# APPLICATION FOR A NEW FEE TARIFF

NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION

Newfoundland Labrador

**<u>This application must be typed</u>. To receive an electronic version (Microsoft Word), please e-mail twhite@nlma.nl.ca or download a PDF from www.nlma.nl.ca/Publications/Documents**

Requested by Dr. (s) _____

FFS Section of _____

## PART 1

1. **Name of Procedure** *(Use language as it might appear in the MCP Payment Schedule)*

2a. **Type of Procedure**: ❒ Diagnostic & Therapeutic ❒ Surgical ❒ Other

2b. **Locations:** where the procedure may be provided *(Check all that apply)*

❒ Office ❒ Emergency Room ❒LTC facility
❒ Hospital-Outpatient ❒ Hospital-Inpatient

2c. **Description of Procedure.** *(Document all steps of the proposed procedure from contact with patient to completion in such a way that any physician, including those not performing it, might have a clear picture of its nature).*

2d. What are the indications for doing this procedure?

2e. If applicable, describe the normal post-procedure care provided by the physician:

2f. Is the procedure restricted to your specialty? Yes \ No

*(If NO, describe the specific training or accreditation that is required.)*

2g. **Associated Procedures -** List any other procedures that will be usually performed in preparation for, at the time of, or following the procedure and indicate the existing fee codes. (i.e. codes that may be billed in addition to).

3a. **Time** - For the "*average"* case, estimate the time for:

Total time for the procedure: _____

Direct physician to patient contact: _____

3b. Is an **Anesthetic** required? *(Check all that may apply)*

❒No anesthetic ❒ Local ❒ I.V. Sedation ❒ Regional (Epidural/Spinal) ❒ GA

3c. Are Surgical Assistant(s) required? Yes \ No

4. **Comparisons to existing procedures -** In terms of time, risks, responsibilities and required skills, compare this procedure to an existing similar procedure. (Indicate existing fee code for comparison)

## PART II

5. Has the provision of this procedure been approved in principle by the Regional Health Authority?

6. If yes, has the RHA received approval for the provision of this procedure from DHCS?

## PART III

7. Estimate how often this procedure will be performed in the province on an **annual basis** by all physicians in your specialty.

   Approximately _____ services per annum shall be provided.

7a. Will this procedure be done in place of an existing procedure (in whole or in part)? If yes, indicate which existing fee codes and estimate to what extent?

7b. Is this procedure **currently performed** in the province? Yes \ No

7c. **Compensation -** How is the procedure currently claimed and paid for by MCP? - *[i.e. Not Paid; **or** claimed IC (if IC, indicate amount paid by MCP)]*

## PART IV

**(i) List the comparable tariffs and fees, if any, in other provinces.**

Province _____ Fee code _____ Listed rate _____

**(ii) Provide additional type-written comments if any, supporting this request and attach to this application.**

**(iii)** This application is submitted by: _____
(Please sign)

DATE: _____

**Return completed original to:**

**Health Policy & Economics**
**Newfoundland & Labrador Medical Association**
**164 MacDonald Drive**
**St. John's, NL A1A 4B3**

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**Office use only:**

Date Received _____

Submission to PSRC _____

Additional information requested: