This amendment reflects the provisions of the following Policy Directives/Guidelines/Information Bulletins:

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<td>PD2005_505</td>
<td>Repatriation Patients, Ex-Service Personnel and Dependants of Deceased Ex-Servicemen - Procedures</td>
<td>Government Relations advised 14/3/19 the PD should not be active and they will organise to make it obsolete.</td>
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<td>Veterans Entitled Provision of Public Health Services - 1998/99 Arrangements</td>
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Where a number appears at the bottom of an amended page [e.g. 252(17/09/15) – amendment number, date] an alteration has been made or new section included. Amendment numbers are sequential, the date represents the date the source document was published on the Policy Distribution System (PDS).

With this amendment the following pages have been updated on line on 14 March 2019

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MEDICARE INELIGIBLE AND RECIPROCAL HEALTH CARE AGREEMENT – CLASSIFICATION AND CHARGING FOR NSW PUBLIC HEALTH SERVICES (PD2016_055)

1 PD2016_055 rescinds PD2016_031

2 PURPOSE
This Policy Directive provides the key policy information about the classification and charging of overseas visitors, temporary Australian residents and other Medicare ineligible persons for services provided by NSW public hospitals and facilities.

3 MANDATORY REQUIREMENTS
Charges are to be raised for all services where a patient is not eligible for free or subsidised treatment as detailed in this Policy Directive and attached Procedures.

Hospitals are to:
- Ensure all persons presenting to an emergency department with an urgent clinical condition be assessed and provided with treatment clinically required at that time
- Identify and classify patients accurately
- Inform patients of all applicable charges
- Verify insurance status of patients
- Ensure payment or guarantee arrangements are made prior to service provision, except in emergency situations when arrangements should be made at the appropriate time
- Ensure the ability of NSW Health to fund the treatment of overseas patients does not interfere with the physical, clinical and / or financial capacity of any health service to meet clinical priorities for Australian residents.

4 IMPLEMENTATION
Local Health District / Speciality Health Network Chief Executives are to ensure that the requirements of this Policy Directive and Procedures are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

Staff can access the State-wide Revenue Toolkit at http://staterevenue.wsha.nsw.gov.au for further information on policy application and implementation.

1 BACKGROUND

1.1 About this document
This document has been created to:
- Provide a consolidated reference document of policy determinations and other information relevant to charging overseas visitors, temporary residents and Medicare Ineligible persons for services provided by NSW Health public hospitals and facilities
- Enable staff to easily establish the correct classification of overseas visitors, temporary residents and Medicare Ineligible persons when accessing services provided by NSW Health public hospitals and facilities.
2 INTRODUCTION

2.1 Key principles

1. All persons presenting to an emergency department with an urgent clinical condition should be assessed and provided with treatment clinically required at that time.
2. Treatment of overseas patients must not interfere with the physical, clinical and/or financial capacity of any health service to meet clinical priorities for Australian residents.
3. This policy **does not** apply to the following categories of Medicare eligible people:
   a. Australian citizens
   b. Holders of permanent residence visas
   c. Persons applying for a permanent resident visa who have a parent, spouse or child who is an Australian citizen or has the right to stay in Australia permanently
   d. New Zealand citizens who have left NZ and are now living in Australia
   e. Diplomats and their families from a country with a Reciprocal Health Care agreement (RHCA) – other than Belgium, New Zealand, Norway and Slovenia.

**NOTE:** All the above classifications should present a valid Medicare card to confirm eligibility. If no Medicare card is presented the patient should be presumed ineligible until such time as a card is presented.

4. All persons **not** in one of the above categories are Medicare Ineligible. In accordance with this policy directive they must be:
   a. Assessed for eligibility for medically necessary treatment at no charge or
   b. Charged at the appropriate rate.

Where required, interpreters and family or community support should be utilised to ensure all the necessary information is captured to determine the patient’s status

*The flow chart in section 2.3 and detailed policy in section 3 guides this assessment and determination.*

2.2 Terminology

*Valid Medicare Card*
Name is consistent with other identification and dates of service provided are within dates on card.

*Eligible Insurance*
Insurer has been contacted, insurance cover is appropriate to treatment and payment has been guaranteed.

