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| Application for Medical Fee Item (New or Split)  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 information on a  separate sheet of paper.  **Please place N/A in all boxes that do not apply.** |  |

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| 1. **Fee Information** | Fee item is: | | | | | | | | New  Split (check ONE box only) | | | | | | | | | | | | | | | | |  | | |
| 1) Full title of new or amended fee item for Printing in Guide |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 2) Billing Note(s) for Printing in Guide |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 3) Source of Funding | New Fee Item Funding  Revenue Neutral:  Fee Code Deletion  Fee Reduction  Split Fee Item  Other (e.g., allocation): | | | | | | | | | | | | | | | | | |  | | Rationale/Details: | | | | |  | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| 4) Brief Outline of Service  *Document all steps of procedure from contact of patient to completion* |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 5) Provide details of efficacy of proposal compared to current standard of care (gold standard)  *Please provide health technology assessments or phase III clinical trials of prospective randomized clinical trials published in peer reviewed medical or surgical journals which demonstrate significant clinical benefit to patient using this new procedure, and medical certification that the new procedure is now an accepted standard of care.* |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 6) Is this service specific to a particular diagnosis? (e.g. for malignancy) | Yes  No | |  | | | If YES, please list diagnosis. | | | | | | | | | | | | | | | | | | | |  | | |
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| 7) Is this specialty restricted? | Yes  No | |  | | | | If YES, which specialities may bill this item? | | | | | | | | | | | | | | | | | | |  | | |
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|  | Rationale for restriction: | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 8) Does this service require special training or accreditation? If YES, please describe. |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 9) Special equipment required  *Please specify any special devices or equipment used or required for this service. Is this devise supplied by the Health Authority?* |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 10) Services generally performed in association with this item. | List procedures: | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | Advise if the additional service is included in this fee or billable in addition. | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | If billed in addition at what % (percent) should it be paid?      % | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 11) What fee item(s) would **NOT** be billable in conjunction with this fee item? |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 12) Is there a daily maximum number per patient of allowable services on this item? | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | If more than one, what are the numbers and rationale? | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 13) Anticipated frequency of repeat services (e.g., every 3 months, every 6 months) |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 14) Will other physicians be involved in the provision of this service but bill a different fee item? | Yes  No | | | | | |  | | | | | If YES, what fee item(s) would be billed? | | | | | | | | | | | | | |  | | |
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|  | If YES, please specify the speciality of the other physician that will be involved with the provision of this service: | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 15) If this is an age specific fee, please state the age | Age | | | | | |  | | | | | Explanation if required. | | | | | | | | | | | | | |  | | | |
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| 16) Is this a once in a lifetime fee? | Yes  No | | | | | |  | | | | |  | | | | | | | | | | | | | |  | | | |
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| 17) If this is a gender specific fee, please indicate sex | Male  Female | | | | | |  | | | | |  | | | | | | | | | | | | |  | | | |
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| 18) Is this eligible for a Telehealth equivalent fee item? | Yes  No | | | | | |  | | | | |  | | | | | | | | | | | | | |  | | | |
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| 19) Could this be done for cosmetic reasons? | Yes  No | | | | | |  | | | | |  | | | | | | | | | | | | | |  | | | |
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| 20) Anticipated number of services per year in BC. *Please specify the epidemiology data used to arrive at your utilization estimates and the source of the data (e.g., Stats Canada)* | No. of Services Per year | | | | | |  | | | | | Provide details of calculation and rationale. | | | | | | | | | | | | | |  | | |
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| 21) Provide comparable services (i.e., list other fee items that compare in time, intensity and complexity to the new fee item **AND** an explanation of their relationship to the new fee item) |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 22) Average time | Hours |  | | Minutes | | | | | | | | | | | |  |  | | | | | | | | |  | | |
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| 23) Is this a time-based fee (i.e., paid by amount of time)? | Yes  No | | | |  | | | | | If YES, specify time unit (e.g, per 15 minutes) | | | | | | | | | | | | | | | |  | | |
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| 24) Current billing of service | Are these services currently billed under existing fee item(s)?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | If YES: List all fee item(s) it is being billed under and provide the percentage of services (or estimated # of services) billed under ***each*** of the fee items listed: | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | Existing  Fee Code | | | | | | | | | | | | | | % or Volume Estimate | | |  | | Existing  Fee Code | | | | % or Volume Estimate | |  | |
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|  | Please list any fee item(s) that are to be deleted: | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 25) Is this service done primarily on an elective or emergent basis? | Elective  Emergent | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 26) Patient Risk Factor | Low  Moderate  Complex | | | | | | |  | | | | | Select ONE option from the left and explain | | | | | | | | | | | |  | | | |
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| 27) Technical Difficulty | Low  Moderate  Complex | | | | | | |  | | | | | | Select ONE option from the left and explain. | | | | | | | | | | |  | | | |
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| 28) Is an Anesthetic required for this service? | Yes  No | | | | | | |  | | | | | Type of anesthesia (e.g., general, local, regional, conscious sedation) | | | | | | | | | | | | |  | | | |
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|  | Who will provide the anesthesia? | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| 29) How is clinical suitability determined? |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 30) Recommended MSP Fee: | Total Fee  $ | | | | | | | | | | | | | | |  | Professional Fee  $ | | | | |  | Technical Fee  $ | | |  | | | |
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| 31) Recommended Doctors of BC (BCMA) fee: | $ | | | | | | | | | |  | | | | | | | | | | | | | | |  | | |
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| 1. **Submission and Approval** | | Section Submitted by | |  | | | |  |
| Please attach minutes from your Executive Meeting | | (Please print) | |  | | | |  |
|  |  | | | | | | |
|  | Approved by the following Sectional President or Chair |  | |  |  |  |  |
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|  | (Please print) |  | |  |  |  |  |
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| 1. **Section of Anesthesiology** |  | | | | | |  |
| Recommended anesthesia procedural unit:  (if greater than 0 explain) |  | | | | | |  |
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|  | Signature | |  | mm | dd | yyyy |  |
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| 1. **Requesting Physician Contact Information** | Name: | Mailing Address: | | | | |  |
| Please provide contact information of the physician most appropriate to answer questions regarding this proposal | Phone:  Cell: | Email: | | | | |  |
|  |  | | | | | | |