

*San Joaquin Community Hospital*

# New Technology Review Packet

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**For Tracking Use Only**

Request Received: \_\_\_\_\_ Tracking # Assigned: \_\_\_\_\_  
Date

Screener Assigned: \_\_\_\_\_  
Employee Name

Department Contact: \_\_\_\_\_ Ext: \_\_\_\_\_

Requestor Contacted: \_\_\_\_\_  
Date and Time

Requestor Name: \_\_\_\_\_

**Data/Information Tracking:**

Goal/Time/Date	Requested:	Date	Received:	Date	N/A
_____ Purchasing:	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
_____ Clinical Engineering (equipment):	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
_____ Medical Records/Coding:	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
_____ Contracts:	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
_____ PBO/Reimbursement:	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
_____ Finance/Proforma	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
Medical Staff Review:	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
New Technology Team Review:	<input type="checkbox"/>	_____	Approved	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Executive Team Review:	<input type="checkbox"/>	_____	Approved	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____ Implementation Plan:	<input type="checkbox"/>	_____	_____		
_____ Evaluation/Monitoring/Follow-up:	<input type="checkbox"/>	_____	_____		

*Responsible*

**\*Please attach supporting documentation that can assist us in the review of your idea  
Such as Vendor Business Card, Product Information or Brochure**

## Screening Form

Description of Product/New Business: \_\_\_\_\_

If Product-List Manufacture/Vendor Name: \_\_\_\_\_

Diagnosis Description/DRG/ICD-9/CPT \_\_\_\_\_

Reason for Request/Explanation of use:

New Product Explain: \_\_\_\_\_

New Procedure/Service Explain: \_\_\_\_\_

Lower Cost Explain: \_\_\_\_\_

Improve Clinical Outcome Explain: \_\_\_\_\_

1. Annual volume Anticipated?

2. Will this product replace an existing product?  Yes  No  N/A

3. Can old product be used as substitute?  Yes  No  N/A

4. Will this product be used in conjunction with another product?  Yes  No  N/A

5. Does this product require purchase of any equipment?  Yes  No  N/A

6. Is staff training required?  Yes  No  N/A

7. Is physician credentialing needed?  Yes  No  N/A

8. Will a change in this product/service impact labor?  Yes  No  N/A

9. Will this product/service have an impact on our physical plant?  Yes  No  N/A

10. Will this product/service enhance our image?  Yes  No  N/A

11. Is this product an implant device?  Yes  No  N/A

12. Does this product/service increase cost?  Yes  No  N/A

13. Does this product/service improve patient outcomes?  Yes  No  N/A

14. What is your expected response time for this request?  Yes  No  N/A

Additional Information:

Information provided by: \_\_\_\_\_

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

Technology Screener: \_\_\_\_\_

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

**REMINDER: Include product information and all scientific research available.**

# Data Collection/Review Worksheets

## Information Obtained from Vendor and/or Purchasing Department

N/A

Is new product we are requesting on Premier contract?  Yes  No

If replacing product, is old product on Premier contract?  Yes  No

If dual or multi source, who are other vendors? \_\_\_\_\_

If product trial/evaluation required, will vendor provide supplies for trial at no cost?  Yes  No

Does vendor have knowledge of CPT codes for charging?  Yes  No

CPT Code: \_\_\_\_\_ Description: \_\_\_\_\_

CPT Code: \_\_\_\_\_ Description: \_\_\_\_\_

CPT Code: \_\_\_\_\_ Description: \_\_\_\_\_

**New Product Cost (each)** \_\_\_\_\_

**Old Product Cost (each)** \_\_\_\_\_

**Cost Increase/(Decrease)** \_\_\_\_\_

Old Product Annual Usage: \_\_\_\_\_

Old Product Annual Cost: \_\_\_\_\_

\_\_\_\_\_  
Signature Person Completing Section

\_\_\_\_\_  
Date

## Information Obtained from Vendor and/or Clinical Engineering Department

N/A

Is requested equipment consistent with equipment at other facilities (standardized)?  Yes  No

Is service education needed? Yes  No

If yes, is tuition free at time of purchase?  Yes  No

Is special test equipment required?  Yes  No

**Tuition Cost** \_\_\_\_\_

**Test Equipment Cost** \_\_\_\_\_

**Total Cost** \_\_\_\_\_

Special Parts Concern: \_\_\_\_\_

Other Concerns: \_\_\_\_\_

\_\_\_\_\_  
Signature Person Completing Section

\_\_\_\_\_  
Date

REMINDER: attach Any pertinent product/cost information.

**Information Obtained from Contract/Reimbursement Department**

N/A

**Expected Reimbursement: CPT/DRG**

Inpatient

Outpatient

Medicare: \_\_\_\_\_  
Medical: \_\_\_\_\_  
Blue Cross: \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicare: \_\_\_\_\_  
Medical: \_\_\_\_\_  
Blue Cross: \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature Person Completing Section

Date

**Information Obtained from Patient Business Office Department**

N/A

**Chargemaster:**

Is this new technology patient chargeable?  Yes  No

Patient ChargeMaster description

APC / HCPC / CPT Code: \_\_\_\_\_

Charge Number: \_\_\_\_\_

Cost (each): \_\_\_\_\_

Signature Person Completing Section

Date

**New Technology Team Review / Action**

**Action taken:**

- |   |             |
|---|-------------|
| <input type="checkbox"/> Recommended for approval               | Date: _____ |
| <input type="checkbox"/> Recommend not to approve               | Date: _____ |
| <input type="checkbox"/> Trial/Evaluation scheduled             | Date: _____ |
| <input type="checkbox"/> Contact requestor for more information | Date: _____ |
| <input type="checkbox"/> Implementation plan requested          | Date: _____ |
| <input type="checkbox"/> Refer to Executive Committee           | Date: _____ |
| <input type="checkbox"/> Other                                  | Date: _____ |

Comments:

Signature Person Completing Section

Date