*Health Service*
Inclusive of NSW public: hospitals, outpatient clinics, community health, mental health, palliative care, transactional teams, executive teams, and any other location or service directly related to NSW Health
2.3 Quick Reference Flow Chart
This Policy Directive introduces a simplified approach to classification and charging of Medicare Ineligible persons.
3  PATIENT CLASSIFICATION

3.1  Compensable Patients

All compensable patients including overseas visitors and temporary Australian residents who meet the criteria for coverage by a compensable insurer or employer must be classified under the appropriate financial classification and normal charging arrangements for compensable patients applied. The categories this applies to are:

- NSW motor vehicle accidents - Motor Accident Authority (MAA) and the Lifetime Care Support scheme (LTCS)
- Workers compensation - employer or insurer
- Third party insurer - public liability claim in place, or interstate motor vehicle accident (MVA).

**Process**

Using the patient interview and admission election/declaration form, ensure:

- All patient details are captured
- Alternative election and/or payment details in the event that the compensable claim is rejected

3.1.1  NSW Motor Accident Authority - MAA at Fault

For Medical Billing purposes only, the driver/rider at fault is not considered a compensable patient and must make an alternative election according to eligibility: Reciprocal Health Care Agreement (RHCA), Medicare Ineligible, Private, Public, Department of Veterans Affairs (DVA).

For accommodation purposes the patient is covered under the bulk billing arrangement.

**Process**

Collect medical billing payment up front or ensure guarantee of payment.

3.2  Prisoner

All prisoners, including overseas visitors and temporary Australian residents, are entitled to free medically necessary inpatient and non-inpatient services provided by NSW public hospitals. For full fees policy on prisoners, refer to current Policy Directive titled Health Services Act 1997 - Scale of Fees for Hospital and other Health Services.

**Note:** For immigration detainees see section 3.10

3.3  Victim of Crime

Where an overseas visitor or temporary Australian resident presents at a NSW public health service as a victim of crime for inpatient or non-inpatient treatment they are to be classified according to the following:

- If the police are in attendance or have supplied an event number, which confirms that the person is a victim of crime, then treatment should be provided by a hospital nominated doctor and the patient is to be classified as Medicare Ineligible but no hospital/medical charges are to be raised.
- In all other instances the patient is classified and charged in accordance with this document, e.g., RHCA, Overseas Visitor, etc.
3.4 Organ Donor

Once the determination has been made, following appropriate policy, that a brain dead patient is a potential donor the potential donor should be classified as non-chargeable.

Live donation

When a suitable foreign donor has been accepted for a live transplant for a Medicare eligible Australian resident they should be classified as a non-chargeable Medicare ineligible donor for all medical treatment related to the donation.

3.5 Reciprocal Health Care Agreements (RHCA)

Reciprocal health care agreements have been negotiated between the Commonwealth of Australia and eleven other countries. These agreements govern access to free or subsidised health care for each country’s residents when in the other country.

A ready reckoner has been developed and is available here (Appendix C)

Countries that have a RHCA with Australia are:

- Belgium
- Finland
- Ireland, Republic of
- Italy
- Malta
- The Netherlands
- New Zealand
- Norway
- Slovenia
- Sweden
- United Kingdom including:
  - England
  - Scotland
  - Wales
  - Northern Ireland
  - Isle of Man
  - Channel Isles:
    - Jersey
    - Guernsey.

To be eligible for free or subsidised treatment under a RHCA:

- The person must meet the eligibility requirements specified in the RHCA with their country.
- The treatment must be medically necessary at that time.
- The patient must be classified as a public patient in a public hospital or as a public outpatient.

This does not mean that all assessment, treatment and ongoing care must be provided by a public health organisation.

With the exception of residents of New Zealand or the Republic of Ireland, people covered by a RHCA can enrol for Medicare and access alternatives for primary and ambulatory medical care. They are able to:

- Access Medicare benefits when consulting a GP or referred to a Specialist in private practice, including diagnostics
- Access prescription pharmacy items dispensed under the Pharmaceutical Benefits Scheme (PBS).
If, after the initial clinical assessment, further diagnosis and/or care could be managed by a professional in the private sector, the patient can be advised and referred to a private sector provider. 

**Privately insured - RHCA**

People who are eligible residents of RHCA countries are entitled to elect to be treated as a private inpatient in NSW public hospitals for medically necessary and non-medically necessary treatment however, they will not be able to claim Medicare benefits to cover medical and diagnostic service charges.

It is important that eligibility checks are completed with insurers in order to fully inform the patient of their financial obligations prior to treatment.

**Dialysis - RHCA**

Acute dialysis required as part of the treatment of an urgent medical condition is part of medically necessary treatment under the RHCA.

Maintenance renal dialysis is not covered by the agreements with Malta, Italy, Finland and Norway.

