LEGAL AND REGULATORY SERVICES BRANCH

FEES PROCEDURES MANUAL
FOR
PUBLIC HEALTH ORGANISATIONS

AMENDMENT NO.
100(7/9/16)
101(20/7/16)
102(14/8/13)

Where a number appears at the bottom of an amended page [e.g. 84(16/07/15) – amendment number, date] an alteration has been made or new section included. The amendments as indicated reflect the provisions of Policy Directives/Guidelines/Information Bulletins:

- **Chapter 6 – IB2011_048 - OBSOLETE** - Update of Staff Specialist & Radiation Oncology References for NSW Health Fees Procedures Manual

- **Chapter 6- PD2005_533 - OBSOLETE** - Pathology Services - Principles of Funding of NSW Public Health Sector

- **Chapter 6 – PD2005_429 - UPDATED** - Senior Medical Practitioners employed in public health system

as notified by Strategic Relations and Communications on

- 7 September 2016
- 20 July 2016
- 14 August 2013


If you choose to print the amendment, make sure you print it double sided.

If you are missing any amendments please email cgrm@doh.health.nsw.gov.au The amendment can be emailed to you in an electronic version.

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Any reference to hospital in this section should also be taken to mean Area Health Service/ District Health Service.

38(5/02)
A. GENERAL PRINCIPLES

1. GENERAL

1.1 Salaried specialists (exercising rights of private practice) and visiting medical diagnosticians are able to charge in their own names for diagnostic services rendered to private and other chargeable inpatients in public hospitals; this relates only to services provided within the precincts of hospitals. Separate instructions are issued in respect of pathology specimens sent by hospitals to other hospitals or to outside laboratories for testing and reporting.

Fees should not be charged for pathology services which have been performed as part of the hospital’s tissue audit, organ donors, surgical audit, fees review or quality control program. (79/315) All transactions are to be operated through the Special Purposes and Trust Fund.

Rates of Fees Charged

Fees charged in the names of staff specialists and visiting medical officers shall be in accordance with the provisions and rates as published in the Medicare Benefits Schedule Book.

Nuclear Medicine should be charged at the “C” rate, see explanatory notes page 273 of the Medicare Benefits Schedule Book.

2. INVOICING AND ACCOUNTING PROCEDURES

Each hospital shall obtain the authority of each visiting or salaried diagnostician, either in writing or verbally, to issue invoices in his/her name and collect fees on his/her behalf for services to private patients. Hospitals should provide the following information to the Commonwealth Department of Health for entry into their Central Register of Medical Practitioners (CROMP):

- Doctor’s full name
- Practice Address
- Provider Number
- Hospital to which Agreement applies
A. GENERAL PRINCIPLES

Subject to receipt of the necessary authority, hospitals will issue invoices on stationery which shows clearly the full name and initials of the visiting diagnostician or the salaried diagnostician, his/her degree (desirable), provider number, and his/her address as being care of the hospital issuing the invoice.

Details on the invoice must include the date of the service, the item number, the schedule fee as listed in the Commonwealth Medicare Benefits Book at the rate appropriate to a specialist where a specialist has reported on an examination or test. In the case of pathology it should include the date each test was requested, by whom requested, date test performed, and, where a test is performed more than once on any one day the times when it was performed.

At the foot of the invoice (or on the reverse side) there should be a direction to the patient that in the event of the medical benefit being assigned to the doctor the contributor (who may not always be the patient) should send the cheque received from his/her medical benefit organisation together with a remittance of the “gap” between the fee and the benefit, if not already paid, to the doctor care of the hospital. It could be added that medical benefit cheques will be accepted as part payment, with the “gap” paid later in full settlement if applicable.

Where possible hospitals should, collect fees at the time of discharge of a private patient.

All fees collected directly or as assigned benefits are to be receipted by hospitals, with the receipts handed or posted to the patient (or contributor), where the patient (contributor) has requested a receipt. If payment is made with a patient’s personal funds a receipt is to be issued.

Receipts shall be issued in the name of payees with the doctor’s name appearing on the receipt.

These transactions shall be recorded through a separately identified special account, not through the General Fund.

Invoices should be issued from a book containing pre-numbered forms in triplicate, or from pre-numbered sets also in triplicate. The original is to be issued to the patient or be sent to the patient’s private health insurance fund with a claim form on which the patient has assigned the benefit. The duplicate should be issued to the doctors if required and the triplicate retained for the hospital’s record. (It is expected that where benefits are assigned the amount thereof will be accepted in full settlement in many cases.) In respect to hospitals billing by computer the system should provide a numbered invoice.
A. GENERAL PRINCIPLES

PATHOLOGY

Visiting Pathologists

2.4.6.11/2 A charge shall be made to the visiting pathologist(s) for the use of hospital facilities and/or staff (including clerical services provided by hospital staff) in respect of pathology services to private inpatients. The charge shall be a percentage of the fees collected, as follows:

CATEGORY 6 – PATHOLOGY SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Percentage</th>
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<tr>
<td>65060 – 65082</td>
<td>Haematology</td>
<td>80%</td>
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<tr>
<td>65084 – 65087</td>
<td>Bone Marrow examination</td>
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</tr>
<tr>
<td>65090 – 65181</td>
<td>Haematology</td>
<td>80%</td>
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<tr>
<td>66500 – 66900</td>
<td>Chemical</td>
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<tr>
<td>69300 – 69500</td>
<td>Microbiology</td>
<td>80%</td>
</tr>
<tr>
<td>71057 – 71203</td>
<td>Immunology</td>
<td>80%</td>
</tr>
<tr>
<td>72813 – 72857</td>
<td>Tissue pathology (Histopathology)</td>
<td>10%</td>
</tr>
<tr>
<td>73043 – 73065</td>
<td>Cytology – Scanning only</td>
<td>90%</td>
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<tr>
<td></td>
<td>Cytology - Involving review and report</td>
<td>10%</td>
</tr>
<tr>
<td>73287 – 73324</td>
<td>Genetics</td>
<td>10%</td>
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<tr>
<td>73521 – 73529</td>
<td>Infertility and pregnancy tests</td>
<td>80%</td>
</tr>
<tr>
<td>73801 – 73811</td>
<td>Simple basic pathology tests</td>
<td>10%</td>
</tr>
</tbody>
</table>
A. GENERAL PRINCIPLES

Update of Staff Specialist & Radiation Oncology References for NSW Healths Fees Procedures Manual (IB2011_048)

Policy status changed to obsolete 7 September 2016 as it is no longer current.
C. PATHOLOGY

6.44

I. PATHOLOGY SERVICES - GENERAL PROCEDURES

1. Visiting pathologists shall be remunerated monthly on the following basis:

- Fees collected in respect of services to private inpatients including ineligibles less charges for the use of hospital facilities and/or staff;

- A percentage of the appropriate scheduled fee for services to compensable inpatients;

- Sessional fees for services to other patients (including organ donors) and for managerial, administrative and consultative duties; and

- A fee for each autopsy performed on behalf of the hospital.

2. REQUEST FOR PATHOLOGY SERVICES (See also Category 6 “Pathology Services” Medicare Benefits Schedule Book)

2.1 Chargeable Patients

Approved pathology practitioners must hold a request in writing for all services requested by any other practitioner before billing patients. This includes requests from partners and other members of a group practice. Requests in writing are not required for the 11 specified simple basic tests. The request in writing must show:

- in the requesting practitioner’s own handwriting -
  “the individual pathology services, or recognised groups of pathology tests of particular organ or physiological function to be rendered”. The description must be sufficient to enable the item in which the service is specified to be identified;

- the requesting practitioner’s signature and date of request;

- the surname, initials of given names and practice address of the requesting practitioner (the practitioner’s surname and initials will be satisfactory unless there is more than one practitioner with the same surname and initials at the same address); and provider number - the provider number may be obtained by enquiry to the Commonwealth.

- the name and address of the patient;

- the date the pathology services were determined to be necessary;
where the patient is attending a recognised hospital, or Central Service the classification of that patient as a private inpatient, or hospital (public) inpatient, non-inpatient or compensable patient; and

the name and address of the approved pathology practitioner, or an Approved Pathology Authority, requested to perform the pathology services (refer to MBS for referral requirements).

There is no official “request in writing” form, and the doctor’s own stationery, or pre-printed forms supplied by approved pathology practitioners are acceptable (provided there are no check lists or “tick-a-box” lists of individual or groups of pathology services on the forms). Oral requests must be confirmed by a request in writing (conforming with above) before an account is issued.

Approved pathology practitioners and Authorities must retain requests in writing for a period of 18 months and must produce any requests specified if so required by a notice in writing by the Commonwealth Minister for Health.

Where an approved pathology practitioner refers some or all services requested to another approved pathology practitioner the following applies:

(a) where all the services are referred, he/she forwards the initial request to the second approved pathology practitioner;

(b) where some of the services are referred, he/she should issue his/her own request in writing, which should show in addition to the particulars listed in paragraph 2.1 above:

(i) name and provider number or address of the original requesting practitioner; and

(ii) date of initial request.

### 2.2 Specific provisions for Group Services.

#### 2.2.1 Non Chargeable, Inpatients, Compensable and Non Chargeable Non-In Patients.

A request for pathology services will be prepared by the patient’s attending practitioner (this could be a staff specialist, a visiting medical officer, or a registrar or resident acting on the instructions of a staff specialist or visiting medical officer). There is no need for this request to be handwritten or to comply with the provisions contained in the Medicare Benefits Schedule Book, however, the request form must show:
• the individual pathology services, or recognised group of pathology services to be rendered;

• the requesting practitioner’s surname, initials of given names, signature and date of request;

• the patient’s name;

• details of the patient’s status, viz hospital, compensable ineligible.

Where all of the requested services will be undertaken by a group laboratory, a specimen and the request form will be forwarded to the group laboratory for processing.

Where only some of the requested services will be undertaken by a group laboratory, one of the following methods will be used:

• A specimen and a request for the services to be undertaken by the group laboratory will be forwarded to the group laboratory for processing; and

• A specimen and a request for the balance of the services will be forwarded to the hospital laboratory or an approved pathology practitioner for processing.

OR

• A specimen and a request for all of the services will be forwarded to the hospital’s pathologist (either salaried or visiting) who will forward a specimen and a request for those services to be undertaken by the group laboratory to the group laboratory for processing, and who will perform or supervise the performance of the services not to be undertaken by the group laboratory.

After processing and reporting, the group laboratory will issue an account to the participating hospital in respect of the services undertaken by the group laboratory.

The rate of charge by the group laboratory is as per Section 3.

2.2.2 Chargeable Inpatients (Other Than Compensable Patients) and Patients of Private Practitioners

Because of the Commonwealth Department of Health’s specific provisions regarding approved pathology practitioners and the payment of benefits for services to private patients, separate procedures may be necessary where a group laboratory is under the direct control of an approved pathology practitioner, to those necessary where it is not under the control of an approved pathology practitioner.
A request for pathology services will be prepared by the patient’s medical practitioner (in a hospital this could be a staff specialist or visiting medical officer, or a registrar or resident acting on the instructions of a staff specialist or visiting medical officer). **This request must be handwritten** and comply with the provisions contained in the Medicare Benefits Schedule Book.

Where all of the requested services will be undertaken by a group laboratory, a specimen and the handwritten request will be referred to the group laboratory for processing.

Where only some of the requested services will be undertaken by a group laboratory, one of the following methods will be used:

- A specimen and a handwritten request for the services to be undertaken by the group laboratory will be forwarded to the group laboratory for processing; and
- A specimen and a handwritten request for the balance of the services will be forwarded to an approved pathology practitioner for processing.

**OR**

- A specimen and the handwritten request will be forwarded to the hospital’s pathologist (either salaried or visiting) who will forward a specimen and a handwritten request for those services to be undertaken by the group laboratory to the group laboratory for processing, and who will perform or supervise the performance of the services not to be undertaken by the group laboratory.

After processing and reporting, the group laboratory will issue an account to the patient in respect of the services undertaken by the group laboratory. The account will be in the name of the approved pathology practitioner.

The rate of charge by the group laboratory will be as per Section 3.1 fee specified in the Medicare Benefits Schedule Book.

3. **RAISING OF ACCOUNTS FOR PATHOLOGY SERVICES**

Practitioners seeking to be approved pathology practitioners will be asked to give an undertaking to comply with a Code of Conduct which will preclude sharing fees for pathology services. However, the Commonwealth Government has indicated that this will not preclude charges being made to approved pathology practitioners by recognised hospitals for the use of hospital facilities and/or staff.
C. PATHOLOGY

Three arrangements for the provision of pathology services to patients in hospitals are possible. These are:

- provision of all pathology services for a particular patient episode from the hospital’s own laboratories;
- provision of some pathology services for a particular patient episode from the hospital’s own laboratories and referral elsewhere (whether to another hospital, a group laboratory or an outside specialist) of specimens for provision of other pathology services arising from the same patient episode; or
- referral to another hospital, a group laboratory or an outside specialist for all pathology services for a particular patient episode.

Within the public hospital system (including group laboratories) pathology services rendered by approved pathology practitioners shall be charged at the schedule fees in the Medicare Benefits Schedule Book to:

- private inpatients (including ineligibles) of recognised hospitals;
- patients of private hospitals in respect of whom specimens are sent to a public hospital or group laboratory;
- patients of private medical practices in respect of whom specimens are sent to a public hospital or group laboratory;
- privately referred outpatients.

(SEE 3.1 FOR CHARGING ARRANGEMENTS)

NO CHARGE IS TO BE RAISED AGAINST PATIENTS IN RESPECT OF ORGAN DONATIONS. NO CHARGE IS TO BE RAISED IN RESPECT OF HOSPITAL PATIENTS AGAINST THE PATIENT.

Group charges for services provided to the undermentioned patients are to be charged as per 3.1.

1. Hospital non-chargeable patients.
2. Compensable inpatients of recognised hospitals.

38(5/02)
C. PATHOLOGY

A charge at the schedule fees shall also be made by an approved pathology practitioner when a specimen collected from a private inpatient of a public hospital, while in hospital, is referred to such a practitioner for examination at his/her private laboratory (see item 6).

Because of the change to the schedule of pathology services and fees, services that do not share a common item number may be ordered on separate forms and regarded separately for charging purposes. Thus, it would be quite acceptable for separate order forms to be used for biochemistry, haematology, blood cross-matching, bacteriology and histopathology and for separate arrangements to be made for the issue of accounts for each of these types of services.

To ensure the payment of benefits hospitals and group pathology services when issuing accounts on behalf of the pathology practitioners (whether salaried with rights of private practice or visiting) must show on the account of the providing practitioner (i.e. the practitioner providing the service):

(a) The name, address (or ordinary provider code in lieu of the address) and accreditation status of the providing practitioner as at the date on which the services were performed, i.e. state whether approved or not, together with the dates and particulars of the services performed; and

(b) the name and address (or ordinary provider code in lieu of the address) of the requesting practitioner (i.e. the practitioner referring the patient or the specimen to the providing practitioner), together with the date on which the request was made.

The term ordinary provider code means the provider code issued by the Commonwealth Department of Health in connection with the medical practice at a particular address and not a pathology provider code.

General

Every recognised hospital with a pathology laboratory should have available the services of an approved pathology practitioner. Where an approved pathology practitioner is not available, either as a visiting pathologist or salaried specialist with a right of private practice, the Medical Superintendent and/or Deputy Medical Superintendent should apply to become approved. This would ensure that accounts could be issued in respect of pathology services to all private inpatients (excluding compensable patients).

Where the approved practitioner is a hospital superintendent, accounts should be issued and receipted in the name of the superintendent with all fees received being paid initially into the Special Purposes & Trust Fund and then monthly into the Maintenance Account of the hospital through Account “Use of Hospital Facilities - Staff Diagnosticians”.

38(5/02)
3.1 Principles for Funding of NSW Public Health Sector Pathology Services
(PD2005_533)

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 CE or delegate 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 section takes precedence over existing NSW Department of Health policy in regards to NSW Public Health Sector Pathology charging.

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:

   1. a separate arrangement exists between the services and user (including Networking Agreements);

   2. 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 CE or delegate. 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 enquiries are to be referred to Finance Branch (02) 9391 9047 or (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.
Charging Policy for Pathology Services

### Non Admitted Patients

<table>
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<th>Patient Classifications</th>
<th>Notes</th>
<th>Charging Policy</th>
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<td>Public (Including Prisoners) and all no charge patients eg reciprocals</td>
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<td>Within Health Service</td>
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<td>Rates by mutual agreement approved by AHS Board</td>
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<td>External to Health Service</td>
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<tr>
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<td>Charge facility MBS rate</td>
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<tr>
<td>Privately Referred Non-Inpatients</td>
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<td>Charge patient up to the MBS rate</td>
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<td>Veterans’ Affairs</td>
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<td>Within Health Service</td>
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<td></td>
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<td>Ineligible/Overseas</td>
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<td>Charge patient cost recovery</td>
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### Admitted Patients

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</tr>
<tr>
<td>Public (Including Prisoners) and other non chargeables eg reciprocals</td>
<td>(4)</td>
<td>Within Health Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rates by mutual agreement approved by AHS Board</td>
</tr>
<tr>
<td></td>
<td></td>
<td>External to Health Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Charge facility MBS rate</td>
</tr>
<tr>
<td>Veterans’ Affairs</td>
<td></td>
<td>Charge Veterans’ Affairs MBS rate</td>
</tr>
<tr>
<td>Ineligible/Overseas</td>
<td>(2)</td>
<td>Charge patient cost recovery</td>
</tr>
<tr>
<td>Compensable 3rd Party (NSW)</td>
<td>(4)</td>
<td>Within Health Service</td>
</tr>
<tr>
<td>3rd Party (External NSW)</td>
<td>(3)</td>
<td>Rates by mutual agreement approved by AHS Board</td>
</tr>
<tr>
<td>Workers Comp.</td>
<td>(3)</td>
<td>External to Health Service</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Charge facility cost recovery rate</td>
</tr>
</tbody>
</table>
All Patients

<table>
<thead>
<tr>
<th>Service is of a type not listed in the PST (but similar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed in advance with the user of the service.</td>
</tr>
</tbody>
</table>

**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
1. Introduction


Area Health Services are to meet the cost of testing from within their global budget allocation, for clinically/medically required specialised genetic testing for non-Medicare Benefits Schedule items for:

- admitted public patients
- non-admitted public patients, and,
- privately referred non-inpatients referred to a public sector specialist clinic


1.1 Specialised tests for genetic disorders refer to tests which are non Medicare Benefits Schedule items performed by public hospital laboratories and funded by the NSW Health System. The costs of tests are generally in the range of $100 to $2000 per test, and more in rare instances.

These tests are used to:

- diagnose a genetic disorder, including a prenatal diagnosis
- determine if a person is a mutation carrier for a disorder, or
- detect an inherited predisposition to a genetic disorder.

using the following techniques or processes:

- molecular genetic testing, including PCR based methods
- molecular cytogenetics testing procedures such as FISH testing
- biochemical genetic testing, including functional studies, but excluding first-line urine metabolic screening tests
- microsatellite instability and immunohistochemistry of tumours in cancer genetics testing

1.2 It is to be noted that the scope of this definition does not include tests for non-inherited disorders which may use the same testing techniques, for example the diagnosis of bacterial, viral or malignant conditions for therapeutic purposes, or testing for multifactorial disorders, which are the result of an interaction of multiple genes with environmental factors.

1.3 As specialised genetic testing is generally complex with low throughput, it is appropriate that most testing for the State’s population is provided by a limited number of laboratories. It should be noted that the complexity of some testing might create a lengthy period to achieve a result. Some tests may need to be sent overseas and may incur transport costs. The exact cost of a test may not be known at the time of the request.
2. Charging policy within the public sector

2.1 Funding of testing


Area Health Services are to meet the cost of testing from within their global budget allocation, for clinically/medically required specialised genetic testing for non-Medicare Benefits Schedule items for:

- admitted public patients
- non-admitted public patients, and,
- privately referred non-inpatients referred to a public sector specialist clinic

The rationale for this variation to include privately referred non-inpatients of a public sector specialist clinic is that the lack of Medicare Benefits rebates and the lack of public patient clinics would unfairly discriminate against patients with, or at risk of, genetic conditions by imposing test costs on them. A public sector specialist clinic is a clinic managed and controlled by a Public Health Organisation as defined under the Health Services Act 1997 (NSW).

2.2 Cost recovery processes


The laboratory performing the test shall invoice the facility/Area Health Service requesting the test so that the laboratory can recover the full cost of the test. Facility is defined as an Area Health Service, or its delegated authority, e.g. hospital, pathology service or clinical unit. The facility/Area Health Service requesting the test needs to identify a source of local funds to cover the cost of the tests. The majority of tests are requested by a limited number of tertiary facilities for patients residing both within and outside the facility’s geographic area. Where a facility/Area Health Service requests tests for patients residing outside its geographic area, the facility/Area Health Service requesting the test may make agreements with patients’ Area Health Services of residence to recoup test costs in accordance with Section 3.4 of PD2005_533.

2.3 Responsibility for authorising tests


Local arrangements are to be negotiated concerning clinical responsibility for authorising testing as well as budget responsibilities for approving test requests. This would most appropriately rest with the head of a clinical genetics unit or delegated staff member. Referral to public sector genetics services will provide the patient with clinical geneticist expertise not generally available in the private sector. It will not guarantee testing, as it will need to be assessed and prioritised according to clinical necessity.

In some instances, the specialty of genetics overlaps with other specialties for example, oncology, gastroenterology or neurology. Where this occurs it may be appropriate for responsibilities to rest also with such units.
2.4 Public patients where public sector services are not available

In circumstances where patients elect to be public patients but public hospital clinical or pathology collection services are not available, the Area Health Service may agree to meet the cost of testing by arrangement with requesting physicians or private pathology collection services. Written authority must accompany test requests so that the testing laboratory can bill the authorising Area Health Service, otherwise the patient is assumed to be private and would be billed accordingly (see Section 3 below). Services may not be available or accessible due to geographical or other circumstances, eg

- where public clinics, eg neurology or paediatrics are not provided in some rural areas
- where public pathology collection services are not available eg Port Macquarie and private pathology collection services are used
- Where private pathology collection services are used due to difficulties with access to public pathology collection eg referrals from disability services

2.5 DNA predictive testing for serious adult onset disorders which may reduce normal life expectancy

DNA predictive testing for serious adult onset disorders undertaken by NSW Health public hospital laboratories may be subject to special requirements, ie shall only be undertaken when requested by clinical geneticists or other specialists with expertise in the genetics of the specific disorder.

Generally these would be Class B tests (Appendix 1) as classified by the National Pathology Advisory Accreditation Council’s document Laboratory Accreditation Standards and Guidelines for Nucleic Acid Detection http://www.health.gov.au/npaac/pdf/naageneticstest.pdf, ie

- diagnostic tests for which complex genetic analysis is required to identify mutations and for which negative test results also require detailed genetic counselling (e.g. hereditary cancer syndromes)
- predictive tests for untreatable adult onset conditions (e.g. Huntington’s disease).

The rationale is that this type of testing raises complex genetic and psychosocial issues for the patient and is best provided through a multidisciplinary clinical and laboratory service to ensure appropriate clinical care and interpretation of the results and their implications.

2.6 Cost recovery processes and patient privacy and confidentiality

The above-mentioned Class B tests, carry with them special privacy considerations. Optimal patient care requires formal written consent and confidentiality procedures. On completion of testing the molecular genetics laboratory is to send the result report to the referring practitioner. The referring laboratory is to be advised for their records that testing has been completed and that the report has been issued to the referring practitioner. The advice to the referring laboratory will not include test results for reasons of privacy and confidentiality. The patient’s name and address details may also be withheld, provided there is a sufficient audit trail including: laboratory episode number, broad test category, date of service, name of requesting clinician and test cost. The patient’s postcode must be included.

3. Charging for Patients in the Private Sector

3.1 Private patients are defined as patients who consult with and have tests requested by general practitioners or specialists in private rooms outside public hospitals.
3.2 Charging private patients - Where public hospital laboratories provide specialised genetic/DNA tests which are non Medicare Benefits Schedule items to private patients, the patients will be responsible for their own test costs. The special requirements in 2.5 above are to be noted concerning requests for predictive testing through clinical geneticists and other specialists with expertise in the genetics of the specific disorder.

3.3 Consent to testing - Patients should consent to testing on an informed basis, in regard to their financial obligations as well as to the test and its implications. Before commencing testing, public hospital laboratories require all the information indicated on the template Request Form (Appendix 2) including an acknowledgement that the patient has been advised of the test cost and agreed to meet the cost. The laboratory may also require a copy of the clinical consent form to indicate appropriate test and specimen management.

3.4 Provision of information about costs to the patient - Concerning financial consent, the patient should be informed about the following:

- the test cost
- there is no Medicare rebate, and
- there is an alternative for testing without cost to the patient through the public sector genetics services (Appendix 3). It should be noted that the intent of this point is not to dissuade private practitioners or private laboratories from collecting and forwarding specimens to public hospital laboratories, but simply as part of the process of ensuring informed financial and clinical consent.
- referral to a public sector genetics service will not guarantee testing as it will need to be assessed and prioritised according to clinical necessity.

3.5 Tests forwarded by public pathology collection centres on behalf of private patients will be billed directly to the patient. The referring laboratory must clearly indicate that the patient is private or the Area Health Service will be billed.

3.6 Tests forwarded by private pathology collection centres are to be treated as private patient referrals, (unless special arrangements have been made - see 2.4 above). The account is to be sent to the patient. If patient details are not provided the account is to be forwarded to referring pathology laboratory.

3.7 Privacy and confidentiality of test results – see 2.6.

The NSW public health system will meet the cost of specialised genetic testing for non-Medical Benefits Schedule items for admitted public patients, non-admitted public patients and privately referred non-inpatients referred to a public sector specialist clinic, ie a specialist clinic managed and controlled by a Public Health Organisation as defined under the Health Services Act 1997 (NSW).

Private patients are responsible for their own test costs.


41(1/04)
### Patient Classification

<table>
<thead>
<tr>
<th>Eligible patients</th>
<th>Pathology Collection</th>
<th>Costs to be met by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• admitted public patients</td>
<td>Public hospital pathology collection service</td>
<td><em>Area Health Service/public facility requesting the test</em></td>
</tr>
<tr>
<td>• non-admitted public patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• privately referred non-inpatients referred to a public sector specialist clinic</td>
<td>Private pathology collection service (only where initial referral is from a public sector specialist clinic)</td>
<td><em>Area Health Service/public facility requesting the test</em> provided there is written authorisation indicating its agreement to meet the test cost. Otherwise patient to be considered private and billed accordingly.</td>
</tr>
</tbody>
</table>

### Non-Eligible Patients

- Patients who consult with and have tests requested by general practitioners or specialists in private rooms outside public hospitals.

Note: Some tests provided by public sector laboratories shall only be undertaken when requested by clinical geneticists or other specialists with expertise in the genetics of the specific disorder.

<table>
<thead>
<tr>
<th>Public hospital pathology collection service</th>
<th>Private patient - bill the patient direct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obtain informed financial consent prior to testing.</td>
<td></td>
</tr>
<tr>
<td>• Clearly indicate private patient’s contact details for billing, otherwise the bill will be sent to the <em>referring laboratory</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private pathology collection service</th>
<th>Private patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>As above</td>
<td></td>
</tr>
</tbody>
</table>
The NPAAC document Laboratory Accreditation Standards and Guidelines for Nucleic Acid Detection Techniques recognises that many human genetic tests simply require the patient’s verbal consent after the provision of appropriate information by a qualified practitioner. There are however other human genetic tests where pre- and post-test genetic counselling as well as formal consent and confidentiality procedures are appropriate parts of the testing process and are required for optimal patient care. The current definitions of testing classes are as follows.

Class A: Diagnostic Genetic Tests

Tests in this class are conducted largely on symptomatic patients with the aim of making a diagnosis for the purpose of treatment, patient management or else are supported as routine public health measures by a State or Territory Department of Health (e.g. newborn screening tests). The tests in this class require verbal consent of the individual being tested (or legal guardian) and do not require specific pre-test counselling for genetic disease. Tests in this class are appropriate for access by the health professionals providing patient care. This class of tests is expected to represent the substantial majority of nucleic acid based tests conducted by multidisciplinary laboratories.

Class B: Predictive, Carrier and Prenatal Genetic Tests

This class of tests would typically be the province of a specialist laboratory working in close association with clinical genetics units or a number of specialist referrers. The tests in this category are largely conducted on samples from non-symptomatic patients, for the purpose of determining carrier status or predictive testing, or for prenatal diagnosis. They require formal consent, pre- and post-test counselling, confidentiality procedures, and close dialogue between laboratory and clinical services.

In order to encourage uniformity of practice in human molecular genetics laboratories NPAAC requested that stakeholders* provide guidelines as to which molecular genetic tests should be categorised as ‘Class A’ or ‘Class B’ tests.

There was consensus that the following four indications could be undertaken as Class A tests:

- Diagnostic tests for which a simple definitive test exists (e.g. Fragile XA)
- Predictive tests for conditions where a simple treatment exists (e.g. Haemochromatosis)
- Screening tests supported as a public health measure by a State or Territory Dept of Health (e.g. Newborn Screening Tests)
- Some carrier tests for autosomal recessive or X-linked conditions (e.g. Tay Sachs disease).

There was consensus that the following indications should be undertaken as Class B tests:

- Diagnostic tests for which complex genetic analysis is required to identify mutations and for which negative test results also require detailed genetic counselling (e.g. hereditary cancer syndromes)
- Predictive tests for untreatable adult onset conditions (e.g. Huntington’s disease)
- Prenatal diagnostic tests
- Some carrier tests for autosomal recessive or X-linked conditions (e.g. Duchenne Muscular Dystrophy).

The major discriminator between whether a test falls into Class A or Class B is the reason for the performance of the test rather than the test itself. For example a Fragile XA test could be a Class A or Class B test depending on whether it is offered for diagnosis in a developmentally delayed child or undertaken on a sample from a known carrier for prenatal diagnosis.

Further information relating to the ethics of laboratory genetic testing is available in the NHMRC publication: Ethical Aspects of Human Genetic Testing: an Information Paper (2000).

*Responses were received from: the Human Genetics Society of Australasia, Royal College of Pathologists of Australasia, Australasian Association of Clinical Geneticists, Australian Society of Genetic Counsellors, Genetic Services Advisory Committee of the New South Wales Department of Health, Victorian Clinical Genetics Service, Queensland Clinical Genetics Service.
## Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Disorders

- Must be used for non-Medical Benefits Schedule items
- Before testing is commenced, the laboratory may require the following details (see "Guidelines for Specialised DNA Testing for Genetic Disorders" [link](https://www.health.gov.au/health-public-affairs/publications/gentest/))

<table>
<thead>
<tr>
<th>Send by courier/express post to:</th>
<th>Patient ID</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>First name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Address</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

### Sample

<table>
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<tr>
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<th>Blood</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>EDTA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lithium heparin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>amniotic fluid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cultured amniocytes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CVS sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other DNA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other, specify:</th>
<th>Other DNA</th>
</tr>
</thead>
</table>

### Test requested

- **PLEASE ATTACH FAMILY/PEDIGREE INFORMATION**

### Purpose of test

- Confirm clinical diagnosis
- Predictive/presymptomatic testing
- Carrier Status
- Prenatal Diagnosis - complete box below
- Determine feasibility of prenatal Dx
- Family study (no report for this individual)
- For research (no report for this individual)
- Bank DNA until further notice
- Other

### Pregnancy Information (if applicable)

- Is this individual or the partner of this individual currently pregnant
  - L.M.P. (dd/mm/yyyy) 
  - Amnio (dd/mm/yyyy)
  - CVS (dd/mm/yyyy)

### Family Information

- Have samples from this family been sent to a DNA lab before?
  - Yes
  - No
- If Yes, specify
- Date of birth or age
- Ethnic background

### Consent to Testing

- Has a Consent Form for Specialised/DNA Testing been completed?
  - Yes
  - No

### Consent to payment

- Public patient, or
- Privately referred non-patient
- Payment to be made by Area Health Service by arrangement
- Authorised by

- Private patient - Payment to be made by patient

### Consent Form for Specialised/DNA Testing

**Appendix 2**
<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Camperdown</strong></td>
<td>Department of Molecular and Clinical Genetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Royal Prince Alfred Hospital, Missenden Road</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAMPERDOWN NSW 2050</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 9515 5080</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 9515 7595</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Liverpool</strong></td>
<td>Dept of Clinical Genetics, Health Services Building</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cnr Campbell &amp; Goulburn Sts, LIVERPOOL NSW 2170</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 9828 4665</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 9828 4650</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Penrith</strong></td>
<td>Nepean Hospital, Summerset Street, PENRITH NSW 2750</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 4734 3362</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 4734 2567</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Randwick</strong></td>
<td>Dept of Medical Genetics, High Street, RANDWICK NSW 2031</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 9382 1708</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 9382 1711</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Westmead</strong></td>
<td>Dept of Clinical Genetics, The New Children’s Hospital, Hawkesbury Road, WESTMEAD NSW 2145</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 9845 3273</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fax. 9845 3204</td>
<td></td>
<td></td>
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<tr>
<td><strong>Newcastle</strong></td>
<td>Hunter Genetics, Cnr Turton &amp; Timonee Streets, WARATAH NSW 2298</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 4985 3100</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fax. 4985 3105</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goulburn</strong></td>
<td>Child Development Unit, Cnr Albert and Clifford Streets, GOULBURN NSW 2580</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 4827 3951</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 4827 3958</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kogarah</strong></td>
<td>Women’s &amp; Children’s Health, St George Hospital, Gray Street, KOGARAH NSW 2217</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 9350 2315</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fax. 9350 3901</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>St Leonards</strong></td>
<td>Fetal Medicine Unit, Royal North Shore Hospital, Pacific Highway, ST LEONARDS NSW 2065</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 9926 6478</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fax. 9006 1872</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bathurst</strong></td>
<td>Community Health Centre, 158 William Street, BATHURST NSW 2795</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 6331 5533</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 6332 2039</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Broken Hill</strong></td>
<td>Community Health Centre, BROKEN HILL NSW 2880</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. (08) 8080 1556</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. (08) 8080 1611</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Canberra</strong></td>
<td>The Antenatal Clinic, The Canberra Hospital, Gilmore Crescent, CANBERRA ACT 2605</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 6244 4042</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 6244 3422</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coffs Harbour</strong></td>
<td>Coffs Harbour Health Campus, Pacific Highway, COFFS HARBOUR 2450</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 6656 7806</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 6656 7817</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gosford</strong></td>
<td>Child Health Centre, 297 Henry Parry Drive, WYOMING NSW 2250</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 4337 0207</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 4337 0217</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lisnmore</strong></td>
<td>Child &amp; Family Health Centre, 37 Oliver Avenue, GOONELLABAH NSW 2480</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 6625 0111</td>
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<tr>
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<td>Fax. 6625 0102</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mudgee/Dubbo</strong></td>
<td>Mudgee Community Health Centre, MUDGEE NSW 2850</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel. 6372 6455</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax. 6372 7341</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Muswellbrook</strong></td>
<td>Community Health Centre, Brentwood Street, MUSWELLBROOK NSW 2332</td>
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<td>Fax. 6542 2005</td>
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<td><strong>Port Macquarie</strong></td>
<td>Hastings Macleay Community Health, Morton Street, PORT MACQUARIE 2444</td>
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<td>Tel. 6588 2882</td>
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<td><strong>Tamworth</strong></td>
<td>Community Health Centre, Cnr Dean and Johnson Streets, TAMWORTH NSW 2340</td>
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<td></td>
<td>Tel. 6766 2555</td>
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<td>Fax. 6766 3967</td>
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<td><strong>Taree/Forster</strong></td>
<td>Community Health Centre, 64 Putney Street, TAREE NSW 2430</td>
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<td>Tel. 6592 9315</td>
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<td>Fax. 6592 9607</td>
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Wagga Wagga
Wagga Base Hospital
Edward Street
WAGGA WAGGA NSW 2650
Tel. 6938 6393
Fax. 6921 5632

Randwick
Prenatal Diagnosis
Royal Hospital for Women
Barker Street
RANDWICK NSW 2031
Tel. 9382 6098
Fax. 9382 6706

Cancer Genetics Specialised Services
Darlinghurst
Family Cancer Clinic
Dept of Medical Oncology
St Vincent’s Hospital
Victoria Street
DARLINGHURST NSW 2010
Tel. 8382 3395
Fax. 8382 3386

Wollongong
Maternal and Paediatric Services
Wollongong Hospital
Crown Street
WOLLONGONG NSW 2500
Tel. 4222 5216
Fax. 4222 5477

Penrith
Fetal Medicine Unit
Nepean Hospital
Summerset Street
PENRITH NSW 2750
Tel. 4734 3163
Fax. 4734 3206

Kogarah
Cancer Care Centre
St George Hospital
Belgrave Street
KOGARAH NSW 2217
Tel. 9350 3815
Fax. 9350 3958

MotherSafe
Statewide Medications in Pregnancy and Lactation Advisory Service

Royal Hospital for Women
Barker Street
RANDWICK NSW 2031
Tel. 9382 6539 (Sydney calls)
Tel. 1800 647 848 (Other calls)

St Leonards
Fetal Medicine Unit
Royal North Shore Hospital
Pacific Highway
ST LEONARDS NSW 2065
Tel. 9926 7280
Fax. 9906 1872

Liverpool
Liverpool Hospital
Elizabeth Drive
LIVERPOOL NSW 2170
Tel. 9828 4665
Fax. 9828 4650

Prenatal Diagnosis & Counselling Services
Camperdown
Fetal Medicine Unit
King George V Hospital
Missenden Road
CAMPERDOWN NSW 2050
Tel. 9515 8258
Fax. 9515 6579

Westmead
Fetal Medicine Unit
Westmead Centre
Hawkesbury Road
WESTMEAD NSW 2145
Tel. 9845 6802
Fax. 9845 7793

Randwick
Hereditary Cancer Clinic
Prince of Wales Hospital
High Street
RANDWICK NSW 2031
Tel. 9382 2587
Fax. 9382 2588

Liverpool
Fetal Medicine Unit
Liverpool Hospital
Elizabeth Drive
LIVERPOOL NSW 2170
Tel. 9828 4145
Fax. 9828 4146

Newcastle
Prenatal Diagnosis Unit
John Hunter Hospital
NEWCASTLE NSW 2310
Tel. 4921 4694
Fax. 4921 3133

Westmead
Familial Cancer Services
Westmead Hospital
Hawkesbury Road
WESTMEAD NSW 2145
Tel. 9845 5079
Fax. 9687 2331
C. PATHOLOGY

Newcastle
Hunter Genetics
Cnr Turton & Tinonee Streets
WARATAH NSW 2298
Tel. 4985 3100
Fax. 4985 3105
AGSA

Association of Genetic Support of Australasia Inc.

66 Albion Street
SURRY HILLS NSW 2010
Tel. 9211 1462
Fax. 9211 8077
Email. agsa@ozemail.com.au

Further Information
On services in other areas and newly developed services:

NSW Genetic Education Program
PO Box 317
ST LEONARDS NSW 2065
Tel. 9926 7324
Fax. 9906 7529
C. PATHOLOGY

4. PERFORMANCE OF 11 BASIC TESTS BY NON-APPROVED PATHOLOGY PRACTITIONERS

Group P9 of Section 6 of the Medicare Benefits Schedule contains 11 simple basic pathology tests which a practitioner who is not an approved pathology practitioner may perform in respect of patients of his own practice.

The circumstances in which benefits are paid for such services do not apply in hospitals. No charges will be made for such services provided to patients in hospitals, nor will fees be paid by hospitals for such services.

5. DISTRIBUTION OF FEES COLLECTED IN RESPECT OF SERVICES TO PRIVATE INPATIENTS

Any fees collected on behalf of the visiting pathologist(s) in respect of services provided to private inpatients should be paid into the special account(s) in accordance with the provisions of the Diagnostic Services charging procedures.

These collections should be recorded and shall be distributed at the end of each month on the following basis:

- Firstly, to the hospital for the use of hospitals facilities and/or staff, the appropriate percentage of all fees collected and paid into the special account(s).
- Secondly, to the visiting pathologist(s), the balance of any funds in the special accounts(s).

GENERAL

Apart from the distribution of fees collected in respect of services to private, ineligible and Veterans’ Affairs inpatients, a visiting pathologist shall be remunerated from the Maintenance Account on a monthly basis, as follows:

(a) For services to compensable inpatients, the appropriate scheduled fee less a charge for the use of hospital facilities and/or staff.

(b) For services to “hospital” inpatients or registered non-inpatients, and for managerial, administrative and consultative duties, sessional fees at the rates agreed upon between the Health Department and the New South Wales Branch of the Australian Medical Association.

Such rates shall be subject to periodic review and variation by agreement between the Department and the Association.

(c) For a full three cavity autopsy, the Coronial rate - through Maintenance Account No. 1640. These rates include remuneration for any associated microscopic examination.

Where a hospital is attended by more than one visiting pathologist, the share of fees payable to the pathologists may be on an individual basis or such other basis as may be agreed between the pathologists.

Each hospital will submit accounting documents and records relating to fees for pathology services to its auditor during every audit of the hospital’s accounts and records. A visiting pathologist may also arrange an independent audit, at his/her own expense, of the special account into which fees collected on his/her behalf are paid. Access by a registered public accountant nominated by a pathologist for this purpose should be permitted.
C. PATHOLOGY

PROVISION OF PATHOLOGY SERVICES TO PRIVATE IN-PATIENTS IN PUBLIC HOSPITALS (PD2010_048)

PURPOSE

In 2009, the public health organisations covered by this policy lodged notifications with the Australian Competition and Consumer Commission (ACCC), seeking immunity under the Trade Practices Act 1974 for conduct that may be third line forcing (and in the absence of immunity, illegal under the Act). On 27 May 2010, the ACCC advised that it did not (at that time) intend to take any further action with respect to the notifications, and the notifications were allowed to stand. Accordingly, the notified conduct is immune against action for third line forcing under the Trade Practices Act, and will remain immune unless (and until) the ACCC decides to revoke the notifications.

This policy implements the notifications lodged with the ACCC, and replaces PD2005_381.

MANDATORY REQUIREMENTS

Pathology services for private in-patients in public hospitals must be supplied by public health organisations (PHOs) in accordance with this policy.

Pathology services for private in-patients must, in all circumstances other than those set out below, be supplied by pathology practitioners appointed by PHOs as salaried senior medical practitioners or visiting medical officers.

Salaried senior medical practitioners and visiting practitioners may, in the treatment of private in-patients, refer pathology tests to private pathology providers or seek a second opinion only where:

- the referral of the test to the private pathology provider is in the best interests of the patient;
- unless impractical for medical reasons, the patient or their guardian has signed a Financial Consent acknowledging that she or he will pay any out of pocket expense incurred in connection with the pathology test or second opinion, and a Waiver relating to the PHO’s responsibility for the services performed by the private pathology provider and associated risks;
- the referring doctor has satisfied himself or herself as to certain matters set out in this policy and the attachments to it regarding the capacity of the private pathology provider to provide safe, timely, high quality pathology services; and
- the private pathology provider has entered into a Deed of Indemnity with the PHO in accordance with sections 10 to 11 of the attached Procedures: Provision of pathology services to private in-patients in public hospitals and Model clauses for deeds of indemnity.

In order to ensure that PHOs and patients are not adversely affected by the use of private pathology providers by private in-patients, this Policy Directive requires PHOs to have signed Deeds of Indemnity in place with any private pathology provider engaged by a private in-patient. The Deed of Indemnity is to contain clauses to ensure:

- Timely, prompt and efficient delivery of services;
- Compatible reporting systems; and
- Indemnity is granted to the PHO.
IMPLEMENTATION

PHOs are to ensure that this policy directive is brought to the attention of all relevant staff of the organisation and that all relevant staff comply with its requirements.

If a private in-patient consents to use a private pathology provider for a test in accordance with this policy, the attending medical officer must complete the form recommending the use of the pathology provider for the test, the patient signs a Financial Consent and Waiver, and that the nominated pathology provider has signed a Deed of Indemnity with the PHO. The PHO must also have systems in place for monitoring the compliance of private pathology providers with the requirements of the Deed of Indemnity.

The criteria for referring private in-patients’ tests and procedures for obtaining patient consent for the referral of those tests, and establishing a Deed of Indemnity, as set out within the attached Procedures: Provision of pathology services to private in-patients in public hospitals, are to be followed by PHOs in implementing the requirements of this policy directive.

The Model clauses for deeds of indemnity should be used by PHOs in establishing Deeds of Indemnity with private pathology providers. The model clauses are not intended to be exhaustive, and Deeds of Indemnity may contain clauses addressing other matters, as agreed by the parties.

Introduction

On 7 April 2004, the Australian Competition Tribunal gave an authorisation permitting NSW Health to require private in-patients in NSW public hospitals to obtain pathology services from NSW Health public pathologists. The authorisation was subject to a condition that treating medical practitioners could refer pathology services to private pathologists if the medical practitioner considered it to be in the patient’s best interests to do so and had obtained a written acknowledgement from the patient to pay any out of pocket expenses associated with the service. The authorisation was implemented by way of the NSW Health policy directive, Provision of Pathology Services to Private in-patients in Public Hospitals PD2005_381.

The authorisation by the Tribunal expired on 7 April 2009.

In March and April 2009, the public health organisations covered by this policy lodged notifications with the Australian Competition and Consumer Commission (ACCC), seeking immunity under the Trade Practices Act 1974 for conduct that may be third line forcing (and in the absence of immunity, illegal under the Act). On 27 May 2010, the ACCC advised that it did not intend to take any further action with respect to the notifications, and the notifications were allowed to stand. Accordingly, the notified conduct is immune against action for third line forcing under the Trade Practices Act, and will remain immune unless the ACCC decides to revoke the notifications. The ACCC has the power to revoke a notification if it forms the view that the notified conduct is likely to generate a detriment to the public which outweighs the benefits to the public.

This policy implements the notifications lodged with the ACCC, and replaces PD2005_381. This policy no longer imposes the requirement of temporary appointment and credentialing of private pathology providers, on the basis that they are not providing an on site service. Instead, private pathology providers will be required to enter into a Deed of Indemnity with the relevant PHO.

In order to ensure that PHOs and patients are not adversely affected by the use of private pathology providers by private in-patients, the Policy now requires PHOs to have signed Deeds of Indemnity in place with any private pathology provider engaged by a private in-patient. The Deed of Indemnity is to contain clauses relating to:

53(08/07/10)
• Timely, prompt and efficient delivery of services;
• Compatible reporting systems; and
• Indemnity for the PHO.

The indemnity provided by the Deed of Indemnity is not directed at, and does not cover, treating medical practitioners exercising rights of private practice.

Procedure for referral to private pathology providers

Pathology services for private in-patients in public hospitals must be supplied by PHOs in accordance with this policy.

Pathology services for private in-patients must, in all circumstances other than those set out below, be supplied by pathology practitioners appointed by PHOs as salaried senior medical practitioners or visiting medical officers.

Salaried senior medical practitioners and visiting practitioners may, in the treatment of a private in-patient, refer a pathology test to a private pathology provider or seek a second opinion only where, in relation to the particular test:

(a) the referral of the test to the private pathology provider is in the best interests of the patient;
(b) unless impractical for medical reasons, the patient or their guardian has signed a Financial Consent acknowledging that she or he will pay any out of pocket expense incurred in connection with the pathology test or second opinion, and a Waiver relating to the PHO’s responsibility for the services performed by the private pathology provider and associated risks;
(c) he or she has satisfied himself or herself as to the matters set out in section 5 below and acted in accordance with the requirements of that section; and
(d) the private pathology provider has entered into a Deed of Indemnity with the PHO in accordance with sections 10 to 11 below and the attached Model clauses for deeds of indemnity, and that the Deed of Indemnity remains current.

The treating medical practitioner must be satisfied of each of the above matters, and must follow the process set out in section 5 below, in respect of each pathology test proposed to be referred to a private pathology provider.

Relevant factors a treating practitioner should consider in making a determination that referral of a test to a particular private pathology provider is in a patient’s best interests include:

(a) whether the pathology service is unavailable from the public pathology provider;
(b) whether a lower price is charged by the private pathologist;
(c) whether there is a need to maintain the continuity of the patient’s hospital pathology testing history because of the patient’s particular condition;
(d) whether the private pathology provider provides a faster turnaround time for the test than the public hospital’s pathology provider; and
(e) whether a more comprehensive clinical consultation is offered by the private pathology provider.
Before referring a pathology test to a private pathology provider, the referring practitioner must:

(a) complete the “Patient’s best interests declaration” on the Private In-patient Pathology Referral form (sample attached) recording the objective basis upon which he or she has determined that the referral is in the patient’s best interests;

(b) advise the patient that there may be an increased risk for adverse incidents or outcomes if a private pathology provider is used, as a result of the specimen not being collected, transported or stored, or the results not being reported back to the treating medical officer or recorded within the hospital’s records, in accordance with the usual procedures in place for the use of public pathology services, and confirm that the patient accepts these risks;

(c) satisfy himself/herself that these risks are outweighed by the benefit that using the private pathology provider for the particular test will provide to the patient;

(d) ensure the patient or their guardian signs the Financial Consent and Waiver sections of the Private In-patient Pathology Referral form, unless it is impractical to obtain the consent and waiver at this time, in which case the referring practitioner must obtain written consent and waiver when it becomes practicable to do so;

(e) provide the facility and the relevant public pathology provider with a copy of the Private In-patient Pathology Referral form; and

(f) satisfy himself/herself that the private pathology provider:
   (i) holds current accreditation from the National Association of Testing Authorities, Australia or equivalent to provide the particular pathology services proposed;
   (ii) is able to perform the test, and report test results, in a timely, prompt, safe and efficient manner;
   (iii) is capable of interfacing with the hospital’s current clinical information systems and will provide the test results in a way that is compatible with the hospital’s systems and existing pathology test reporting practices; and
   (iv) has entered into a Deed of Indemnity with the PHO in accordance with sections 10 to 11 below and the attached Model clauses for deeds of indemnity, and that the Deed of Indemnity remains current.

In the interests of proper patient care, if the private in-patient’s pathology test is referred out to a private pathology provider in accordance with this policy, the referring medical practitioner must make an entry in the patient’s medical record:

(a) identifying the pathology test requested;

(b) noting the pathologist and pathology practice to which the request has been referred, and their contact details;

(c) noting the anticipated time and date of collection;

(d) recording confirmation of the collection of specimens; and

(e) recording confirmation of receipt of the results/report. The referring medical practitioner must also arrange for the filing of the results/report in the patient’s medical record in a timely manner.

This will ensure that the hospital staff will have a record that the patient’s specimen has been sent outside the Hospital to a private pathology provider.
The referring medical practitioner must make his or her own arrangements for collection, storage and transportation of the specimen by the private pathology provider or the private pathology provider’s staff.

The PHO must not accept any liability for the collection, storage or transportation of the private in-patient’s specimen where it is to be provided to a private pathology provider in the circumstances outlined in this policy. Hospital staff are not to be involved in the collection, storage or transportation of such specimens.

Hospital staff have no responsibility for the availability or handling of associated paperwork such as request forms or reports, although arrangements will be implemented to ensure that reports are filed as part of the medical record. No public hospital consumables or equipment are to be used in the process for referring patient specimens to a private pathology provider. This includes all specimen tubes and containers, as well as all items used during venipuncture.

Deed of Indemnity

In order to ensure that PHOs and patients are not adversely affected by the use of private pathology providers by private in-patients, PHOs are required to enter into a Deed of Indemnity with any private pathology provider engaged by a private in-patient in accordance with this policy.

Deeds of Indemnity must contain clauses in accordance with Model clauses for deeds of indemnity attached to this policy directive. The indemnity provided by a private pathology provider seeks to ensure:

(a) Safety, treatment and care of patients is not compromised

The safety, treatment and care of patients in public hospitals should not be compromised due to private pathology providers providing pathology services to private in-patients.

To address the increased risks arising from the provision of pathology services to patients in public hospitals, including the access by private pathology provider staff to public hospital facilities to take, collect or deliver pathology specimens, and the performance of off-site pathology testing by private pathology providers, Deeds of Indemnity must:

(i) Require that the private pathology provider complies with ‘best practices’ in providing pathology services to patients at public hospitals, which must include the following requirements (but may include other matters agreed between the parties):

- performance of services with due care and skill and administered in a timely and efficient manner and without unnecessary or unreasonable delays;
- compliance with any standards, guidelines or requirements in respect of pathology services which are issued or endorsed by the National Pathology Accreditation Advisory Council or the Therapeutic Goods Administration from time to time;
- compliance with the hospital’s security and identification requirements; and
- compliance with the New South Wales Ministry of Health’s Employment Checks - Criminal Record Checks and Working with Children Checks (PD2013_028) and any other policy or guideline of the New South Wales Department of Health or of the PHO, which relates to the safety and care of patients, and which is notified to the private pathology provider by the PHO from time to time.
(ii) Ensure that the hospital is indemnified for any loss or damage (including any claim, action, proceeding or demand made by a patient or a third party) resulting (directly or indirectly) from:
   - any failure by the private pathology provider to perform services in accordance with best practices; or
   - the private pathology provider’s negligence, wrongful act or omission in providing services to private in-patients at the hospital.

(iii) Confer on the hospital the right to terminate the Deed of Indemnity in circumstances of unremedied, ongoing, recurrent or persistent failure by the private pathology provider to perform services in accordance with best practices or with due care and skill, and to immediately suspend the Deed of Indemnity in circumstances where the private pathology provider’s breach gives rise to a risk to the health or life of a patient.

(b) Hospitals are not out of pocket

Failure by private pathology providers to provide pathology services to patients in public hospitals in accordance with best practices and with due care and skill may increase risks and have adverse flow on effects on hospitals and patients, and increase costs for hospitals.

For example, an increase in reporting timeframes resulting from off-site testing by private pathology providers may impact significantly on the delivery of medical care and on the efficiency of the hospital. The costs of any such inefficiency will be borne by the public through reduced access to public hospital services and increased waiting times.

Hospitals’ funds should continue to be utilized to provide health care services to the public. Hospitals should not be out of pocket for any costs, liabilities or expenses which they incur as a result of the provision of pathology services to private in-patients by private pathology providers, such as:

(iv) administrative costs associated with creating and providing a system of dealing with the multiple ordering and reporting of pathology tests in the hospital clinical environment;

(v) costs incurred as a result of the interaction of the private pathology providers’ information reporting systems with the systems employed by the hospital; and

(vi) costs incurred as a result of delays in the reporting of results by private pathologists.

Deeds of Indemnity must ensure that hospitals are indemnified by the pathology provider for any cost, expense or liability incurred by the hospital in enabling the private pathologist provider to provide pathology services to private in-patients in the public hospital(s) operated by the PHO, or resulting (directly or indirectly) from, or in connection with, the provision of such services.

Related Policy Directives

- Pathology Services –Principles of Funding of NSW Public Health Sector, PD2005_533- (Obsolete 20/7/2016)
- Employment Checks - Criminal Record Checks and Working with Children Checks (PD2016_047)
PRIVATE IN-PATIENT PATHOLOGY REFERRAL FORM

PART A - Doctor Declaration – Referral in Patient’s Best Interests

I ………………………………………………………………………………………… wish

[insert doctor’s name] [provider no]

to refer …………………………………………………………………………………………………

[insert patient’s name] [other patient details]

to Dr…………………………………………... for………………………………………………….

[insert name of private pathology provider]    [name/number of pathology test(s)]

It is in the patient’s best interests to refer this test to ………………………….……..because:

• considering the patient’s existing condition it is more important to maintain the continuity of the patient’s non-hospital pathology testing history than the patient’s public hospital pathology testing history *

• A lower price is charged by the private pathologist *

• Provision of the above pathology service is not available from the public hospital’s pathology provider *

• The private pathology provider can provide the results of the test more quickly than the public hospital’s pathology provider *

• The private pathology provider will provide a more comprehensive clinical consultation for my patient than the public hospital’s pathology provider *

* Delete inapplicable reason/s above and tick applicable reason/s

• Other reason/s (please specify):

• ……………………………………………………………………………………………

• ……………………………………………………………………………………………

I have:

• advised the patient of the potential increased risk for adverse incidents or outcomes if a private pathology provider is used, arising from the specimen not being collected, transported or stored, or the results not being reported back to the treating medical officer or recorded within the hospital’s systems, in accordance with the usual procedures in place for the use of public pathology services.

• considered the above-mentioned risks, and I am of the view that they are outweighed by the benefit that using the private pathology provider will provide to the patient.

• satisfied myself that the private pathology provider:

  o is able to perform the test, and report test results, in a timely, prompt, safe and efficient manner;

  o is capable of interfacing with the hospital’s current clinical information systems and will provide the test results in a way that is compatible with the hospital’s systems and existing pathology test reporting practices; and

  o has entered into a Deed of Indemnity with the public health organisation.

Signed: ……………………………………   Date………………………

Referring medical practitioner
PART C – WAIVER [to be completed and signed by patient]

I understand that the public hospital is not responsible for the collection, storage, transportation of my specimen/s which is/are being referred to the private pathology provider.

I understand that the public hospital is not responsible for the accuracy or quality of any test done by the private pathology provider.

I understand that the public hospital considers that there may be increased risk for error or adverse outcome if a private pathology provider is used, arising from the specimen not being collected, transported or stored, or the results not being reported back to the treating medical officer or recorded within the hospital’s systems, in accordance with the usual procedures in place for the use of public pathology services. I accept these risks.

I understand that by consenting to the use of a private pathology provider, I will have no right to bring any claim, demand etc against the public health organisation arising from the professional services of the private pathology provider, including the collection, transport, or storage of the specimen, or the reporting of results back to the public health organisation, by the private pathology provider.

Signed .................................................. Date........................................

Patient/guardian
C. PATHOLOGY

MODEL CLAUSES FOR DEEDS OF INDEMNITY

In order to ensure that PHOs and patients are not adversely affected by the use of private pathology providers by private in-patients, the Policy requires PHOs to have signed Deeds of Indemnity in place with any private pathology provider engaged by a private in-patient. The Deed of Indemnity must include the model clauses set out in this document.

The model clauses are not intended to be exhaustive, and Deeds of Indemnity may contain further clauses (not inconsistent with the model clauses) addressing other matters, as agreed by the parties.

<table>
<thead>
<tr>
<th>MODEL CLAUSE</th>
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<tr>
<td>1. INDEMNITY AND LIABILITY INSURANCE</td>
</tr>
<tr>
<td>1.1 Indemnity relating to Services</td>
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<tr>
<td>[Private Pathology Provider] must indemnify and keep indemnified [PHO] from and against all actions, suits, claims, demands and proceedings for which [PHO] or any of its employees, contractors or agents shall or may become liable and from and against all losses, damages, compensation, costs (including legal costs on a full indemnity basis), charges and expenses whatsoever which [PHO] or any of its employees, contractors or agents may suffer:</td>
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<tr>
<td>(a) in respect of the failure by [Private Pathology Provider] to carry out the Services in accordance with Best Practices; or</td>
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<tr>
<td>(b) as a result of [Private Pathology Provider]’s negligence, wrongful act or omission in providing the Services.</td>
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<tr>
<td>[Private Pathology Provider] agrees that this indemnity will be a continuing indemnity and will survive the termination of this Deed.</td>
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<tr>
<td>1.2 Indemnity relating to other costs incurred by [PHO]</td>
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<tr>
<td>[Private Pathology Provider] must indemnify and keep indemnified [PHO] from and against any cost, expense or liability incurred by [the PHO] in connection with the provision of Services, including, but not limited to:</td>
</tr>
<tr>
<td>(a) administrative costs associated with creating and providing a system of dealing with the multiple ordering and reporting of pathology tests in the hospital clinical environment;</td>
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<tr>
<td>(b) costs incurred as a result of the interaction of the pathologists’ information reporting systems with the systems employed by the hospital; and</td>
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<tr>
<td>(c) costs incurred as a result of delays in the reporting of results by private pathologists.</td>
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### MODEL CLAUSE

#### 1.3 Liability Insurance

(a) [Private Pathology Provider] must effect and maintain, and must ensure that each [Pathologist] employed or engaged by [Private Pathology Provider] maintains, liability insurance which must:

(i) be written for professional indemnity on a claims made basis;

(ii) contain a minimum limit of indemnity in respect of professional indemnity for any one occurrence or a series of occurrences arising out of any one event of [$20 million] and an aggregate limit of indemnity in respect of professional indemnity in respect of any one year of [$20 million] or as reasonably required by [PHO]; and

(iii) in the case of liability insurance maintained by each [Pathologist] employed or engaged by [Private Pathology Provider], be approved professional indemnity insurance under the *Health Care Liability Act 2001* (NSW).

(b) [Private Pathology Provider] agrees not to do or permit to be done any act, matter or thing which renders void or voidable any of the insurances required to be effected by it under this Deed, or any insurances of [PHO].

(c) [Private Pathology Provider] must ensure that the insurances referred to in clause 1.3(a) are in force before the [Private Pathology Provider] commences providing the Services contemplated by this Deed and are maintained in force until the [Private Pathology Provider] ceases to provide the Services and for a period of 7 years thereafter.

(d) A [Private Pathology Provider] will satisfy the obligation to ensure that each [Pathologist] employed or engaged by [Private Pathology Provider] maintains the insurances referred to in clause 1.3(a) in force for a period of 7 years after ceasing to provide the Services contemplated by this Deed if the [Pathologist]:

(i) is covered for the entirety of that period under the run-off cover scheme established under the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth); or

(ii) maintains in force for the entirety of that period run-off cover or tail cover (howsoever described) of an equivalent limit of indemnity in respect professional indemnity as the insurances referred to in clause 1.3(a).

(e) The [Private Pathology Provider] must, in respect of the insurances referred to in clause 1.3(a), provide [PHO] acceptable proof of currency and coverage before the [Private Pathology Provider] commences providing the Services contemplated by this Deed and thereafter annually and on request from [PHO].

(f) Clauses 1.1-1.3 [indemnity and insurance clauses] survive the termination or expiry of this Deed.

#### 1.4 Termination and Suspension

[PHO] may terminate this deed with immediate effect by written notice to [Private Pathology Provider] if:

(a) [Private Pathology Provider] either:

(i) fails to comply with any obligation under this Deed (including carrying out the Services in accordance with Best Practices); or

(ii) [Private Pathology Provider] is negligent, or commits a wrongful act or omission, in providing the Services, and

(b) such failure to perform the Services, or negligence, wrongful act or omission in providing the Services, is not remedied within *30 Days* after the giving of notice by [PHO] to [Private Pathology Provider].

If the [PHO] reasonably considers the [Private Pathology Provider]’s failure under sub-clause [1.4(a)(i)] above, or negligence, wrongful act or omission under sub-clause [1.4(a)(ii)] above, gives rise to a risk to the health or life of a patient, the PHO may suspend this deed with immediate effect by written notice to [Private Pathology Provider].
### MODEL CLAUSE

**1.5 Effect of termination**

If this deed is terminated, then all rights and obligations under it terminate other than:

(a) The rights or obligations of the parties under clauses 1.1-1.3 [indemnity and insurance clauses] or any other clauses expressed to survive termination or expiry; and

(b) The rights of the parties that accrued on or before that termination.

**Best Practices** means the practices and methods reflecting best practices in the provision of pathology services by Pathologists and management of Patients requiring such services and to the standard of a tertiary health facility including:

(a) with due care and skill and administered in a timely and efficient manner and without unnecessary or unreasonable delays;

(b) in accordance with all relevant or applicable codes of practice (including Occupational Health and Safety Codes), accreditations, authorisations, statutory, regulatory or professional requirements or practices for the delivery of pathology services, including the Services, and such other standards, requirements and guidelines as [the PHO] may nominate and notify to the [Private Pathology Provider] from time to time;

(c) in accordance with any standards, guidelines or requirements in respect of pathology services which are issued or endorsed by the NPAAC or the Therapeutic Goods Administration from time to time;

(d) in accordance with any standards and guidelines in respect of pathology services, as may be published from time to time by the Clinical Excellence Commission, the Australian Council on Health Care Standards (ACHS), or the Royal College of Pathologists of Australasia (RCPA);

(e) in accordance with the New South Wales Ministry of Health’s Employment Checks - Criminal Record Checks and Working with Children Checks (PD2013_028) and any other policy or guideline of the New South Wales Department of Health or of the [PHO], which relates to the safety and care of patients, and which is notified to [Private Pathology Provider] by [PHO] from time to time;

(f) complying with all NSW Health data collection and other requirements with regard to the Services, and those required to enable [the PHO] to comply with its reporting requirements to NSW Health, as notified by [the PHO] to [Private Pathology Provider], including those in relation to the performance standards required under the NSW Health quality and safety framework and complying with NSW Health’s Booked Patient Management Operating Guidelines;

(g) in accordance with the Hospital’s security and identification requirements, as notified to [Private Pathology Provider] from time to time;

(h) causing as little disturbance as possible to the operation of the Hospitals or [the PHO];

(i) in accordance with any Performance Criteria agreed in writing between [PHO] and [Private Pathology Provider];

(j) [complying with [the PHO]’s Code of Conduct as in force from time to time and notified to [Private Pathology Provider];] and

(k) [complying with the reasonable directions of [PHO]’s Chief Executive or delegate (but not so as to derogate from [Private Pathology Provider]’s obligations under this Agreement).]

**Hospitals** means [list hospitals for which PHO is responsible and which are to be covered by the agreement].

**NPAAC** means National Pathology Accreditation Advisory Council, which is managed by the Australian Government Department of Health and Ageing.

**Pathologist** means a registered Medical Practitioner holding specialist qualifications in pathology (Fellowship or other specialist recognition) for the purposes of the Health Insurance Act 1973 (Commonwealth) [approved in writing by [PHO] (such approval not to be unreasonably withheld).]
**C. PATHOLOGY**

<table>
<thead>
<tr>
<th><strong>Patient</strong> means private inpatient, being a patient who is an eligible person under the provisions of the Health Insurance Act 1973 (Commonwealth) and who elects to receive treatment or services as a private patient (as defined in the National Healthcare Agreement between the Commonwealth of Australia and the States and Territories, including the State of New South Wales) at the Hospitals.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Criteria</strong> may be agreed between the Hospital and [Private Pathology Provider], and include criteria such as turn around times. If the parties have agreed to Performance Criteria, the criteria must be set out in Schedule [1] to this deed.</td>
</tr>
<tr>
<td><strong>Policy</strong> means the policy issued by the New South Wales Department of Health in relation to the provision of pathology services to private in-patients in public hospitals.</td>
</tr>
<tr>
<td><strong>Services</strong> means pathology services to be provided by [Private Pathology Provider] to a Patient upon referral by the Patient’s treating doctor in accordance with the Policy.</td>
</tr>
</tbody>
</table>
The Institute of Clinical Pathology and Medical Research is granted approval to charge for pathology services to patients of recognised hospitals and of private practitioners. However, the approvals related to those services “other than those of public health significance”.

The Department of Health, NSW determines which tests performed in the Institute of Clinical Pathology and Medical Research are of public health significance and under what circumstances should be exempted from payment of fees.

Those services provided by the Institute in relation to those diseases listed in Table 1 charges are exempted in all cases. Table 1 lists those communicable and notifiable diseases which are a major threat to the community. When such conditions are diagnosed or suspected, tests are carried out immediately to prove the diagnoses, or to detect carriers and ascertain the status of those who have been in contact with the patients. The table includes tests for tuberculosis and sexually transmitted diseases for which the Minister for Health had previously granted exemption from charging.

Table 2 lists those diseases which are less of a threat to the community than those listed in Table 1 but which are notifiable under the Public Health Act. Services provided by the Institute of Clinical Pathology and Medical Research with respect to diseases listed in Table 2 will be exempt from fees (a) when investigations of the notifiable disease will need to take place pursuant to any action under the Public Health Act 1991, or (b) in the course of epidemiological surveys or to prevent an outbreak of such diseases. The investigations for diseases listed in Table 2 will be exempt from fees only when requested by the Senior Specialist - Public Health, Director or Deputy Director, Division of Epidemiology or a Regional Director, Deputy Regional Director or Assistant Regional Director of Health.

Table 3 lists a number of infectious conditions which are not notifiable under the Public Health Act, but which may assume importance in the public health situation from time to time and would need to be investigated and controlled. The tests related to diseases listed in Table 3 should be exempted from charges if requested by any one of the Health Department officers as are listed for diseases in Table 2.

**TABLE 1**

Arbovirus infection (including Dengue)
Diphtheria
Leprosy
Poliomyelitis
Smallpox
Sexually Transmitted Disease (all forms)
Tuberculosis (all forms)
Typhoid and Paratyphoid fever
Typhus (all forms)
### TABLE 2

- Acquired immunodeficiency syndrome (AIDS)
- Acute viral hepatitis
- Arboviral infections
- Brucellosis
- Diphtheria
- Foodborne illness in two or more related cases
- Gastroenteritis among people of any age, in an institution
- Gonorrhoea
- Haemophilus influenzae type B:
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hepatitis D (Delta)
- Hepatitis E
- Human immunodeficiency virus (HIV) infection
- Hydatid Disease
- Legionella Infections
- Leprosy
- Leptospirosis
- Listeriosis
- Malaria
- Measles
- Meningococcal infections
- Mumps
- Mycobacterial infections including M tuberculosis
- Ornithosis
- Paratyphoid
- Pertussis (Whooping Cough)
- Poliomyelitis
- Q Fever
- Rubella
- Salmonella infections
- Syphilis
- Tetanus
- Typhoid
- Any other infectious conditions as determined from time to time.

### TABLE 3

- Conjunctivitis (epidemic)
- Chorioretinitis (Toxoplasmosis)
- Erythematous/Rashes Unknown aetiology
- Glandular fever
- Pediculosis
- Methicillin Resistant Staph. Aureus in Hospitals
- Primary Meningoencephalitis (Amoebic)
- Post vaccination, seroconversion
- Nosocomial infections
- Scabies
- Diseases caused by Coxsackie, Adenovirus, or other viruses
- Any other conditions as may be determined from time to time.
ACCREDITATION OF NSW HEALTH PATHOLOGY LABORATORIES

The Commonwealth requires that for a pathology service to attract Medicare benefits the pathology laboratory is to be accredited for the kinds of services that are being provided. The standards used to assess accreditation for pathology laboratories are Standards for Pathology Laboratories developed by the National Pathology Accreditation Advisory Council (“NPAAC”). These set out the minimum standards acceptable for good pathology practice in Australia. It should be noted that these Standards also require the laboratory to be certified to ISO 15189:2003 | AS4633-2004. The Commonwealth has chosen the National Association of Testing Authorities (NATA) to act on its behalf to undertake the accreditation and certification of laboratories. For full information of the Commonwealth’s requirements for obtaining accreditation refer to the Medical Benefits Schedule Category 6 — Pathology Services which can be obtained from http://www9.health.ppv.au/mbs/index.cfm.

NSW Area Health Services are to ensure that the accreditation of pathology laboratories is maintained. By maintaining accreditation it is expected that laboratories will meet uniform standards of practice, competently perform tests/examinations, and produce accurate and reliable results for the tests for which they are accredited.
D. SALARIED MEDICAL SPECIALISTS – RIGHTS OF PRIVATE PRACTICE

SALARIED MEDICAL SPECIALISTS EMPLOYED IN AREA HEALTH SERVICES, SECOND, THIRD AND FOURTH SCHEDULE HOSPITALS AND ORGANISATIONS RIGHTS OF PRIVATE PRACTICE (PD2005_429)
(POLICY PD2005_429 WITHDRAWN 14 AUGUST, 2013)

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102(14/8/13)
1. INTRODUCTION

1.1 Following upon the recommendations contained in the Final Report of the Committee of Inquiry into rights of Private Practice in Public Hospitals (the Penington Committee) negotiations were conducted with the Public Medical Officers’ Association concerning the rights of private practice for staff specialists in Second and Third Schedule hospitals and Fourth Schedule organisations. Substantial agreement was reached with the Association on new arrangements to apply from 1st January 1985, details of which were set out in PD2005_429 (Obsolete).

1.2 Further discussions were subsequently held on matters that needed clarification. PD2005_429 (Obsolete) consolidated the results of those discussions.

1.3 Following arbitration of a dispute between the parties, an amendment to the above Circular was issued as PD2005_429 (Obsolete).

1.4 In 1989 the parties reached agreement on a number of points arising from a claim made by the Association. This Circular reflects the agreed position of the parties.

1.5 The arrangements are based on the adoption of the principal recommendations of the Penington Report which are enumerated at Recommendation 40.

2. ARRANGEMENTS PRIOR TO 1ST JANUARY 1985

Staff specialists employed as at 31st December 1984, may continue to work under their present private arrangements whilst ever they are employed in the Second/Third/Fourth Schedule system, of Area Health Boards, including if they transfer from one hospital to another (provided their services are “continuous” as defined in the Transferred Officers’ Extended Leave Act) subject to the following:

2.1 “Present arrangements” means whichever of Arrangement “A”, “B”, “C” or “D” of PD2005_499 or other previously approved arrangements, the officer was working under as at 31st December 1984.

2.2 In the case of Arrangement “C”, an officer is limited to whichever of the three (3) remuneration packages he/she was working under as at 31st December 1984. Such officers will be regarded as being on part-time leave without pay.
2.3 Officers who remained on PD2005_499 arrangements are also to retain existing Trust Fund arrangements, contained in that Circular, except that all recommendations for disbursements are to require approval by the Board of Directors which shall have a right to disallow or vary these recommendations. Operation of Trust Funds are to be subject to audit annually with the cost thereof being met by the trust funds.

2.4 Where a staff specialist elects to remain with PD2005_499 private practice arrangements he/she has the right to transfer to one of the new Schemes described hereunder in any subsequent financial year. However, where a Staff Specialist does transfer to one of the new Schemes he/she cannot later transfer back to the pre-1985 arrangements.

2.5 The pre-1985 arrangements are not available for any staff specialist employed after 31st December 1984.

3. CURRENT ARRANGEMENTS

The following arrangements apply from the first pay period on or after 12 December 1989. Arrangements in the period between 1 January 1985 and 12 December 1989 are detailed in PD2005_429 (Obsolete).

For the purpose of this agreement, salary shall mean actual award salary plus the Special Allowance as defined in Point 4.

3.1 Scheme “A”

(i) Payment of a salary supplement of 20 per cent of the officer’s salary (excluding any administrative allowance) (refer clause 3 for Definition of Salary) from the General Fund. PAYE taxation deductions are to be made in respect of these payments.

(N.B. Participants in Scheme “A” have no entitlement to the private practice expenses allowance or the “second hospital” allowance which applies under Scheme “B” but they are eligible for the 17.4 per cent special allowance.

3.1 (ii) It is a requirement of participation that the payment of the Scheme “A” allowance is conditional upon the Specialist Medical Officer giving the hospital written authority to render accounts in his name to all chargeable patients he/she might see in the course of his/her duties.
D. SALARIED MEDICAL SPECIALISTS – RIGHTS OF PRIVATE PRACTICE

(iii) Study Leave and Conference Leave shall be accrued on the same basis as for Scheme “B” and paid out of the General Fund.

3.2 Scheme “B”

This Scheme will include the following features:

(i) one Trust Fund for all participants within the hospital;

(ii) subject to legal advice on the taxation and trust aspects, one or both of the alternative models proposed by the Penington Report (Recommendation No. 18) must be adopted; viz. control of management of Trust Funds should rest with the Board of Management of the hospital or its equivalent through a Committee on which either nominees of the Board form a majority or where this is not so, that all recommendations for disbursements require approval by the Board with a right to disallow or vary these recommendations. Operation of Trust Funds is to be subject to audit at least annually;

(iii) participating specialist to have drawing rights (to be made calendar monthly) from Trust Fund in accordance with their individual or agreed group (e.g. “Departmental”) contributions to the Fund up to a maximum of 25 per cent of salary (excluding any administrative allowance). (refer clause 3 for Definition of Salary)

Note: Where individual or agreed group contributions are not sufficient to permit drawings of 20 per cent of salary, supplementation up to 20 per cent to be made from that proportion of charges which would otherwise have been appropriated as facility charges paid to the hospital/AHS by staff specialists.

Where individual or agreed group contributions are sufficient to permit drawings of 20 per cent but less than 25 per cent of salary, (excluding administrative allowance) supplementation up to 25 per cent to be made from that proportion of charges which would otherwise have been appropriated as facility charges paid to the hospital/AHS by staff specialists.

Supplementation to the 20 per cent of salary level is to be made quarterly, at 31st March, 30th June, 30th September and 31st December each year. An adjustment is to be made at 30th June each year in cases where supplementation may have occurred in one or more quarters but receipts in excess of 20 per cent were made in other quarters.

Supplementation to the 25 per cent of salary level, in appropriate cases, is to be made once each year, i.e. for the year ended 30th June.

PAYE deductions are not to be made in respect of Scheme “B” in relation to monies paid from the Trust Fund.
(iv) Where sufficient Trust Funds are available from the individual or agreed group contributions after payment of the initial drawings, further drawings (to be made calendar monthly) up to a maximum of 15 per cent of salary may be permitted by way of a private practice expenses payment.

(v) (a) Where by agreement between hospitals, a participating specialist provides a regular service at a hospital other than normally works the one in which he/she is employed, further drawings (to be made calendar monthly) up to a maximum of 10 per cent of salary may be permitted provided sufficient Trust Funds are available from the individual or agreed group contributions after payment has been made for the initial drawing and private practice expenses payment.

(b) Where under circumstances involving the acceptance of additional responsibilities (such as providing a regular service to a different hospital to the one in which he/she normally works without attending at that hospital) he/she may, subject to the Corporation’s approval, make drawings as provided in (a) above.

(c) The maximum drawings that may be made under 3.2(v) of this Circular is 10 per cent of the salary.

Note: Payment of the further drawings permitted under sub-clauses (iv) and (v) above are to be made calendar monthly, subject to there being sufficient Trust Funds available. An adjustment is to be made at 30th June each year in cases where sufficient Trust Funds were not available in a particular month to enable payment to be made to eligible staff specialists but Trust Fund funds over the whole year are sufficient to enable payments under sub-clause (iv) and/or (v).

(vi) The drawings referred to in (iii), (iv), (vi) and (v) above shall be payable during paid absences on approved annual, sick, long service, conference and study leave but shall not be paid where the monetary value of leave is paid on the termination of employment. The said drawings shall only be considered in relation to private practice and shall not be taken into account for the calculation of any award entitlement or public sector superannuation purposes.

3.3 Full Time Staff Specialists with Approved Leave Without Pay (Scheme “C”)

Staff specialists are permitted to elect to take leave without pay subject to the following conditions:
D. SALARIED MEDICAL SPECIALISTS – RIGHTS OF PRIVATE PRACTICE 6.64

(i) leave without pay is permitted for 25 per cent of the full-time commitment in that specialty;

(ii) no private practice is to be undertaken during the 75 per cent of time for which a salary is payable (this relates to aggregated time and means that participating specialists must not spend more than an average of 25 per cent of their total working time in the treatment of private patients).

(iii) private practice is limited geographically to the employing hospital, except where approval is given by the principal employing hospital, because of special circumstances, to undertake “outside” private practice;

(iv) participating specialists are to contribute to the same Trust Fund as other full-time specialists;

(v) total drawings by each participating specialist, subject to sufficient individual or agreed group contributions to Trust Funds, to be a maximum of 100 per cent of full-time salary (excluding any administrative allowance). (refer clause 3 for definition of salary);

(vi) the drawings referred to in (v) above shall be payable during paid absences on approved annual, sick, long service, conference and study leave but shall not be paid where the monetary value of leave is paid on the termination of employment. The said drawings shall only be considered in relation to private practice and shall not be taken into account for the calculation of any award entitlement or public sector superannuation purposes.

PAYE deductions are not to be made in respect of Scheme “C” in relation to monies paid from the Trust Fund.

3.4 Half-time Employment (Scheme “D”)

Subject to the service requirements of the employing hospital, half-time employment is to be permitted subject to the following conditions:

(i) employment to be 50 per cent of the full-time commitment in that specialty with entitlements to pro-rate leave entitlement;

(ii) no private practice is to be undertaken during the time for which a salary is payable;
(iii) approval to operate under this Scheme includes the automatic appointment of the Specialist as a Visiting Medical Practitioner. Except in the cases where the initial appointment was to Scheme D, if the hospital declines to renew an appointment as a Visiting Medical Practitioner, the Specialist has the option to automatically revert to one of the full-time schemes. Private practice must be conducted on the same basis as applies to Visiting Medical Practitioners;

(iv) half-time Specialists working under this Scheme cannot remain at the hospital on a geographic full-time basis. There must be an “outside” private practice;

(v) half-time Specialists who hold visiting practitioner appointments at hospitals other than their employing hospital, may accept sessional payments in respect of services provided to public patients at those other hospitals;

(vi) where a Specialist gains approval to operate under Scheme “D” and transfers from a full-time scheme, sick leave shall be subject to the following conditions:

(a) sick leave accrued at the date of transfer shall remain available;

(b) while operating under Scheme “D” sick leave shall accrue at the normal rate of 14 calendar days per year;

(c) sick leave taken while under Scheme “D” shall be paid for at half the full-time rate of pay;

(d) sick leave taken while under Scheme “D” shall be credited firstly against sick leave credits accrued whilst under Schedule “D” and then against sick leave credits accrued whilst a full-time staff specialist.

(vii) If a staff specialist referred to in (vi) above subsequently transfers from Scheme “D” to Scheme “A”, Scheme “B” or Scheme “C”, sick leave accruals shall be treated as follows:

(a) sick leave to credit at the date of transfer, which has not been utilised shall be credited to the full-time staff specialist on the basis of one half day’s credit for each day accrued;
(b) sick leave to credit at the date of transfer, which accrued whilst under a previous period as a full-time staff specialist, which has not been utilised, shall be credited on the basis of one day’s credit for each day accrued.

(viii) For a staff specialist who transfers from Scheme “D” to Scheme “A”, Scheme “B” or Scheme “C”, sick leave accrued but not utilised, whilst under Scheme “D” shall be credited to the full-time staff specialist on the basis of one half day’s credit for each day accrued.

(ix) Specialists employed under Scheme “D” shall be entitled to the paid leave at half time rates set out in Clause 6 Conference Leave and Clause 7 Study Leave of this Circular, but, subject to Clause 8.4 Subsistence Allowance, shall not be entitled to Airline Tickets or Expenses (paid either from General Funds or Trust Funds) for that proportion of their service spent working under Scheme “D”.

3.5 Staff specialists may elect whichever of Schemes “A”, “B” or “C” they wish to work under each financial year. No separate approval, by the Board of the employing hospital/AHS is required. However, half-time employment is permissible only at the discretion of the employing hospital.

4. SPECIAL ALLOWANCE

4.1 All staff specialists working under any of the new arrangements operating from 12 December 1989 shall be paid a Special Allowance of 17.4% of award salary.

Officers working only 75 per cent or 50 per cent of full-time shall be paid 75 per cent or 50 per cent respectively, of the allowance which would be paid to them if they worked in a full-time capacity. Payment of this allowance is to be funded from the General Fund.

4.2 This allowance shall be payable during paid absences on approved leave and shall be paid where the monetary value of leave is paid on the termination of employment. The allowance shall be considered part of the base rate as defined for all purposes, including the allowance in lieu of exercising a right of private practice in Scheme “A” and Private Practice drawings in Scheme “B” and “C”.

4.3 The allowance is to be met as an award cost.

4.4 It should be noted that payment of this allowance does not apply in the case of any officer who elects to continue working under the pre-1985 private practice agreement.
4.5 The Special Allowance is to be considered as salary for Superannuation purposes.

5. **ON-CALL AND RECALL**

5.1 It has always been part of the job requirements for staff specialists that they be available at any time specified by their employer and consequently the Department would consider that such arrangements should continue.

As such all staff specialists working under any of the new arrangements operating from 12 December 1989 should be available for on-call and recall duties outside of the hours of 8.00 a.m. to 6.00 p.m. Monday to Friday and on weekends and public holidays.

6. **CONFERENCE LEAVE**

6.1 One period of leave, of up to one week, on full pay shall be allowed to each staff specialist participating in Schemes “A”, “B” or “C” during each year of continuous service in one or more public hospital in New South Wales for the purpose of **conference leave**; provided that where, in any year of continuous service, the whole or any part of such leave is not taken by the officer nor granted by the hospital, any leave not so taken shall be granted during the following year provided further that the maximum amount of such leave that may be allowed to any officer shall not exceed two (2) weeks in any year of continuous service.

6.2 Conference leave may be taken during the year in which it accrues.

6.3 In respect of each period of conference leave a specialist shall be granted:

(i) The actual cost of air fares up to a maximum cost of Business Class rates (in the case of Scheme “A” participants, air fares are also limited to a maximum of the cost of a Business Class Sydney/Perth return fare), or where air travel is not available, First-class return rail fares; and

(ii) Subsistence allowance in accordance with Clause 8.1.

6.4 Fares and expenses associated with conference leave are to be funded as follows:

(i) for specialists on Scheme “A” - from the General Fund;

(ii) for specialists on Schemes “B” or “C” - from Trust Fund residual.
7. STUDY LEAVE

7.1 Each staff specialist participating in Schemes “A”, “B” or “C” shall be allowed three (3) months leave on full pay after five (5) years continuous service in one or more public hospital/AHS in New South Wales for the purpose of overseas study leave and shall be allowed a further period of three (3) months leave on full pay for each completed period of five (5) years continuous service thereafter with such leave being allowed to be deferred, provided that no officer shall be allowed to take accumulated leave in excess of six (6) months in any one period; provided further that an officer who has served for a minimum of five (5) years may, subject to employer convenience, elect to take his/her overseas study leave in broken periods.

7.2 In respect of each period of study leave a staff specialist on Scheme “A” shall be granted a travelling and subsistence allowance in accordance with Clause 8.

7.3 The actual cost of air fares up to a maximum of Business Class rates shall also be granted to a staff specialist. In all cases a maximum of three air fares shall be paid in respect of each completed five years continuous service where leave is taken in broken periods at employer convenience. The source of funding for fares and expenses associated with Study Leave is to be the same as for Conference Leave and therefore depends on the nature of the Scheme selected as to whether it is paid from General or Trust Funds.

8. SUBSISTENCE ALLOWANCE (CONFERENCE AND STUDY LEAVE)

8.1 The subsistence allowance payable to staff specialists under Scheme “A” for expenses associated with Conference Leave and Study Leave shall be in accordance with the rates determined by the New South Wales Public Service Board for Special Division Officers and Full-Time Statutory Appointees employed in the New South Wales Public Service, as varied from time to time.

If Conference Leave or Study Leave is taken within Australia a daily allowance is payable in recompense for all expenses OR an amount equivalent to the actual necessary expenses for meals and accommodation together with a daily rate determined for incidental expenses is payable.

If Conference Leave or Study Leave is taken outside of Australia a daily rate is paid plus actual accommodation expenses. The rate of the daily allowance is dependent upon the level of the staff specialists base award salary.
Because of a number of variables (e.g. the multiplicity of currencies, regular changes to the rates etc.) it is not intended to advise the actual amounts payable from time to time. Specific details can, however, be obtained by telephoning the Industrial Relations Unit of the Premier’s Department on (02) 228-4381. In seeking such information from this Unit it is important to quote the **salary actually being paid to the staff specialist at the date the conference or study leave is to commence**.

Should a staff specialist consider that he/she has been disadvantaged by the payment of the above allowances he/she may claim all inclusive actual expenditure. Any such claim should be assessed for reasonableness by the hospital/area health service.

8.2 The subsistence allowance for Specialists under Scheme “B” or “C” is a matter for the Trustees of the appropriate Staff Specialists’ Hospital Charitable Trust to determine having due regard to the payment made to Specialists under Scheme “A”.

8.3 No subsistence allowances or travelling expenses are payable to staff specialists under Scheme “D” except as provided for in 8.4 hereunder.

8.4 Where a specialist transfers to or from Scheme “A” and has accrued a right to study leave partly under Scheme “A” and partly under Scheme “B”, “C” or “D”, he/she shall be entitled to receive from the hospital’s general fund 1/20th of the cost of return air fare and 1.5 days subsistence allowance for each completed month of service under Scheme “A”, less any study leave already taken in respect of study leave accrued under Scheme “A”. Both air fares and subsistence allowances shall be calculated at the rates applying at the time of the taking of the leave. Accommodation expenses may also be paid at the rate of 1.66% of total accommodation costs, for each completed month of service served under Scheme “A”.

9. TRAVEL INSURANCE

In respect of travel undertaken by Specialists under **Clause 6 Conference Leave** and **Clause 7 Study Leave** the following arrangements are to apply:

9.1 The Managed fund has arranged for the Department, its Areas and Hospitals additional short-term cover for the period the Specialist is overseas in the event of death, for an amount not less than ten times the salary (as defined in clause 3) for the individual staff member, payable to the Specialist’s nominated beneficiary.

At the present time the Department will not be seeking repayment from either the Hospital or the Trust Fund. (91/88)
9.2 For Specialists under Schemes “B” and “C” the Trust Fund is to arrange appropriate insurance having due regard for the arrangements made for Specialists under Scheme “A”.

10. PRIVATELY REFERRED NON-INPATIENTS

10.1 The Department of Health has completed negotiations with the New South Wales Public Medical Officers’ Association and other bodies regarding charging arrangements for privately referred non-inpatients to all staff specialists who have been granted rights of private practice by the hospital or area health service (previous PD2005_502 (Obsolete) and PD2005_501 (Active) still apply).

10.2 The arrangements will not affect those patients who are inpatients or registered non-inpatients of a recognised hospital but will apply to privately referred non-inpatients who satisfy the following conditions:

(i) The referral must be to the doctor by name and not to the hospital or the outpatient department.

(ii) The referral must be made by a doctor in private practice (including a staff specialist or visiting medical officer exercising a right of private practice); it must not be made by an intern, a resident medical officer, registrar or medical superintendent.

(iii) No patient who presents at casualty or an outpatient clinic is to be privately referred for treatment of, or examinations relating to, the episode of illness which caused him/her to present at casualty or the outpatient clinic.

(iv) At the time the appointment is being made, patients are to be advised that they will not be treated as registered non-inpatients of the hospital, and that they will be charged by the attending specialist(s) as well as for diagnostic services ordered by that specialist.

(v) Referrals are to be genuine referrals made “at arm’s length”, i.e. the referral letter should be completed before the patient’s first appointment is made for an examination, treatment or consultation.

10.3 In General

(i) Privately referred non-inpatients will not be registered as non-inpatients.
(ii) The hospital will issue accounts as the agent and the fees collected will be recorded and disbursed under the terms and conditions under which the staff specialists engage in private practice.

(iii) It is the doctor’s responsibility to ensure that the criteria for a privately referred non-inpatient outlined in this Circular have been met.

11. DISPUTES PROCEDURES

11.1 Should a dispute occur between the Association and the Department:

(i) concerning rights of private practice;

(ii) concerning an interpretation of this Circular;

(iii) concerning this agreement or its interpretation;

(iv) concerning any breach or alleged breach of any of the provisions of this Circular

such disputed matter(s) may be referred to a Committee of two or four persons on which the Association and the Department will be equally represented.

11.2 The Committee shall investigate the disputed matter(s) and endeavour to recommend upon how the dispute should be resolved.

11.3 If the dispute is not resolved by reference to a Committee referred to in 11.1 above the Association may seek in writing that the matter be considered by the President of the Association and the Director, Human Resources of the Department of Health who may by mutual agreement:

(i) make a joint determination as to the matter in which the matter in dispute may be solved;

(ii) refer the matter to a person selected by them for determination in which case the determination of such person shall be final.

11.4 No party shall initiate any action at law or in equity in respect of any dispute between the parties regarding any matter arising from an interpretation of this Circular until such dispute has been dealt with in accordance with this Clause.

11.5 Each party shall be responsible for the payment of his own costs and expenses in the resolution or determination of the referred matter or matters.
12. GENERAL ACCOUNTING PROCEDURES

12.1 It should be noted that accounting records in respect of fees raised for services rendered to private patients by specialists working under Arrangements “B” and “C” will need to be kept separately from those records maintained in respect of visiting medical officers.

12.2 All accounts for services rendered to private patients by specialists working under Arrangements “A”, “B” and “C” are to be issued by the hospital acting as the agent for the specialists, only with the prior approval of the specialist as to the quantum, in the specialist’s name. In no case shall a fee be charged in excess of the schedule fee contained in the Commonwealth Department of Health Medical Benefits Schedule Book.

12.3 It should be noted that the hospital must also obtain, in writing, authority from each specialist prior to the issue of any accounts in his/her name.

12.4 All fees when received, by whomsoever received, shall be dealt with in accordance with this instruction.

12.5 Details regarding fees raised and moneys received are to be made available to each participating specialist.

12.6 Applications for conference and study leave which do not meet the terms prescribed by these Instructions may be considered by the hospital in the light of the circumstances of each individual case and, if considered justified, shall be the subject of a recommendation to the Department for its approval or otherwise.

12.7 There shall be no entitlement to the payment of the monetary equivalent of conference or study leave not taken or not granted, or to any further payment from a trust fund in accordance with the foregoing provisions, by the employing hospital on the termination of an officer’s service for any reason to that staff specialist.

12.8 Accounting procedures for PRIVATE PRACTICE TRUST FUND provisions are also incorporated in the Accounts & Audit Determination and the Accounting Manual for Area Health Services and Public Hospitals.

12.9 Expenditure from Private Practice Trust Fund

There shall be paid into the Private Practice Trust Fund 100% of fees received arising from the rendering of accounts to private patients seen by those specialists who are working under this arrangement.
12.9.1 From the fees so paid into the Private Practice Trust Fund, there shall be paid as a first charge the following facility charges to the hospital for the provision of services and facilities, which will be percentage of the gross fees received pursuant to paragraph 12.9.

(i) fees received for diagnostic radiology (see v), nuclear medicine and ultrasonic scans, 40%.

(ii) computerised tomography, 84% (83/141)

(iii) fees received for pathology services:-

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histopathology</td>
<td>20%</td>
</tr>
<tr>
<td>(including cytolopathology)</td>
<td></td>
</tr>
<tr>
<td>Microbiology</td>
<td>60%</td>
</tr>
<tr>
<td>Immunology</td>
<td>60%</td>
</tr>
<tr>
<td>Haematology</td>
<td>80%</td>
</tr>
<tr>
<td>Chemical Pathology</td>
<td>90%</td>
</tr>
</tbody>
</table>

(iv) other fees received (including cardiological and neurophysiological) 20%

(v) for Radiation Oncology and field settings items 15203 to 15214 and 15500 to 15533 the facility charge is **NIL**.

The following procedures shall be deemed to be histopathology procedures for the purpose of these charges:

- infertility and pregnancy tests;
- anatomical pathology;
- gross and microscopic examinations;
- frozen section examinations;
- bone marrow reporting;
- cytology entirely reported by the pathologist without technical scanning assistance;
- other procedures performed entirely by the pathologist such as skin allergy test, Mantoux tests, Schillings and BSP tests, lumbar punctures and joint fluid aspirations;
- cytology reported with technical scanning assistance shall be deemed to be a chemical procedure for the purpose of these charges.
12.9.2 Facility Charges for Scheme “D”

Facility charges for staff specialists/visiting medical officers operating under Scheme “D” are to be applied on the same basis as those percentages applying to visiting medical officers.