**FEE COMMITTEE Application process**

# **The Fee committee**

The Fee Committee (FC) is a committee under the 2016 Master Agreement. The FC is comprised of members from Doctors Nova Scotia (DNS), the Nova Scotia Department of Health and Wellness (DHW) and the Nova Scotia Health Authority (NSHA).

The mandate of the FC is to make decisions on all matters pertaining to the Fee Schedule, including: the introduction of new fees; revisions or deletions of existing fee codes; additions, revisions or clarifications of the Preamble to the MSI Physician’s Manual.

# **Application submission**

All applicants should discuss their proposed application with DNS or DHW staff as appropriate before completing the application form to ensure their proposal can be reviewed by FC. All requests will be responded to within 30 days by staff with an explanation of the process to be followed. If the proposal includes multiples health service issues a separate application form is required for each request.

All stakeholders may submit requests to the FC including: individual physicians, Sections, DNS, MSI, DHW and NSHA/IWK. Submission deadlines are March 31st and September 30th each year.

Once completed applications are forwarded by staff to FC they will be reviewed on a first come first served basis. In the interest of efficiency, FC reserves the right batch similar applications.

# **Application review**

All applications will be reviewed by staff for completeness of documentation. If complete, the application will be assigned an FC tracking number and forwarded to FC for consideration. Only complete applications will be considered.

At any time during the review process FC may ask the applicant for more information or clarification to ensure the application is evaluated fairly.

Applications must be completed and submitted electronically via e-mail to:

**fee.committee@doctorsns.com**

Jessica Moore

Compensation Manager, Master Agreement & Fee Schedule

Phone: (902) 481-4922 or 1-800-563-3427 ext 4922

**fee committee application form**

This form must be completed when requesting a change to the Physician Fee Schedule, including: new health service code requests, changes to existing codes or fee values, deletion of codes, changes to the preamble and other relevant requests. Each request requires a separate application.

The application form contains the following sections:

|  |  |  |
| --- | --- | --- |
| Section |  | To be completed by: |
| A | General Information, Executive Summary and Checklist | All Applicants |
| B | New Health Service Code or Code Adjustment | Applicants requesting new codes or code revisions for cognitive (evaluation and management) services or interventional (surgical, diagnostic or therapeutic) services |
| C | Preamble Change | Applicants requesting a change to the governing rules of the Preamble |
| D | Health Service Code Deletion  | Applicants requesting deletion of a code e.g related to an outdated procedure. |

**PLEASE NOTE: An application will not be accepted if it is incomplete (e.g. missing operative reports and records for surgical applications) or if the required clinical documents contain patient identifying information.**

**Section A**

# **General Information**

All applicants are required to complete this section

1. Date:
2. Applicant Name:
3. Applicant Specialty/Service:
4. Applicant Contact Information:
	1. Mailing Address:
	2. Phone number(s):
	3. E-mail:

## **Executive Summary**

In 500 words or less please provide a brief summary of your application including the exact nature of the request (a description of the service, the advantages over the present service and the patient/system benefits), the rationale for making such a request, details of any events that have precipitated the request (for example, issues arising from audit), and any previous efforts made to address the underlying issues (for example, previous fee applications)

## **Checklist**

[ ]  I have completed the General Information

[ ]  I have completed the Executive Summary

[ ]  I have completed the appropriate Section related to my request, please check

 [ ]  B (new and revised codes) [ ]  C (Preamble change) [ ]  D (code deletion)

[ ]  I have included the required supporting documentation to indicate the time required to provide the service (operative reports and records, nursing notes, booking sheets or schedules).

 [ ]  I have included a list of the codes currently used to report this service.

[ ]  Patient-identifying information has been redacted from any parts of my application, including supporting documents.

section b

# **New fee or fee adjustment**

## **Summary of the service**

1. Name of the new or adjusted health service and the suggested description for the MSI Manual

1. Provide a complete and detailed description of the new health service from initial patient contact to completion of the service including:
	1. The indications for the health service
	2. Details of the efficacy of the proposed service compared to the current standard of care
	3. The anticipated outcomes and benefits for both the patient and the health system

1. What is the average time to complete this service?

 Documentation requirements:

Include documentation to support the time and, if possible, provide documentation from various locations and providers.

* + 1. Interventional services:
			1. A minimum of 10 recent OR/procedural reports, including timed records, case logs and case reports, and
			2. OR record

**Note**: Synoptic reports on their own are not sufficient. When possible, a mixture of community based and tertiary reports should be provided.