Maintenance renal dialysis may be made available free of charge to other RHCA eligible visitors to Australia but this will depend on the availability of resources in the treating hospital.

**Conditions:**

- Arrangements directly between the overseas health authority and NSW health services must be made in advance of arriving in NSW and agreed to by the service provider’s General Manager or equivalent delegation level.

- No more than 10 treatments are required during one visit to Australia.

Where arrangements are not made in advance or the number of treatments exceeds 10 services, treatment should be charged at the ineligible dialysis rate. For full fees policy and rates for ineligible dialysis, refer to current Policy Directive titled *Health Services Act 1997 - Scale of Fees for Hospital and other Health Services*.

**Magnetic Resonance Imaging (MRI)**

Where the patient holds a Medicare card and a physician provides a referral indicating the MRI is required as a matter of urgency, Medicare will cover outpatient MRI services.

Visitors who do not hold a valid Medicare card are not covered for outpatient MRI services and charges should be raised to these patients at the AMA rate.

**Medically Necessary Definition**

Medically necessary refers to assessment, diagnosis and treatment of an injury, sickness or other health condition that is clinically required during the RHCA patient’s stay in Australia. It may include investigation, follow-up and stabilisation needed to enable the person to return to their home country.

The following categories of services are considered to be medically necessary:

- Emergency department assessment and treatment where the assessment and treatment cannot reasonably be referred to an appropriate professional who is able to accept new patients that day or on the next business day.

- Clinically required acute admission as a public patient to a:
  - Public hospital
  - Public mental health service.

- Admission for a non-elective booked procedure where the patient is placed on a hospital booking system and the urgency category for that booking meets the same clinical criteria as for a Medicare eligible patient.
INPATIENTS

2.5.2

- Ambulatory care, mental health services and other community health services where the
  assessment and treatment cannot be referred to an appropriate professional who is able to accept
  new patients with a time frame equivalent to that experienced by Medicare eligible patients

- Outpatient clinic attendances referred by an ED clinician or community health staff where the
  assessment and treatment cannot reasonably be referred to an appropriate professional within a
  time frame equivalent to that experienced by permanent Australian residents

- Antenatal, confinement and postnatal services equivalent to that provided to Medicare eligible
  patients in the public health system.

Inter-hospital patient transport required for continuing care.

Not covered by RHCA

RHCAs do not cover a range of health related services or other services arising from a health
condition. In addition to not covering treatment that is not “medically necessary” as outlined above,
RHCAs do not cover:

- Costs of primary ambulance services (from accident or emergency to hospital)
- Treatment that has been pre-arranged before arrival in Australia with the exception of limited
dialysis
- Funerals
- Medical repatriation costs for return home or transfer to another country.

3.5.1 Belgium

Visitors and visas not mentioned below

- Patient is eligible for medically necessary treatment as long as they can show a current:
  ○ Yellow (RHC) Medicare card or
  ○ Belgium passport and a valid European Union health insurance card.

- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment,
  including non-medically necessary. If patient intends to use their travel or health insurance it is
  important that the patient confirms their eligibility and supplies evidence to the health service.
  Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and
  charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary
  treatment under the RHCA as long as they can show a current Belgium passport and a valid European Union health insurance card.

- Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not
  mandatory.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary
  treatment otherwise they must maintain adequate health insurance to meet the cost of all health
  services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate.
  The patient may receive a refund of this charge if they obtain a Medicare card that is valid for
  the date of service.

Visa subclass 485 – Temporary graduate

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary
  treatment otherwise they must maintain adequate health insurance to meet the cost of all health
  services.
INPATIENTS

- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

**Visa subclass 405 or 410 – Retirement**
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

**Diplomat**
- Patient is not eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

3.5.2 Finland

**Visitors and visas not mentioned below**
- Maintenance dialysis is not covered by the agreement
- Patient is eligible for other medically necessary treatment as long as they can show a current:
  - Yellow (RHC) Medicare card or
  - Passport issued by Finland.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. Patient must confirm their eligibility and supply evidence to the health service. Patient will not be able to claim Medicare rebates and charges will be raised at the ineligible rate.

**Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant**
- Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

**Visa subclass 401, 403, 416, 420 or 457 – Temporary work**
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

**Visa subclass 485 – Temporary graduate**
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

**Visa subclass 405 or 410 – Retirement**
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

**Diplomat**
- Patient is eligible for full Medicare coverage
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.
3.5.3 Ireland, Republic of

Visitors and visas not mentioned below
• Patient is eligible for medically necessary treatment as long as they can show a current passport issued by the Republic of Ireland.
• Temporary visitors from the Republic of Ireland are not eligible for a Reciprocal Health Care Medicare card and only entitled to medically necessary treatment as an inpatient or outpatient of a public hospital.
• Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant
• Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420, 457 & 485 – Temporary work
• Patient is covered by the RHCA.

