fillable form

SASKATCHEWAN
MEDICAL ASSOCIATION

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NEW FEE ITEM REQUEST FORM

NOTE: You are asked to complete the form and fill in each item and relevant subsection within the item. If the amount of space is insufficient, please attach the response/information on a separate sheet of paper. If necessary, use the following abbreviations:

Not applicable – n/a   Not available – N/A   Unknown – U

1. Requested by ______________________________

   from the Section of ____________________, for: (please check one)

   _______ New Item
   _______ Amendment to existing item
   _______ Deletion of existing item
   _______ New General Rule
   _______ Amendment of existing General Rule
   _______ Deletion of existing General Rule

2. Name of Procedure or Service

   NOTE: **Use nomenclature as it would appear in the Schedule. Please do not use eponyms to identify procedures or services.**

3. Description of Service

   NOTE: **If service requested is a surgical procedure, provide a detailed description similar to that of an operative report or attach the actual operative report (deleting patient identification) if you prefer.**

4. Location of Service

NOTE: The procedure or service will be provided in the following locations (please check all that are applicable).

_______ Office

_______ Patient's home

_______ Long term care facility

_______ Ambulatory care facility

_______ Non-hospital surgical facility

_______ Hospital in-patient

_______ Hospital out-patient

_______ Hospital out-patient day surgery

_______ Hospital emergency

_______ Hospital intensive care unit

_______Other (describe location) ____

5. Analysis of Component of Procedure or Service

5.1 PROFESSIONAL COMPONENT:

(a) Pre-Service Component

What services are provided prior to procedure that are to be included as part of a composite fee?

Location	**Type of Service**
Hospital	____
Office	____

(b) Intra-Service Component

Physician time component (specific to the proposed procedure):

NOTE: **Include procedure/service time ONLY as pre-operative and post-operative visits, if applicable, are included in (a) and (c).**

	Minimum (Time)	**Maximum (Time)**	**Average (Time)**
Physician	_______	_______	_______

Analysis of Component of Procedure or Service (5 cont'd)

(c) Post-Service Component

What is the average expected care involved after the procedure which is included in the total fee?

Location	Type of Service	Average Number
Hospital	____________________________	____________
Office	____________________________	____________

TOTAL PROFESSIONAL FEE REQUESTED (a, b and c, above) $______________ *if single fee*

For a more complex fee structure fill out here:
____
____
____
____
____

(d) What other services or fees are billed in addition to the above?

(e) What other practitioners are involved in providing this service or what other costs to the health care system will occur? Please check all that apply.

_______ Surgical assistant
_______ Pathology services
_______ Others (please describe)
_______ Anaesthesia services
_______ Radiology services
_______ Other inter- or intra-specialty consultations

5.2 TECHNICAL COMPONENT* (encompasses technician and overhead)

(a) Technician time component

	Minimum (Time)	**Maximum (Time)**	**Average (Time)**	**Dollar Value**
Technician	_____	_____	_____	$____________

Technical Discipline ____

Hourly Rate ______________________________

*Complete only if technical personnel are involved in the service, and the fee/benefit includes a component to cover their service, e.g., a lab test, measurement of system function.

Analysis of Component of Procedure or Service (5 cont'd)

5.2 TECHNICAL COMPONENT (cont'd):

(b) Overhead Component

(i) Equipment:

Amortization of cost or leasing costs of any special equipment needed to carry out procedure (indicate costs incurred by physician only and basis of amortization, as well as amortization period, percentage per year, tests per year): **NOTE: Details of calculation must be attached**

Equipment cost per test: $____________

(ii) Expendable costs (specific to the proposed procedure, i.e., paper, supplies): Please provide details of the costs, per test. **NOTE: Details of calculation must be attached**

$____________

(iii) Indirect costs (based on the % of time/space/staff dedicated to the procedure. Divide overall costs by the number of services provided in the facility):

Staff: (other than technician) $____________

Rent: $____________

Utilities: $____________

Other*: $____________

$____________

TOTAL TECHNICAL FEE REQUESTED (a, b (i), (ii), (iii)**)** $____________

*Please provide details of all other costs which were included.

