

Pathology Services - Principles of Funding of NSW Public Health Sector

Document Number PD2005_533

Publication date 04-Mar-2005

Functional Sub group Corporate Administration - Fees
Clinical/ Patient Services - Pathology

Summary Charging arrangements for pathology services provided by public health organisations.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Ambulance Service, NSW Dept of Health, Public Hospitals

Distributed to Public Health System, NSW Ambulance Service, NSW Department of Health, Public Hospitals

Review date 04-Mar-2010

Policy Manual Not applicable

File No. 01/4698

Previous reference 2001/113

Issue date 30-Nov-2001

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

CIRCULAR

File No	01/4698
Circular No	2001/113
Issued	30 November 2001
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**PRINCIPLES FOR FUNDING OF
NSW PUBLIC HEALTH SECTOR PATHOLOGY SERVICES**

1 INTRODUCTION:

- 1.1 All health services are required to operate their pathology services (one per health service) as a Business Unit.
- 1.2 The accounting and reporting guidelines for business units are prescribed in Section 9 of the Area Health Service and Public Hospitals Accounting Manual. Revenues collected will include all facility fees and research monies (exclude Special Purpose & Trust Account (SP&T) funds) and expenses will include all direct and indirect costs.
- 1.3 The Accounting Guidelines require a determination of charge out rates (or Prices) on different products with prices to be approved by the Area Board or Area Networking Board as appropriate. Charge out rates for non-NSW Health activities are to include a component to cover assessed Crown Liabilities.
- 1.4 The Peak Pathology Council has considered the matter of charge out rates for Pathology Services to establish a standard methodology across all services but at the same time recognising the right of Area Boards or Area Networking Boards to make the final decision on prices.
- 1.5 When a conflict in policy exist, the contents of this circular takes precedence over existing NSW Department of Health policy in regards to NSW Public Health Sector Pathology charging.

Distributed in accordance with circular list(s):

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

2 PATHOLOGY CHARGE OUT PRICING PRINCIPLES:

- 2.1 All pathology services will have available for distribution to users a schedule of rates and prices for provided services such a schedule to be predominantly based upon the Pathology Service Table (PST) (See Clause 3 below for further explanations). Only one charge can be raised for any one test, such a charge is to cover both the performance and interpretation.
- 2.2 Where the NSW Department of Health issues any direction on pathology fees that direction will be observed and take precedence over Principle 2.1 above.
- 2.3 All services provided by pathology services will be charged in accordance with clauses 2.1 and 2.2 above unless:
 - a separate arrangement exists between the services and user (including Networking Agreements);
 - a health service provides a block grant to cover services not normally associated with the PST (eg forensic pathology, HIV confirmation).
- 2.4 Where a reasonable number of tests are being referred out from a pathology service in one health service to another health service, the referring Area Pathology Service may periodically undertake a “contestability” study to determine if it would be more effective or efficient to do such tests in its own laboratories, such studies to be fully documented by a business case with the final decisions to be made locally. It is emphasised that the selection of providers external to the Area should remain subject to any agreements existing concerning “networking” of pathology services.
- 2.5 Pathology services have a responsibility to ensure timely provision of invoices and other information to enable a journalisation of internal revenues or claims to be issued to other health services and users.
- 2.6 Health services will process internal journals upon receipt from their pathology service. Payments by one health service to a pathology service in another health service for services provided will be within normal trading terms (ie within 45 days of receipt of invoices).
- 2.7 Where a dispute over payment exists within a health service, that dispute will be resolved in accordance with instructions issued by the Chief Executive Officer. Where a dispute over payment exists between two health services that will be resolved in accordance with advice issued by the NSW Department of Health or where a dispute over payment exists with a non NSW Health user, normal debt recovery procedures are to be followed.

3 Guidelines for Determination of Pathology Charges:

- 3.1 Where the services are of a type described in the PST of the Medicare Benefits Schedule (MBS) the following should apply:
 - 3.1.1 Unless otherwise agreed and stated explicitly by the provider, the service will

be provided in accordance with the description of the item in the PST.

- 3.1.2 The episode cap (“grand cone”) should not to apply for any episode to a public hospital inpatient or non-inpatient

Note:

This is consistent with intention of the Health Insurance Act – all of these services are for “referred” patients. The episode cap only applies to pathology episodes arising from unreferred attendances)

- 3.2 Where the provider and user are within the same health service the arrangements fundamentally are for mutual agreement and subject to the approval of the Area Board. It is recommended that these arrangements be detailed in a Service Level Agreement, which should be in accordance with the following guidelines:-

3.2.1 Where the fee is expressed as a percentage of the current MBS fee that percentage should be determined after due process to determine what is required for adequate total cost recovery and not arbitrarily. This should include not only direct costs but also an appropriate moiety for equipment replacement and other infrastructure costs as specified in the “Accounting and Reporting Guidelines for Business Units”

3.2.2 When charging internally an “episode fee” should be used in addition to the test fee(s) the Medicare Benefits Schedule (e.g. “coning rules” and “inbuilt multiple services rule”) should not apply automatically but the issues which these present should be addressed explicitly in the policy document approved by the relevant Area Health Service.

- 3.3 Where the provider and user are in different health services and the services are eligible for a Medicare rebate the requester (user) shall take all reasonable measures to ensure that the request conforms with the requirements of the Health Insurance Act and its Regulations and that the provider will render the service strictly in accordance of the provisions of that Act.

- 3.4 Where the provider and user are in different health services and the person is ineligible for a Medicare rebate (and no NSW Department of Health policy directive applies.)

3.4.1 An agreement in advance involving the requestor, provider and funder of the service is essential, and

3.4.2 Irrespective of the identity of the original requestor a copy of the results of such tests shall be provided to the Area Pathology Service responsible for the geographic area in which the request was originated unless prohibited by law or an administrative decision or by agreement.

3.4.3 The Area Pathology Service performing the test(s) shall invoice the Area Pathology Service responsible for the geographic area in which the request was originated for payment so that the Area Pathology Service performing the tests can recover the full cost of the referred test. This as a rule would only be the charge from the referral laboratory but in some situations a “handling charge” would also apply. The referring Area Pathology Service needs to identify a

source of local funds (consistent with local policy) to cover the cost of referred tests.

3.5 Where the service is of a type, which though not listed in the PST can be described in a form similar to such an item, the following should apply both within and between health services:

3.5.1 The description of the service will be agreed explicitly and in writing by the provider and user(s) of that service (unless determined otherwise by a NSW Department of Health Policy)

Notes:

(a) *Reference may be made to the item descriptions in the Centre for Clinical Epidemiology and Biostatistics (CCEB) / The Royal College of Pathologist of Australasia (RCPA) benchmarking survey to assist with service definition*

(b) *Non-PST "Class A" tests delineated by the Genetics Services should be included in this category.*

3.5.2 The fee will be agreed in advance in writing between the provider(s) and user(s) of the service (unless determined otherwise by a NSW Department of Health Policy).

3.5.3 In arriving at a fee in this clause the charge shall be fair, competitively neutral and have regard to indirect and overhead costs

3.6 Where it has been determined that some activities provided by Area pathology Services are to be funded other than using the PST approach:

3.6.1 The arrangements should be set out explicitly by either a specific NSW Department of Health Policy or by a published Memorandum of Understanding between all relevant parties.

3.6.2 The Services covered by this clause may include:-

- provision of clinical services eg clinical haematology
- teaching
- infection control
- surgical audit
- mortuary services including conduct of autopsies and relevant laboratory testing of autopsy material
- public health testing and advisory activities
- advanced "limited use" tests, eg Non-PST "Class B" tests

3.7 This documentation should include

- An adequate description of the activity/activities (see clause 14.2 for examples)
- the organisation(s) funded to provide them
- the dollar amount of funding allocated and the number of services to be provided for this funding.

- the identity of the person(s) or bodies corporate who may access these services without attracting a “user charge” as specified in clauses 3.5 and 3.6 above.
- the duration for which the arrangement remains in force and the circumstances which would result in re-negotiation between the funder and the provider.

4 Transitional Arrangements for clauses 3.5 and 3.6:

- 4.1 Where parts of Clauses 3.5 and 3.6 impact upon more than one health service, a service level agreement must exist between the provider health service and the user.
- 4.2 Provider and referring health services are not to take unilateral action that will adversely affect the other.
- 4.3 Where agreement cannot be reached (including a meeting of relevant Chief Executive Officers) the matter is to be referred to Finance & Commercial Services of the Department for consideration of resolutions.
- 4.4 Departmental health policies exists as at 1 July 2000 for the following services:-
 - Genetics (Specialised Testing for Genetic Disorders)
 - HIV Testing (in accordance with the formula in “A Guide to Aids program for Area Health Services and Districts 1993/94” as varied from time to time by changes to Department policy).

Further enquires are to be referred to Mark Donaldson on (02) 9391 9047 or Ken Barker on (02) 9391 9178 of the Department who, if appropriate, will seek expert advice from the Peak Pathology Council.

5 Charging of Pathology Services

- 5.1 The attached schedule outlines the NSW Department of Health’s charging policy as reflected in the Fees Manual for Public Hospitals, Departmental Circulars and letters issued by the Department’s Finance Branch.

Robert McGregor
Acting Director-General

Charging Policy for Pathology Services

Non Admitted Patients

Patient Classifications	Notes	Charging Policy
Public (Including Prisoners) and all no charge patients eg reciprocals	(4)	<i>Within Health Service</i> <ul style="list-style-type: none"> Rates by mutual agreement approved by AHS Board <i>External to Health Service</i> <ul style="list-style-type: none"> Charge facility MBS rate
Privately Referred Non-Inpatients		Charge patient up to the MBS rate
Veterans' Affairs		<i>Within Health Service</i> <ul style="list-style-type: none"> Rates by mutual agreement approved by AHS Board <i>External to Health Service</i> <ul style="list-style-type: none"> Charge facility MBS rate
Ineligible/Overseas	(2)	Charge patient cost recovery
Compensable <ul style="list-style-type: none"> 3rd Party (NSW) (Bulk Agreement) 	(4)	<i>Within Health Service</i> <ul style="list-style-type: none"> Rates by mutual agreement approved by AHS Board <i>External to Health Service</i> <ul style="list-style-type: none"> Charge facility cost recovery rate
3 rd Party <ul style="list-style-type: none"> External NSW 	(2)	Charge insurer cost recovery rate
Workers Comp.	(1)	Charge insurer occasions of service rate
Other	(2)	Charge insurer cost recovery rate

Admitted Patients

Patient Classifications	Notes	Charging Policy
Private Patients		Charge patient MBS rate
Public (Including Prisoners) and other non chargeables eg reciprocals	(4)	<i>Within Health Service</i> <ul style="list-style-type: none"> Rates by mutual agreement approved by AHS Board <i>External to Health Service</i> <ul style="list-style-type: none"> Charge facility MBS rate
Veterans' Affairs		Charge Veterans' Affairs MBS rate
Ineligible/Overseas	(2)	Charge patient cost recovery
Compensable <ul style="list-style-type: none"> 3rd Party (NSW) 3rd Party (External NSW) Workers Comp. Other 	(4) (3) (3)	<i>Within Health Service</i> <ul style="list-style-type: none"> Rates by mutual agreement approved by AHS Board <i>External to Health Service</i> <ul style="list-style-type: none"> Charge facility cost recovery rate

All Patients

Service is of a type not listed in the PST (but similar)

- Agreed in advance with the user of the service.

Public Health, infection control etc (Clause 14)

- Memorandum of Understanding between all relevant parties.

Notes:

- (1) By legislation only the occasion of service (OOS) rate can be charged which is tied to the type of hospital eg metropolitan referral, metropolitan non-referral.

An alternative to having the Group Pathology Service (GPS) charge the insurer would be to have the GPS charge:

Within Health Service

- Charge facility rates by mutual agreement approved by the AHS Board

External to Health Service

- Charge facility cost recovery rate

with the facility charging the insurer the OOS rate appropriate to the facility.

In respect to all compensable patients direction is required if GPS charge facility cost recovery which is the present policy or insurers at OOS cost recovery rate whichever is the higher.

- (2) The Department of Health in its allocation letter 97/98 indicated that staff specialists could set own fees in respect of services they provide to ineligible and compensable patients or the OOS rate whichever is the higher.
- (3) The accommodation rates set by the Department of Health incorporate all diagnostic services. Charges have to be raised against facility.
- (4) Present policy indicates that charge is to be cost recovery rate.