

NEW FEE ITEM REQUEST FORM

NOTE: You are asked to complete the form and fill in each item and 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. Request by _____ to the Section of
_____ for: (Please check one)
 New Item New General Rule
 Amendment to existing item Amendment of existing General Rule
 Deletion of existing item 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	_____ Hospital in-patient
_____ Patient's home	_____ Hospital out-patient
_____ Long term care facility	_____ Hospital out-patient day surgery
_____ Ambulatory care facility	_____ Hospital emergency
_____ Non-hospital surgical facility	_____ 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?

<u>Location</u>	<u>Type of Service</u>
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 (cont'd)

(c) Post-Service Component

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

<u>Location</u>	<u>Type of Service</u>	<u>Average Number</u>
Hospital	_____	_____
Office	_____	_____

TOTAL PROFESSIONAL FEE REQUESTED (a, b and c)..... _____

(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 | _____ Anaesthesia services |
| _____ Pathology services | _____ Radiology services |
| _____ Others (please describe) | _____ Other inter- or intra-specialty consultations |

5.2 TECHNICAL COMPONENT: (encompasses technician and overhead)

(a) Technician¹ time component

	Minimum (Time)	Maximum (Time)	Average (Time)	Dollar Value
Technician	_____	_____	_____	\$ _____
Technical Discipline	_____			
Hourly Rate	_____			

¹Complete 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 (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) Other costs² (based on the % of time/space/staff dedicated to the procedure):

**Indirect Overhead Costs (space and time)
per service (overall costs divided 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)) \$ _____

²Costs not covered in specific procedure but common to all procedures e.g. receptionist, billing clerk, rent etc.

³Please 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 (To be completed by Intersectional Council representative)

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

<u>Province(s)</u>	<u>Fee Code Number, Description and Benefit Rate</u>
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 (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.

Other Information (cont'd)

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

(c) Additional information or comments:

Signature: _____