Visa subclass 485 – Temporary graduate
• Patient is covered by the RHCA.

Visa subclass 405 or 410 – Retirement
• Patient is not covered by the agreement and must maintain adequate health insurance or personally meet all costs as an ineligible patient.

Diplomat
• Patient is eligible for full Medicare coverage.
• Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.4 Italy

Visitors and visas not mentioned below
• Patient is eligible for medically necessary treatment as long as they can show a current:
  o Yellow (RHC) Medicare card or
  o A current passport indicating the patient is a citizen of Italy and date of entry to the country is less than 6 months prior to date of treatment.
• Maintenance dialysis is not covered by the agreement.
• Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant
• Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work
• Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment for services provided otherwise they must maintain adequate health insurance to meet the cost of all health services.
• If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.
Visa subclass 485 – Temporary graduate
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat
- Patient is eligible for full Medicare coverage.
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.5 Malta

Visitors and visas not mentioned below
- Patient is eligible for medically necessary treatment as long as they can show a current:
  o Yellow (RHC) Medicare card or
  o Passport indicating the patient is a citizen of Malta and date of entry to the country is less than 6 months prior to date of treatment.
- Maintenance dialysis is not covered by the agreement.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant
- Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat
- Patient is eligible for full Medicare coverage.
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.
3.5.6 Netherlands, The

Visitors and visas not mentioned below

- Patient is eligible for medically necessary treatment as long as they can show a current:
  - Yellow (RHC) Medicare card,
  - Passport issued by The Netherlands and a valid European Union health insurance card.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

- Patient is eligible under the RHCA.
- Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible Visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

- Patient is eligible for full Medicare coverage.
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.7 New Zealand

Temporary visitors

- Temporary visitors from New Zealand must hold:
  - A current New Zealand passport or
  - Any other current passport or current certificate of identity endorsed to the effect that the holder is entitled to reside in New Zealand indefinitely or
  - A current refugee travel document granted by the Government of New Zealand.
- Temporary visitors from New Zealand are not eligible for a Reciprocal Health Care Medicare card and are only entitled to medically necessary treatment as an inpatient or outpatient of a public hospital.
- Temporary visitors from New Zealand are eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.
Permanent residents of Australia

- New Zealand citizens with permanent resident status in Australia are eligible for full Medicare coverage and must present a current Medicare card.
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

**Visa subclasses are not applicable**

- The Trans-Tasman Travel Arrangement allows Australian and New Zealand citizens to live, work and study in each other's country without restrictions and no applicable sub-classes apply.

**Diplomat**

- Patient is **not** eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

### 3.5.8 Norway

**Visitors and visas not mentioned below**

- Maintenance dialysis is **not** covered by the agreement
- Patient is eligible for other medically necessary treatment as long as they can show a current:
  - Yellow (RHC) Medicare card or
  - Passport issued by Norway.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

**Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant**

- Patient is eligible for medically necessary treatment as long as they can show a current passport issued in Norway.
- Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

**Visa subclass 401, 403, 416, 420 or 457 – Temporary work**

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

**Visa subclass 485 – Temporary graduate**

- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

**Visa subclass 405 or 410 – Retirement**

- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

**Diplomat**

- Patient is **not** eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.
3.5.9 Slovenia

Visitors and visas not mentioned below
- Patient is eligible for medically necessary treatment as long as they can show a current:
  - Yellow (RHC) Medicare card or
  - Passport issued by Slovenia and a valid European Union health insurance card.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant
- Patient is eligible under the RHCA.
- Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat
- Patient is not eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

3.5.10 Sweden

Visitors and visas not mentioned below
- Patient is eligible for medically necessary treatment as long as they can show a current:
  - Yellow (RHC) Medicare card or
  - Swedish passport.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates and charges will be raised at the ineligible rate.
Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant
- Patient maintains cover through the Swedish National Board of Student Aid (CSN International) then patient is covered by the Reciprocal Health Agreement and should apply for and hold a current Yellow (RHC) Medicare card (this is not mandatory).
- If patient does not hold cover with CSN then patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat
- Patient is eligible for full Medicare coverage.
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.11 United Kingdom

Visitors and visas not mentioned below
- Patient is eligible for medically necessary treatment as long as they can show a current:
  - Yellow Reciprocal Health Care Medicare card or,
  - Passport issued by the United Kingdom:
    - England
    - Scotland
    - Wales
    - Northern Ireland
    - Isle of Man
    - Channel Isles:
      - Jersey,
      - Guernsey.
- United Kingdom citizens only retain eligibility under the RHCA for a period of up to five years after permanently leaving the United Kingdom, following that time they are to be treated as ineligible unless they have become Medicare eligible.
- Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.
INPATIENTS

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant
- Patient is eligible under the RHCA.
- Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 & 485 – Temporary work and graduate
- Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.
- If neither of the above conditions is met the patient must be charged at the ineligible Visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement
- Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is not covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat
- Patient is eligible for full Medicare coverage.
- Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.6 Infection control and public health containment

To enhance patient compliance and control of certain infectious diseases, with the exceptions of the specifics on charging below, the following will be supplied free of charge.

- Screening, treatment and post-exposure prophylaxis specifically for:
  o Tuberculosis (TB)
  o Leprosy
  o Other notifiable conditions subject to public health unit investigation and control such as but not limited to: hepatitis A, measles, meningococcal disease, whooping cough, typhoid and rabies.

- Infection control treatments prescribed subsequent to attendance at a Sexual Assault Service.

- Immunisation of children in accordance with the NSW immunisation schedule.

Due to the emergence of threats to public health, the specific public health conditions may vary in accordance with directions from the Chief Health Officer, Health Protection NSW or local health district public health unit directors.

Charges apply to:

Onshore Immigration Applicants

Onshore Immigration Applicants who apply to Department of Immigration and Border Protection (DIBP) to extend or amend their visa classification while in Australia are required to undertake health screening as part of their application. The applicant must meet the cost of this screening. However, if TB infection or disease is identified subsequent management, care and/or treatment is to be provided free of charge.

Commonwealth Immigration Detention Centre

Where TB Services are provided to a person held in a Commonwealth Immigration Detention Centre, the health service is to charge the Commonwealth Department of Immigration through its contractor at the appropriate ineligible rate.
Vaccinations outside the recommendations

- Where vaccination occurs outside of the specified NSW Health recommendations a charge should be raised.
- Other vaccinations and travel medication advice not mentioned above must be charged to the patient.
- Where the vaccination is provided by a public health service the charges should be the equivalent of an outpatient consult and the cost of the vaccine.

3.7 Mental Health

- Acute mental assessments and clinically required treatment for overseas visitors and temporary residents in Australia should be provided in accordance with protocols applicable to Australian residents.
- Mental health services provided to overseas visitors and temporary residents by NSW health services (whether non-inpatient or inpatient) are chargeable services.

There are two exceptions to these general charging principles:

- Unless covered by insurance, charges for periods of involuntary or compulsory mental health treatment should be waived or reduced to equal the insurance cover available. Where charges are waived, they should be reinstated once the period of involuntary or compulsory treatment has passed.
- The patient is entitled under a RHCA, the assessment and/or treatment is medically necessary and the patient wishes to receive these health services under the RHCA.

- Overseas visitors and temporary residents needing mental health assessment and treatment retain the right to make an informed choice to be a privately insured patient. The patient will not be able to claim Medicare rebates for medical and diagnostic treatments.
- The insurer will be charged at the ineligible rate.

3.8 High Risk Pregnancy services

- The primary determinant of whether a health service is provided is ensuring the safety of the mother and baby.
- Antenatal, maternity and postnatal services provided to overseas visitors and temporary residents by NSW public health services (whether non inpatient or inpatient) are chargeable services.

There are two exceptions to these general charging principles:

- Unless covered by insurance, charges for services when the pregnancy is high risk to mother and/or baby and charging for the service would result in the mother not presenting should be waived or reduced to equal the insurance cover available. Where charges are waived, they should be reinstated once the need for high risk treatment has passed.
- The mother is entitled under a RHCA, the assessment and/or treatment is medically necessary and the mother wishes to receive these health services under the RHCA.

- Where appropriate, mothers should be encouraged to access routine antenatal and postnatal services which are widely available from private sector GPs, midwives and obstetricians.
3.9 Refugees and Asylum seekers

3.9.1 Refugees

Persons with refugee status who are settled in Australia under the Humanitarian Migration Program are permanent residents with full Medicare eligibility. However, if very newly arrived there may be delays in allocating a Medicare number. Patients with refugee status should be treated as fully eligible and the health service should seek to identify the number as it is issued.

3.9.2 Asylum seekers living in the community

Asylum seekers fall into one of four categories while awaiting refugee status:

1. Asylum seekers provided with a blue (interim) or green (full) Medicare card which allows them access to health care with the same rights as an Australian permanent resident
2. Asylum seekers eligible for federally funded health and welfare schemes such as the Asylum Seekers Assistance Scheme (ASAS)
3. Asylum seekers ineligible for Medicare or the ASAS
4. Asylum seekers in community detention with healthcare funded by a contracted provider (see section 3.10)

Urgent clinical treatment for anyone presenting to a NSW health service should not be delayed while their status and eligibility are being determined.

3.9.3 Determining status for asylum seekers

Asylum seekers without a Medicare card will hold one or more of the following documents:

- A Bridging Visa, which is most commonly of type ‘E’ (with the letters WE stamped on visa), but also may be type ‘A’ or ‘C’. More information about visa types is readily available online.
- A document from the Department of Immigration and Border Protection (DIBP), which may take the form of:
  - An acknowledgement letter that refers to the person’s immigration status (Bridging Visa Type) or
  - A receipt that includes details of the person’s Bridging Visa type.
- Supporting documentation from a status resolution support service which administers the ASAS on behalf of the Department of Immigration such as:
  - Australian Red Cross
  - Life Without Barriers.
- DIBP documentation indicating that the person is in Community Detention and that health care is the responsibility of the contracted provider or
- Documentation from a service providing health care to asylum seekers, such as:
  - Asylum Seekers Centre
  - NSW Refugee Health Service.

3.9.4 Asylum Seeker Assistance Scheme (ASAS) eligible asylum seekers

Where a person covered by ASAS, is hospitalised in a NSW public hospital, they are to be classified and charged using the asylum seeker financial classifications.

They will have a letter from a support organisation which will:

- Be addressed to a specific health service and
- Identify the patient and
- Identify the patient's condition to be treated.
Services outside the scope of the letter should not be provided without the written authority of the support organisation.

In addition to accommodation charges raised at the ASAS rate, the following billing accounts are to be rendered by the health service to the support organisation:

- Diagnostic accounts or accounts for services provided by staff specialists exercising their right of practice
- Surgically implanted prostheses
- Non-inpatient occasions of service
- Non-inpatient pharmaceuticals.

Emergency circumstances may arise which require hospitalisation of an individual who indicates eligibility to ASAS, but is not in receipt of the required documentation. Treatment should not be delayed in these cases.

At the earliest opportunity following treatment, the identified support group must be contacted to determine eligibility. The outcome will determine the course of action to be taken by the health service:

- Bill the support group where accepted under ASAS or
- Follow the process below for non-eligible asylum seekers.

### 3.9.5 Process for non-eligible asylum seekers

Not all asylum seekers are financially disadvantaged; some seek refuge from political or religious persecution and have the means to support themselves.

Where a person identified as an Asylum Seeker but not eligible for ASAS or a Medicare card, it is a requirement that health services:

- Determine eligibility for treatment at no charge in accordance with the other procedures in this document i.e. victim of crime
- Charge outpatient and inpatient fees at the ineligible rate (see Section 4) or
- Evaluate any request for reduction or waiver for persons who do not have the means to pay by ensuring a financial hardship or other appropriate review has been undertaken and approval obtained from the Director of Finance or equivalent delegation.

### 3.10 Immigration Detention Centre patients

The Commonwealth Department of Immigration and Border Protection are responsible for the provision of health services for persons in immigration detention, including Community Detention. The Department arranges health services through contracted providers. The contracted providers have a network of private sector health care professionals and they also utilise public sector health services.

Services for immigration detainees will be pre-arranged by the detention centre or contracted provider. NSW health services must bill the contracted provider for all health services provided to a person in immigration detention, including community detention. Details of the current provider are available in the Immigration Detention Quick Guide on NSW Health Revenue Toolkit quick guide page.

### 3.11 Norfolk Island citizens

From 1 July 2016, residents of Norfolk Island are covered by Australian Government Medicare arrangements. Health services must ensure accurate capture of Norfolk Island residential address including postcode.

Norfolk Island residents are eligible for Australian Medicare cards and unless compensable, may elect to be treated as public or private patients for treatment by NSW Health services. Hospitals will enter private, public or relevant compensable financial classification into the local patient administration system (PAS). Norfolk Island financial classifications are no longer required and will cease being used from 1 July 2016.
3.12 CAFAT, ROMAC or other specific agreement

A number of agreements exist where Medicare ineligible patients are referred for health services in Australia. Some arrangements are government funded and others are funded by charities and other non-government agencies. The arrangements provide assistance to residents of countries in the South Pacific, Oceania and other regions who might benefit from access to specialist health services in Australia.

NSW health services may accept referrals of patients for treatment under these arrangements provided that prior written approval and guarantee of payment are received.

3.12.1 CAFAT

The government of New Caledonia operates the CAFAT social security and health benefit scheme. Persons covered by the scheme will have a written authority outlining what services are covered and the billing arrangements.

3.12.2 ROMAC

ROMAC (Rotary Oceania Medical Aid for Children) is a charitable program established and supported by Rotary to assist children requiring specialist services (usually surgical) that cannot be provided in their home country or another nearby country. Persons being assisted by this scheme will have a written authority outlining what services are covered and the billing arrangements.

3.12.3 OTHER

In some circumstances, clinical staff may donate their time and/or the health service might arrive at an agreement with organisations or individuals regarding particular donations of time or services. In such circumstances, the suggested rate would be based on the concessional (Asylum Seeker) rate, specified in the current Policy Directive titled Health Services Act 1997 - Scale of Fees for Hospital and other Health Services

3.13 Visas - student, work and other temporary residents

Certain temporary visa holders are required as a condition of their visa to have health insurance. These include students, persons permitted to enter Australia for work and retirees.

If the patient is from a country with a reciprocal health care agreement (RHCA) with Australia, refer to the advice specific to their country of origin in section 3.5 of this document.

If a visa holder with a requirement to hold private health insurance, overseas student health cover (OSHC) or overseas visitor health cover (OVHC) cannot produce evidence of appropriate health insurance, they must be charged as an ineligible patient.

Private health insurance policies for temporary visa holders in Australia are different to policies for Australian residents who are eligible for full Medicare. Eligibility checks for patients presenting with these types of policy are critical to ensuring the patient is fully informed about the costs they may incur.

NOTE: More information on specific visas and verification of visas can be found in the Visa Quick Guide on the Revenue Toolkit quick guide page.

3.14 Overseas visitors other than those covered in previous sections

Patients must be classified Medicare Ineligible and fees charged:

- To the individual where there is no insurer, or no confirmation of payment from an insurer
- To the Australian or international insurer when eligibility and confirmation of payment has been established
- To the responsible party in special circumstances i.e. members of the defence forces from countries on official exchange with the Australian Defence Force

NOTE: Diplomats and their families from countries not specified in a RHCA as well as New Zealand and Norway are considered Medicare Ineligible and must be charged at the ineligible rate for all health services.
4 PATIENT ADMINISTRATION AND REVENUE MANAGEMENT

4.1 Patient classification and registration
Whilst clinical assessment and treatment of an urgent condition should not be delayed, health services must ensure that administrative, nursing or medical staff obtain the following details when any person presents for treatment:

- Full name and date of birth
- DVA card colour and number (if applicable)
- Defence Force PMEKeys number (if applicable)
- Private health insurance details, name of fund, policy / account number and contact details (including international or overseas funds)
- Permanent residential address (overseas, if applicable)
- Temporary residential address (Australian)
- Mobile and any other contact phone numbers
- Email address
- Country of birth
- Marital status
- Aboriginal or Torres Strait Islander status
- Next of kin name and contact details
- Name of local GP (if applicable)
- If patient is being treated as a result of a compensable accident or incident.

4.1.1 Further evidence required if patient does not hold a Medicare card:

Compensable
- Debtor details
Prisoner
- None but must present with prison staff
Victim of crime
- None but must present with police or an official police notification
Organ donor
- None

Infectious control and public health containment
- Copy identifying documentation with photo i.e. passport and/or licence (Australian or overseas)
- Copy visa type, class and date of entry to Australia from passport or immigration documentation
- Copy any document from other health services
- Any extra details as required by infection control team

Resident of Norfolk Island:
- Ensure accurate capture of Norfolk Island residential address, including postcode
- Charge PHI or individual where patient has elected to be treated as a private patient
- Follow existing recovery processes where patient is treated as a compensable patient
- Where patient has elected to be public, LHD will raise the MoH as a debtor and the MoH will make a six monthly reconciliation and payment to the LHD based on PAS information

Overseas visitor, immigration detainee or Asylum seeker:
- Copy identifying documentation with photo i.e. passport and / or licence (Australian or overseas)
- Copy or verify visa type, class and date of entry to Australia from passport, immigration documentation or immigration website; instructions for verification of visas can be found in the Visa Quick Guide on the Revenue Toolkit quick guide page
- Copy any documents with prior approval for treatment and billing
• Credit card details or details of other payment methods / agreements (including waivers or reduction of charges by CE or similar delegation level) if treatment is not paid for in advance.

