



## 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                   | 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 the request is for 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).**

	<b>Minimum (Time)</b>	<b>Maximum (Time)</b>	<b>Average (Time)</b>
Physician time:	_____	_____	_____

*Note: For surgical procedures, a sample OR report may be requested.*

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?

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

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

Use space below to provide rationale or for a more complex fee structure:

(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\*, if applicable (e.g. technician and overhead)**

(a) Technician time component

	<b>Minimum (Time)</b>	<b>Maximum (Time)</b>	<b>Average (Time)</b>	<b>Dollar Value</b>
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 number of services/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. Interjurisdictional Scan of the Equivalent Procedures or Services (if unknown enter U)

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

Province

Fee Code, Title or Short Descriptor, Rate

B.C.

\_\_\_\_\_

Alberta

\_\_\_\_\_

Manitoba

\_\_\_\_\_

Ontario

\_\_\_\_\_

Other (optional)

\_\_\_\_\_

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:

10. Medical Necessity and Standard of Care

Please fill out Appendix A on the next page.

**Date:** \_\_\_\_\_

Please also 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?			