* + 1. Evaluation and management services – a series of at least 10 consultation letters or clinical notes that have been used to document this service in the health record, nursing notes, booking documentation, including start and stop times.

Please consult with DNS/DHW staff assisting with your application to ensure you understand which documents are required for your specific application

1. What is the evidence to support this new health service?

Please list citations of relevant literature, research, reports etc

1. What is the level of risk to the patient?

 Low [ ]  Moderate [ ]  High [ ]

1. Has this application been reviewed by other members of your section? Yes [ ]  No [ ]

If not, why not?

1. Will any other sections be affected by this request? YES [ ]  NO [ ]

If YES, have you obtained their input? YES [ ]  NO [ ]

## **value of the service**

1. Proposed fee in Medical Service Units:
2. Is this health service currently being provided? YES [ ]  NO [ ]

 If YES, please indicate what health service code(s) are being used to report the service:

1. How are your colleagues across the country compensated for this service?

1. Are there services listed in the Physician’s Manual that compare in time, intensity and complexity to the service requested? Please list other health service codes that might be comparable.

1. Does this service require special training or accreditation? YES [ ]  NO[ ]

If YES, please describe:

1. Technical Difficulty

 Low [ ]  Moderate [ ]  High [ ]

 Please explain:

1. Will this service become less time consuming as experience is gained or as new technology is introduced?

YES [ ]  NO [ ]

 Please explain:

1. How many services do you foresee being completed in the first year?

In your location:

 In the Province of NS:

## **other service requirements (interventional services only)**

1. Is this a service that may need to be repeated or require subsequent interventions?

YES [ ]  NO [ ]

1. Is it a definitive, single staged procedure?

YES [ ]  NO [ ]

1. Is it a staged procedure and do the different stages require separate service descriptions?

Please explain:

1. Are multiple repeat interventions required to maintain a positive patient outcome?

Please explain:

1. Is a surgical assistant required? YES [ ]  NO [ ]

 If ‘yes’, is a second qualified surgeon required as assistant? YES [ ]  NO[ ]

1. Is special equipment required? YES [ ]  NO [ ]

If ‘Yes’, please list equipment required and indicate if the equipment is currently available at your centre:

1. Please list all other procedures generally performed in association with this procedure: (for example, tracheostomy at the time of a major head and neck cancer excision, colostomy at the time of bowel resection)
2. What are the pre-procedural requirements (i.e. consultation, visits, tests, and diagnostic imaging)?

Please describe:

1. Are any of the pre-procedural services included in the proposed code description?

YES [ ]  NO [ ]

Please explain:

1. Will pre-procedural services be provided by a different physician?

YES [ ]  NO [ ]

Please explain:

1. Is an anaesthetic required for this service? YES [ ]  NO [ ]

If ‘Yes’, what type of anaesthesia?

General: YES [ ]  NO [ ]

Local: YES [ ]  NO [ ]

Regional: YES [ ]  NO [ ]

Conscious Sedation: YES [ ]  NO [ ]

1. What is the anticipated average length of post-procedural hospital stay?

Less than 24 hrs.[ ]  2-7 days [ ]  1-2 weeks [ ]  More than two weeks [ ]

Section C

# **Preamble change**

Please consult with DNS/DHW staff assisting with your application for specific documentation requirements related to Preamble changes.

1. Preamble section number:

1. Current Preamble description:

1. Proposed amended description:

1. Has this application been reviewed by other members of your section? YES [ ]  NO [ ]

If not, why not?

1. Will any other sections be affected by this preamble change? YES [ ]  NO [ ]

If YES, have you obtained their input? YES [ ]  NO [ ]

Section D

# **Deletion of health service code**

1. Health Service code:

1. Current description:

1. Rationale for request to delete health service code: The services described under this code:
	1. Are no longer provided. YES [ ]  NO [ ]

 Please explain:

* 1. Are going to be reported under a new health service code. Please list the proposed new services below:

Be advised that a formal request for a new health service code requires a separate application with completion of Section B.

1. Has this application been reviewed by other members of your section? YES [ ]  NO [ ]

If not, why not?

1. Will any other sections be affected by the deletion of this health service code? YES [ ]  NO [ ]

If YES, have you obtained their input? YES [ ]  NO [ ]

1. Please provide the number of services reported for this health service code over the past 3 years: