



## FORM B – APPLICATION FOR PHYSICAL EXPANSION/ EXPANSION OF SERVICES OR SIGNIFICANT CHANGE OF AN EXISTING DIAGNOSTIC FACILITY

This application is solely for those seeking approval to:

- physically expand an existing diagnostic facility;
- add new or replacement equipment to an existing diagnostic facility;
- make a significant change in the capacity of an existing diagnostic facility; or,
- add a service to an existing *Certificate of Approval*

For all other applications, please review information available at: <http://www.gov.bc.ca/diagnosticfacilitiescommittee>

### IMPORTANT APPLICANT INFORMATION

Any publicly or privately-owned Diagnostic Facility in British Columbia intending to bill the British Columbia Medical Services Plan (MSP) for outpatient diagnostic services must obtain a *Certificate of Approval*, granted by the Advisory Committee on Diagnostic Facilities (ACDF) or the Medical Services Commission (MSC).

All *Certificates of Approval* are **site- and owner-specific and cannot be transferred or assigned**. If a facility is sold, the new owner must apply for a new *Certificate of Approval* in order to bill MSP for the provision of outpatient services.

Approval from the ACDF/MSC is required in order to bill MSP for the following outpatient services:

- Diagnostic Radiology
- Diagnostic Ultrasound
- Nuclear Medicine
- Polysomnography
- Pulmonary Function
- Electromyography (EMG)
- Electroencephalography (EEG)
- Electrocardiography (ECG)

Once an application is approved, the applicant must ensure all required facility accreditation and practitioner credentialing is in place prior to billing MSP for outpatient services.

### HOW TO COMPLETE AND SUBMIT THIS APPLICATION

Applicants should complete the entire application, including the Conflict of Interest Declaration and Disclosure, in as much detail as possible. Additional pages should be added and uploaded along with an application, where additional space is required to provide complete information (please clearly indicate which questions/information you are providing additional information on).

**When complete and authorized, the application must be submitted through the Ministry of Health's secure upload tool located at:** [www.health.gov.bc.ca/diagnosticcommitteeupload](http://www.health.gov.bc.ca/diagnosticcommitteeupload)

**It is the responsibility of the applicant to demonstrate the need for the diagnostic facility or service(s) that are the subject of this application.**

For detailed information on the ACDF and each part of this application, see the *ACDF User Guide to Applications for New, Expansion or Relocation of Public Outpatient Services*, at: <http://www.gov.bc.ca/diagnosticfacilitiescommittee>

For more information on the application and assessment process and the policies that govern it, it is recommended that all applicants review the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*, at: <http://www.gov.bc.ca/diagnosticfacilitiespolicies>

# PUBLIC DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION

## FORM B – PART 1

Application Date (YYYY / MM / DD)
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### TYPE OF APPLICATION (check all that apply)

- Significant Physical Expansion of an Existing Diagnostic Facility (e.g. a new hospital wing)  
Applications involving significant physical expansion of an existing diagnostic facility are subject to ACDF Policy 2.4.2 *Assessment Criteria: Accessibility* (found at <http://www.gov.bc.ca/diagnosticfacilitiespolicies>) and may require additional actions from applicant. If checked, complete this application and contact Diagnostic Facilities Administration at DFAdmin@gov.bc.ca.
- Physical Expansion of an Existing Diagnostic Facility
- New/Replacement Equipment
- Significant Change in Capacity of an Existing Diagnostic Facility
- Addition of a Service (to an existing *Certificate of Approval*)

### TYPE OF SERVICE

**(A) Services Requiring Approval**  
Please specify the service(s) requiring approval by checking the applicable boxes below. **Please note that due to the distinct criteria used to assess each type of application, please reference only ONE modality per application.**

<input type="checkbox"/> Electromyography (EMG)	<input type="checkbox"/> Radiology	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Electroencephalography (EEG)	<input type="checkbox"/> Bone Densitometry	<input type="checkbox"/> Doppler Studies
<input type="checkbox"/> Electrocardiography (ECG)	<input type="checkbox"/> CT Colonography	<input type="checkbox"/> Nuchal Translucency
<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Cardiac CT/CT Coronary Angiography	<input type="checkbox"/> Transthoracic Echocardiography
<input type="checkbox"/> Polysomnography		<input type="checkbox"/> Transesophageal Echocardiography
<input type="checkbox"/> Pulmonary Function		

### (B) Category(s) of Tests or Fee Item(s) Requiring Approval <sup>1</sup>

Category(s) of Tests	Fee Item(s) (if applicable)

### FACILITY ACCREDITATION

Has the diagnostic facility received appropriate facility accreditation from the Diagnostic Accreditation Program (DAP) to provide the service(s) referenced in this application?

Yes     No     Pending DAP approval

### DIAGNOSTIC FACILITY INFORMATION

Diagnostic Facility Name	Diagnostic Facility Number	Diagnostic Facility Payment Number					
Diagnostic Facility Location (street address, city, postal code)							
Diagnostic Facility Mailing Address (if different from above)							
What are the current hours of operation?	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Does the facility's significant change include an increase or decrease in operating hours? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, indicate below the intended new operating hours.							
If applicable, what are the intended new operating hours?	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
What is the current square footage of the area devoted to outpatient clinical use i.e. the area directly providing the outpatient service(s) in this application? (Do not include waiting rooms, staff room, reception or other non-clinical space).							

<sup>1</sup> For further detail on applicable Modalities, Categories and Fees see "Billings & Fees" at: <http://www.gov.bc.ca/diagnosticfacilitiesfeeitems>  
To view the Medical Services Commission Payment Schedule, see: <http://www2.gov.bc.ca/gov/topic.page?id=290D8BF15AA44C1D84A5B4067CAE884E>

**DIAGNOSTIC FACILITY INFORMATION continued**

What is the proposed square footage of the area devoted to outpatient clinical use, i.e., the area directly providing the outpatient service(s) applied for? (Do not include waiting rooms, staff room, reception or other non-clinical space). Proposed Square Footage  No change

Does the facility's expansion include a significant change in capacity? (i.e., +/- 20% or more in volume, in a 12 month period compared with approved baseline, or +/- 30% or more in volume in a 36 month period.) If yes, please provide details.

Yes  No

**EQUIPMENT****▶ 1. Provide details of existing equipment.**

Name/Brand of Equipment	Year/Make/Model	Year Installed	Daily Exam/Test Limit	Detail (as relevant)

**▶ 2. If applicable, provide details of new or additional equipment to be utilized if this application is approved.**

Name/Brand of Equipment	Year/Make/Model	Daily Exam/Test Limit	Detail (as relevant)

Are there leasing or building ownership deadlines impacting this application? If yes, provide date and details of the deadline and impact.

Yes  No

If this application is approved, what is your estimated implementation date?

Month: \_\_\_\_\_ Year: \_\_\_\_\_

Has an application been submitted for this service/facility in the last 18 months? If yes, please provide submission date:

Yes  No

Submission Date (YYYY / MM / DD)

**PUBLIC DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION**

**FORM B – PART 2**

**APPLICANT INFORMATION**

Health Authority / Corporate Name

Health Authority / Corporate Mailing Address

PRIMARY CONTACT INFORMATION	ALTERNATE CONTACT INFORMATION
Name	Name
Title	Title
Email	Email
Phone Number	Phone Number

**CONFLICT OF INTEREST**

Appendix A (Conflict of Interest Declaration) and Appendix B (Conflict of Interest Disclosure) must be completed and submitted with the application in order for this application to be considered. For the relevant policies, see Policy 2.4.4 of the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities* and the *Diagnostic Facility Conflict of Interest Policy* at <http://www.gov.bc.ca/diagnosticfacilitiespolicies>

Are Appendix A and Appendix B included with this application?     Yes     No

**LOCATION OF LIKE DIAGNOSTIC FACILITIES (providing same service as applicant facility)**

Provide the name, location, distance in kilometres and approximate driving time from applicant diagnostic facility to closest public and privately-owned diagnostic facility providing the same service(s) as applicant facility. For a current list of approved diagnostic facilities see "Approved Diagnostic Services Facilities in B.C." at <http://www.gov.bc.ca/diagnosticfacilitiescommittee>

**Closest publicly-owned, ACDF-approved diagnostic facility (e.g. hospital) providing the same service(s) as applicant facility**

Public Diagnostic Facility Name		Diagnostic Facility Street Address
Distance to applicant facility (km)	Approx. driving time to applicant facility	

**Closest privately-owned, ACDF-approved diagnostic facility providing the same service(s) as applicant facility**

Private Diagnostic Facility Name		Diagnostic Facility Street Address
Distance to applicant facility (km)	Approx. driving time to applicant facility	

**RATIONALE FOR APPLICATION**

- Medical Need
- Health & Safety
- Other (please specify)

Please provide detailed rationale for application. Specify any gaps in current availability of this diagnostic service for the geographic area applicant diagnostic facility is expected to serve (as applicable). Append additional information as required.

**IMPACT**

How would this application impact other services within this or other Health Authorities?

Have any such implications or impacts been discussed with the affected Health Authority? Please provide details below.

If applicable, describe how the proposed expansion and/or significant change in capacity will improve the delivery and management of inpatient services at the applicant facility.

## ACCESS

Identify and provide details of any access/availability issues impacting provision of service that this application will address.

## UTILIZATION

Appropriate utilization of diagnostic services is a key focus of the Medical Service Commission (MSC). The MSC's Guidelines and Protocols Committee (GPAC) is responsible for developing provincial guidelines and protocols to support appropriate utilization. The MSC approved guidelines and protocols are available at: <http://www.bcguidelines.ca/>

If this application is approved, how will utilization of the diagnostic service provided be managed? Please provide details below.

- BC Guidelines and Protocols
- Clinical guidelines and protocols (e.g. Canadian Clinical Practice Guidelines)
- Utilization Methods

**VOLUME ESTIMATES / CAPACITY**

If application is approved, information pertaining to volume of MSP billable services will assist with establishing a facility throughput baseline. Baselines are used in the measurement of diagnostic facility throughput increase/decrease, for the purpose of monitoring for Significant Change. Throughput is defined as the volume of approved services rendered in a given time period.

For more information on the policy of Significant Change, see *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*, posted at: <http://www.gov.bc.ca/diagnosticfacilitiespolicies>

Please estimate **both** the projected monthly volume of MSP billable service(s) applied for as well as the potential maximum monthly volume of MSP billable service(s) applied for (i.e. the volume of tests expected if application is approved and the maximum volume of tests that could be done based on facility and equipment capacity detailed in this application).

Estimates should be based on the expanded facility/equipment.

Category of Test(s) and/or Fee Items	Projected Monthly Volume of MSP Billable Services	Potential Maximum Monthly Volume of MSP Billable Services

**STAFFING**

As human resources are a key component of any diagnostic facility, the Advisory Committee on Diagnostic Facilities requires details of current/projected clinical and technical staffing levels.

Medical Director responsible for onsite diagnostic service(s) referenced in application	Department
Email	Phone

What is the basis of the Medical Director's remuneration?  
 Fee-for-service     Contract     Salary     Other (specify):

Please list ALL medical practitioners who will perform and bill the Medical Services Plan for the services applied for. Include Fee-for-Service as well as those medical practitioners who will perform the services and be reimbursed through other methods, i.e., contract, salary. If more lines needed, please append additional listings to this application.

Name of Medical Practitioner	MSP Practitioner Number	Qualifications if No MSP Practitioner Number	Basis for Remuneration (fee-for-service, contract, salary, other)

**STAFFING continued**

Name of Medical Practitioner	MSP Practitioner Number	Qualifications if No MSP Practitioner Number	Basis for Renumeration (fee-for-service, contract, salary, other)

**NOTE: As an MSP Practitioner Number is considered personal information, the applicant is responsible for informing the practitioners listed here that their MSP Practitioner Number is provided as part of this application. The applicant must retain a record of such notification.**

Many modalities under the ACDP require additional credentialing before physicians/practitioners can undertake and bill the Medical Services Plan for that work. Have all required credentialing documents granted through the appropriate health authority or the College of Physicians and Surgeons of BC (for those practitioners working solely in privately-owned facilities) been obtained by all physicians/practitioners seeking to bill the Medical Services Plan for delivering the services currently provided or applied for here?

If yes, please submit all appropriate credentialing letters with this application.  
 If no, please indicate the number of physicians/practitioners that require additional credentialing and when this credentialing will be obtained.

Yes       No



**STAFFING continued**

Please provide the name (if available), title, qualifications, and basis of remuneration for the scientific, technical and supervisory staff involved in providing services applied for. If the number of staff exceeds the available space, please append additional practitioner listings to this application.

<b>Name of Scientific, Technical and Supervisory Staff</b>	<b>Title</b>	<b>Qualifications</b>	<b>Remuneration</b> (e.g., fee-for service, contract, salary)	<b>Hours of Work</b> (e.g., M-F, 9am - 4pm)

Is there any additional clinical and/or technical expertise required to provide the diagnostics service(s) noted in this application?  
If yes, please provide details on the number of experts required, how they will be obtained (e.g. staff recruitment, contracted resources, telemetry etc.) and when they will be available to provide service.

Yes     No



**DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION**  
**APPENDIX A: CONFLICT OF INTEREST DECLARATION**

To: Secretariat and Chair, ACDF

I have read and understood the Diagnostic Facility Conflict of Interest Policy (the "Policy"), and I undertake to be bound by the obligations contained therein.

I understand that it is my responsibility to report to the ACDF the information described in the Policy, and I undertake to do so.

I understand that the information I disclose will be held by the ACDF and that the information may be shared with members of the Medical Services Commission, as necessary.

I agree to inform the ACDF of any change in circumstances that may give rise to a conflict of interest with respect to a diagnostic facility, as soon as it is practicable.

**ATTENTION: The person completing/signing this Declaration Form ( the "Declarant") must be duly authorized to make the declaration on behalf of the person/entity submitting an application.**

Name of diagnostic facility to which this conflict of interest declaration is in respect of:

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Declarant
Name
Title
Date
Signature

**DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION**

**APPENDIX B: CONFLICT OF INTEREST DISCLOSURE**

To: Secretariat and Chair, ACDF

Is there a (potential) conflict of interest to disclose in relation to the diagnostic facility? Check one:

- Yes, there is a (potential) conflict of interest to disclose in relation to the diagnostic facility. If yes, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.
- I am unsure if the circumstances constitute, or may constitute, a (potential) conflict of interest. If unsure, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.
- No, there is no conflict to interest to disclose in relation to the diagnostic facility.

If no conflict of interest is indicated, Appendix B must be completed by signing and completing the Appendix B signature block information.

**ATTENTION: The person completing/signing this Disclosure Form (the “Declarant”) must be duly authorized to make the declaration/disclosure on behalf of the subject person/entity; that is the person who owns or intends to own the diagnostic facility (as applicable).**

If applicable, provide full detail and circumstances that relate to potential conflicts of interest by completing Parts I and II.

**APPENDIX B PART I**

Append additional pages as necessary, to provide all relevant information.

Diagnostic Facility Name(s)	List the names of all relevant practitioners, family members, diagnostic facility owners (including the declarant) or business associates who hold or may hold a relevant financial or material interest	Any relevant affiliations or relationships with the owner or intended owner of the diagnostic facility and the details of any interest or benefit that may relate to a conflict of interest	Any other information, including dates, that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest

**APPENDIX B PART II**

In the space below, provide any additional information (not covered in Part I) that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest. Include any detail regarding proposed avoidance or mitigation measures relating to any actual or potential conflicts of interest. Append additional pages as necessary to provide all relevant information.

Name of diagnostic facility to which this conflict of interest disclosure is in respect of:

Declarant
Name
Title
Date
Signature