Measures of the Institute for the relevance of medical procedures – Amendments to the Framework Agreement

The Institute for the relevance of medical acts has adopted the following new measures:

- Clarifications to emergency care rules;
- Visit for patients deemed to be in Alternate Level of Care (ALC);
- Remote monitoring of pacemakers in cardiology;
- Bank of hours for professional activities carried out on behalf of a regional table for the prevention of nosocomial infections;
- Abolished billing codes and lower rates.

These changes come into effect on the various dates specified in this document.

Clarifications to the Rules of Emergency Care (Rule 14 PG, Rule 4 PG SLE, art. 4 Annex 38)

The following changes are retroactively effective February 15, 2022.

The word ***call*** was changed to ***answer*** to an emergency during the on-call schedule. The term ***speaker*** is also introduced:

A medical specialist who responds to the request of an emergency responder during the call schedule is entitled to payment of increased fees.

Consequently, the FMSQ recommends that you get into the habit of recording the following information in your notes to the file:

- The name of the stakeholder who made the request;
- The date and time of the call;
- The date and time of the services;
- The reason the patient needs to be seen urgently.

Applying the Urgent Care Rule (SUG)

Emergency care **does not apply** to front-line physicians in the establishment's emergency room, that is to say who work their shift on site in:

- An emergency;
- A pediatric emergency;
- A psychiatric emergency;
- An emergency from a heart or pulmonology institute.

In order to be entitled to emergency care within the meaning of PG Rule 14, the doctor **must be registered to the on-call list** defined by the head of department, service or DSP. It is not necessary for the doctor to be identified at the end of an on-call list within the meaning of Annex 25, i.e. it is not necessary for an on-call flat rate to be invoiced .

A doctor who **is not on the call list** can avail himself of emergency care if he is called to lend a hand to another medical specialist in an exceptional emergency situation. In this case, he will have to add the Emergency support context element ***for an exceptional situation (Shortcut #SUS)*** .

For emergency care to be payable, the provider's request must have been made during the call schedule. For example, if you were called at 3:00 p.m. on a Monday and you see the patient only at 9:00 p.m., you are not eligible for emergency care.

The services eligible for the emergency increase are as follows:

- A medical service provided in the emergency room by a medical specialist (observed patients, patients awaiting hospitalization, outpatients), with the exception of first-line services, during the on-call schedule provided for in 14.1;
- A service provided urgently for a hospitalized patient whose condition is deteriorating such that it requires rapid intervention, according to the clinical prioritization of emergencies in the judgment of the doctor. In such a case, the note entered in the file and the patient's management are proof of this. You must describe that you have been called as well as the clinical reason justifying the emergency and the elements of care;
- Any unplanned surgery or diagnostic and therapeutic procedure (PDT) or childbirth.

The services NOT GIVING right to the emergency increase are the following:

- Front-line services such as main and control visits in an emergency, a pediatric emergency, a psychiatric emergency, a cardiological or pneumological emergency;
- A consultation, visit, surgery, diagnostic and therapeutic procedure or any other service performed in an outpatient clinic for an elective patient with an appointment;
- A visit to a hospitalized patient with no change in his state of health requiring rapid action.

Billing Instructions

We remind you that to apply the increase for emergency care, you must:

- Use the context element ***Emergency care according to PG rule 14 (shortcut #SUG);***
- For the physician **not registered on the call list** and who is called in as backup, **also use** the element context of ***Emergency support for an exceptional situation (shortcut #SUS)*** ;
- Enter the exact time of the services;
- Keep the date and time of the call on file.

You have 120 days from **April 13** to contact your advisor to add the context element ***Emergency support for an exceptional situation (shortcut #SUS)*** since **February 15, 2022**, if applicable.

You will be informed in a future newsletter of the date from which the date and time of the call can be indicated on the invoice.

Medical imaging

Specific provisions are planned for medical imaging activities for doctors specializing in **diagnostic radiology** or **nuclear medicine** .

The interpretations and interventions giving right to the emergency increase are as follows:

- a diagnostic examination carried out during the on-call schedule provided for in Article 14.1, for which urgent interpretation is requested and carried out during the on-call schedule.
- a diagnostic examination carried out outside the on-call schedule provided for in Article 14.1, for which urgent interpretation is requested and performed during the on-call schedule.
- a diagnostic procedure or treatment rendered in interventional radiology which is requested in an emergency and carried out during the on-call schedule provided for in Article 14.1.

To determine the increase, the date and time of the performance of the interpretation are considered.

Billing Instructions

When invoicing, you must:

- Use the context element ***Emergency Care per PG Rule 14 (shortcut #SUG)*** ;
- Enter the date and time of the start of the service (interpretation);
- Keep in the patient's file the name of the professional who requested the emergency interpretation as well as the date and time of the examination.