6. Frequency of Procedure or Service

(a) What is the expected utilization of the new procedure or service, by **ALL** practitioners in the province of Saskatchewan in the next 36 months? (be as specific as possible)

(i) First twelve months ____________________ (ii) Second twelve months ____________________ (iii) Third twelve months ____________________

(b) How are the frequency estimates in (a) calculated?

(c) What other section(s) if any, will provide this fee item? **NOTE: Please indicate the percentage of services that will be provided by the involved section(s).**

7. Interprovincial comparison of the Procedure or Service (if unknown, leave blank)

Is a comparable benefit code provided in other province(s)? (please detail the elements included in the listed benefits):

Province	Fee Code Number, Description, and Benefit Rate
Ontario	____________________
Manitoba	____________________
Alberta	____________________
B.C.	____________________

8. Relationship Between the Proposed Procedure or Service and Items Currently Listed in the Payment Schedule

(a) Is the proposed procedure/service currently paid by Saskatchewan Health? If yes, indicate the current payment schedule code(s) and payment rate(s) for which payment has been made for the proposed item.

Yes __________ No __________

Relationship Between the Proposed Procedure or Service and
Items Currently Listed in the Schedule of Medical Benefits (8 cont'd)

(b) Indicate the current payment schedule code(s) that may be replaced by the new procedure or service.

____

____

(c) If codes are to be replaced, indicate the portion (percentage of services detailed in (b) above) of services provided under the existing benefit code(s) that may be replaced by the new procedure or service.

(d) Describe the overall cost impact to the Health Care System - either savings or expenditures - of using the new service compared to the previous services in (b) and (c) above (e.g., fewer hospital days, additional practice costs etc.).

(e) Will the implementation of this item result in a shift of services from one sector to another (e.g., hospital to fee for service)? If so, please indicate which sectors are involved and the volume of services affected.

(f) Indicate how the proposed value relates to similar related procedures within either the same section of the Schedule or other sections of the Schedule, in terms of time spent with the patient, complexity of the procedure, responsibility, etc.

9. Other information

(a) List scientific references describing the procedure:

NOTE: **Where applicable please provide photocopies of the scientific references (articles or relevant sections of textbooks) appropriately referenced.**

(b) Is any part of the payment to be paid by any other agency? If so, how much?

(c) Additional information or comments:

Signature: ____

Date: ________________

Please fill out Appendix A on the next page.

Appendix A

	MEDICAL NECESSITY ANALYSIS	Y	N	N/A
1.	Will the service **prevent deterioration** in the patient's condition?			
2.	Will the service **alleviate** the patient's **symptoms**?			
3.	Will the service **improve** the patient's level of **functioning**?			
4.	Will the service assist in **restoring normal development**?			
5.	Would a **delay** in payment to the physician be **inappropriate**?			
6.	Would a **delay** in providing the service be **detrimental to the patient**?			
7.	Is the service **'reasonable'** and **'necessary'** for the diagnosis or treatment of illness or injury?			
8.	Is there a current/existing method that would provide an **equivalent** medical and/or diagnostic **outcome**?			
9.	Is the service **clinically appropriate** in terms of type, frequency, extent, site and duration?			

	STANDARD OF CARE ANALYSIS	Y	N	N/A
1.	Is the service considered standard of care in **other jurisdictions**?			
2.	Is the service in accordance with generally accepted **standards of medical practice**?			
3.	When was the service **established**?			
4.	Who can perform the service? (**scope**)			
5.	Is the service primarily for the **convenience** of the **patient** or **physician**?			
6.	Is there credible, scientific evidenced published in peer-reviewed **medical literature** to support the request?			
7.	Is the service **more costly** than a current/existing method with an equivalent medical/diagnostic outcome?			
8.	Will the service produce the intended results and expected **benefits** that **outweigh** potential **harmful effects**?			