estimates at the section level about the number of subsequent visits that occur between day 2 and day 14 post op. We will forward that work as soon as the data is available.

Re: Impact of Shared Fee Codes for Elective and Non-Elective Surgery and Lack of Complexity Modifiers

The after-hours premiums E409 and E410 are designed to provide a premium analogous to overtime, wherein there is an increase in the hourly rate of income. However, most surgical procedures when done as an emergency are more complicated and take significantly longer than the same procedure done electively. These cases are typically performed on sicker patients, have a much higher complication rate and have significantly longer lengths of stay. In addition, most operating rooms run at much reduced efficiency after hours, with reduced staffing levels and without specialty specific nursing teams. The net result is that it takes much longer to do the same procedure after hours and they have a longer length of stay requiring more postoperative care. This usually completely nullifies the impact of the premium codes, and often makes the remuneration rate on a per time basis **less than day time billing**.

This is in marked distinction to non-surgical specialties and anesthesia who are time based and have additional E code premiums for the sicker patients and non-elective status and can consistently have a higher income level per hour worked at unsocial hours.

We have requested that OMA economics do an analysis of this by comparing anesthetic time units and length of stay for cholecystectomy (S287) done emergently and electively to provide evidence of this effect. In addition to the time component, we have also asked OMA economics for a comparison of the total billing increment for anesthesia vs surgeons for non-elective surgery, comparing several fee codes that are done both electively and emergently. This will demonstrate that the impact of looking after emergency patients is out of relativity between sections. We will submit this data as soon as it is available.

The overall impact of this is that surgeons are at a disadvantage compared to other specialties with regards to proportion of billings that are in nonsocial hours. Basically, our out-of-hours fee codes are “out of relativity” compared to other physicians, and using them in the relativity formula just perpetuates the lack of relativity. We would ask that a “nonelective” multiplier be applied to non Z-code surgery that is done emergently for purposes of CANDI calculation.

The advent of acute care services in the last decade means that a lot of these emergency cases are now done during day time hours. They still have all the complexity and increased time obligations of non-elective cases but no premiums at all. Essentially, our participation in acute care services which shift emergency care to daytime hours (a good thing) has deprived us of E-code billing that partially compensated for the increased complexity of such cases (a bad thing).

In the long run, we would request fee schedule changes that correct this longstanding inequity. Anesthesia has E-codes premiums for non-elective cases and for complexity, it would make logical sense for surgeons to be afforded the same.

Re: "Overtime" Without Overtime Pay

All surgeons and anesthetists have long been frustrated by the arbitrary rule of cases that are started during daytime hours are billed at daytime hours even if they extend well into the evening and cases that start in the evening may well extend well past midnight without the after midnight premium. This results in significant underreporting of emergency work and over-reporting of daytime work - artificially inflating ANDI. It is all the more frustrating as the other allied health professionals working in the same operating room are all typically getting paid overtime from the first minute that they stay late, and if called in from home get a minimum of six hours pay.

The corollary wherein a case starts early in the morning and extends into daytime is a very rare event that in no way offsets the inequities of the far more common scenario of a case extending into evening or after midnight hours.

We are also frustrated by the arbitrary rule that no special visit premiums are to be paid for hospital rounds even if they are on weekends or holidays. While some specialties have very few inpatients, others including general surgery have significant inpatient loads and rounding on patients on Saturdays, and Sundays is essential for patient care and the smooth running of the health care system. We would argue that the lack of a weekend premium for this work is unfair. Surgeons are NOT shift workers, they provide continuity of care with significant sacrifice of their weekend and holiday time.

Re: Impact of Part-Time Physicians

We have major reservations about both CANDI and RAANI with regards to its treatment of part-time physicians. There are 2 types of part-time physicians - those that work reduced hours per day and those that still work full days but then take full days off. Both RAANI and CANDI methodologies strongly favour specialties wherein part timers work reduced hours per day rather than taking days off. A physician working at 33% but 5 days a week is essentially considered full time and nicely brings down the average daily income of their specialty, while a physician who does the same amount of work in 2 days and takes 3 days off keeps the ANDI high. The RAANI methodology suggests that 19,000 of Ontario physicians work less than full time and analysis of OMA data shows that the top billing 20% do over 50% of the work, so there are a large proportion of part time doctors.

While office based practitioners such as GP's can control their hours and can arrange flexible part time practices of reduced hours per day, that is not possible for surgeons and other hospital based practitioners. In the pursuit of efficiency, most hospitals no longer allow half day ORs or endoscopy lists. This differential treatment of part time physicians has a huge impact on final values in both CANDI and RAANI and likely accounts for a significant component of the overall variation in daily income for GP's. We would strongly favour revisiting the trim levels and inclusion criteria for both RAANI and CANDI with the objective of only including those that are highly likely to be working full time only. We would recommend only including the 50th to the 90th percentile of billers in each specialty. This would then avoid the issue of part timers.

Re: Unmeasured Out-of-Hours Work

We are aware that many physicians are disgruntled that busy schedules force a lot of clinical administrative paperwork and telephone calls to be done in unsocial hours. There is no doubt that there is a lot of practice variation and a significant number of doctors who review their lab results, path results and other clinically important paperwork - either after hours or in half days in the office dedicated to clearing of one's desk. Such work is not captured by either CANDI or RAANI. We feel that such work is common to all branches of medicine, is highly variable according to individual practice patterns and habits, and is difficult to capture accurately. We suspect that surgeons in general have a higher proportion of such work out-of-hours, as their schedules are aligned with hospital schedules and they do not have the flexibility of office based practices. If the OMA is considering a survey on this issue, we would like to participate, though we would have strong reservations as to the validity of such a survey and in general, we would discourage it.

Furthermore, there are elements of after-hours work not captured by the OHIP schedule premiums. For after-hours premiums to apply, the work must both be after hours and be emergent in nature (not scheduled elective work). In many larger hospitals, some operating rooms run elective surgeries until 6 pm, and thus the portion of elective surgery between 5 pm and 6 pm, sometimes portions of cases and occasionally entire cases, are performed after hours yet billed as daytime work. In many other places, emergency surgeries start at 3 pm or 4 pm, but cannot be billed with after-hours premiums if they start before 5 pm. Thus, an emergency bowel resection that runs from 4 pm till 8 pm is billed and attributed entirely to daytime income, even though 3 hours of this work was performed after hours. As such, the current after hours premiums fail to catch much of the after-hours surgical work.

Re: Out-of-Hours Work of Other Specialties

We feel that all specialties should be treated fairly and equally with regards to out-of-hours work premiums. There are large relativity issues with regards to treatment of out-of-hours work and they need to be adjusted for within the CANDI methodology. Of all these issues, the dominant one is the unfair treatment of our block fees.

Respectfully Submitted,

Chris Vinden

Section Chair on General Surgery