Keep in the patient's file:

- the name of the professional who requested the emergency interpretation.
- the date and time of the examination.
- the date and time of the request for urgent interpretation.

You have 120 days from **April 13** to contact your advisor to retroactively change your services from **February 15, 2022,** if applicable.

You will be informed in a future newsletter of the date from which this information must be indicated on the invoice.

Visits for patients deemed to be in Alternate Level of Care (ALC)

Rule 5.8 is added to the General Preamble of the Specialist Physician Handbook – Fee-for-Service. This rule specifies the visits applicable for patients in a short-term care center (CHSCD) deemed to be in an alternative level of care (NSA), waiting for an intermediate family-type resource (RI-RTF) or waiting for a residential and long-term care center (CHSLD).

Doctor

If you act as the attending physician for a patient known to be in NSA, you can bill **only one follow-up visit per week** for this patient, including weekend rounds. You cannot charge tour, transfer tour or another daily package. However, if the

patient has a significant or urgent deterioration in their condition that requires prompt medical evaluation and a change in status to non-ASN active, you may bill at the usual visit pricing. In the week when the patient's final departure occurs, you can also invoice a **departure visit** when applicable in your specialty. If the departure visit is not planned for your specialty, you can exceptionally invoice a second control visit during the same week.

Consulting physician

If you are acting as consulting physician in the file of a patient deemed to be in NSA for whom a visit was scheduled or would have been scheduled in an outpatient clinic had he been in an RI-RTF or a CHSLD, **a single visit may be billed per week, per specialty**. You must then bill for a visit to the Outpatient **Clinic section of your specialty** by entering the Outpatient Clinic sector of activity, regardless of the sector in which the patient is hospitalized.

This change is effective retroactively to **April 1st, 2022**.

Remote monitoring of pacemakers - Cardiology

Rule 19.8 is added to Application Rule 19 – Cardiology of the Specialist Physicians' Handbook – Fee-for-Service.

For the specialist doctor classified in cardiology, a main visit or telemedicine check-up cannot be billed for follow-ups carried out for the same patient, by the same doctor, on the same day as the following services:

- programming or verification of an internal defibrillator under electrocardiographic control (maximum of six (6) programming's or verifications per calendar year, except if carried out on hospitalized patients, patients in the coronary unit or in the emergency room) (**billing code 313)**;
- verification of sensitivity and drive thresholds under electrocardiographic control with programming of a permanent unifocal pacemaker, if applicable (maximum two per calendar year for the same patient unless performed in hospitalized patients, patients in the coronary artery unit or emergency room) – beneficiary 2 years or older (**billing code 685)**;
- verification of sensitivity and drive thresholds under electrocardiographic control with programming of a permanent bifocal pacemaker, if applicable (maximum two per calendar year for the same patient unless performed in hospitalized patients, patients in the coronary artery unit or emergency room) – beneficiary 2 years or older (**billing code 693)**.

This change is effective retroactively to **April 1st, 2022**.

The RAMQ will reassess the services concerned. No action is required on your part.

Bank of hours for professional activities carried out on behalf of a regional table for the prevention of nosocomial infections

Article 7.1 of the Memorandum of Understanding relating to the remuneration of certain professional activities carried out on behalf of a regional table for the prevention of nosocomial infections is modified. The bank of hours allocated by year is reduced to **1,250 hours.**

Article 7.2 is modified. The bank of overtime hours per calendar year is reduced to **250 hours**.

These changes come into effect retroactively to **january 1st, 2022**.

Abolished billing codes and lower prices – Medical Genetics

In the Biochemical Genetics and Molecular Genetics sections of Tab M – Medical Genetics of the Specialist Physicians' Manual – Institutional Laboratory Services, the following billing codes will be abolished:

- 9614: Disaccharidases.
- 9620: Fumarylaketoacetate hydrolase.
- 9621: Galactose-1- PO4 uridyl transferase.
- 9627: Hippuric acid.
- 9631: Phytanic acid (quantitative);
- 9649: Other metabolites.
- 9643: Mucopolysaccharides (qualitative);
- 9659: Molecular study of the same gene by truncation test of one or more different fragments of the protein coded by the gene studied.
- 9668: Molecular study of the same gene by Southern genomics using one or more digestion reactions (polymorphism(s)).

In the Medical genetics section of tab B – Fees for visits of the Specialist physicians' manual – Fee-for-service, the pricing of the supplement for the complexity of the laboratory investigation required for non-availability in Quebec will be reduced to $10,10 (**billing codes 9005, 9010, 9018, and 9025)**. These changes will come into effect on **May 1st, 2022**.