4.1.2 Extra details required for RHCA patients:
• If patient is from Belgium, the Netherlands or Slovenia and accessing medically necessary treatment through the RHCA: copy valid European Union Health Insurance card.
• If patient is from Sweden and holding a student visa (500, 570 – 576, 580, or 590) and accessing medically necessary treatment through the RHCA: copy valid Swedish National Board of Student Aid (CSN International) card.

4.2 Charging and collection procedure
Medicare Ineligible patients who are not eligible for free or compensable treatment under section 3 of this document must be charged according to section 5: Fees and Charges

4.2.1 Insured admitted patients:
• Complete ineligible patient declaration
• Copy passport including visa type and class
• Copy health insurance card / notice
• Contact the health insurer and confirm patient eligibility for treatment and excess rate (if not eligible follow process for non-insured and non-guaranteed patients)
• If overseas fund, request written confirmation that accounts will be paid (if not eligible follow process for non-insured and non-guaranteed patients)
• Charge any excess to the patient prior to treatment
• Send all accounts to insurer (Australian or payment confirmed) or patient in a timely manner.

4.2.2 Patients with prior written approval for treatment and billing (e.g. ROMAC, ASAS):
• Complete ineligible patient declaration
• Copy identification
• Copy any documentation including written letters of introduction or approval
• Send all accounts to approving organisation in a timely manner.

4.2.3 For non-insured, non-guaranteed admitted patients and non-admitted patients:
• Complete ineligible patient declaration
• Copy passport including visa type and class
• If Visa class should be insured but is not, follow procedure to notify to Department of Immigration and Border Protection (DIBP) Section 6
• Ensure patient is fully informed of the costs likely to be incurred, the estimate of cost forms may be used to assist with this
• Raise accounts at the time of booking/admission or prior to discharge with as much detail as possible to allow patients to claim from travel or overseas insurers with no guarantee.

Receive payment in the following priority order:
1. In advance of booked procedures or services with a written understanding that further accounts may be raised following the procedure
2. Prior to or at the time of service in cash or by EFTPOS
3. Prior to discharge of inpatients in cash or by EFTPOS
4. In instalments by direct debit agreement
5. In instalments with a written agreement with patient or family.
Facilitation

Health services must ensure that staff is able to receive payment and/or confirm credit card pre-authorisation.

4.3 Booked patients

Ensure the ability of NSW Health to fund the treatment of overseas patients does not interfere with the physical, clinical and/or financial capacity of any health service to meet clinical priorities for Australian residents.

4.4 Guarantor agreements

If it is likely that a Medicare Ineligible patient, or prospective patient, may be unable to pay for some or all of the costs of the medical and other services that are expected to be provided to that patient, it will be necessary for the relevant financial officer to consider whether it would be appropriate to request a supporting patient guarantee from a suitable person. A suitable person would be a person who is willing to provide a guarantee to support the future financial obligations of the patient to the Hospital in respect of the required medical services. A suitable guarantor may be a family member of the patient, or another third party associate of the patient.

Before deciding to seek or accept a guarantee from a prospective guarantor, it will be appropriate to consider whether that person is a suitable person to provide such a guarantee. Matters such as their country of residence or financial capacity may be relevant.

The factors to be considered, and recommended processes to be followed, when seeking a guarantee of the patients liabilities from a suitable supporting person are outlined in the Medicare Ineligible Financial Guarantees - Guide for Revenue or Finance officers. (Attachment A)

The processes and procedures set out in this Information Guide should be followed whenever a supporting patient guarantee is sought from a third person.

When taking a supporting guarantee, it is recommended that the standard template Guarantee document be used, together with the template Information Statement for Guarantors.

4.5 Payment by instalment

Where it is necessary to set up a payment plan, health services must follow a delegation and approval process to set up and manage instalment plans in a fair and reasonable manner with realistic timeframes.

4.6 Debt recovery

Normal debt recovery action should be undertaken and a debt not written off until every avenue has been exhausted and it is clear that payment is not achievable.

4.7 Waiving or reducing charges

Except in the circumstances indicated in section 3 of this document, fees should not be waived or reduced unless a financial hardship or other appropriate review has been undertaken and approval obtained from the Chief Executive or similar delegation.

Where fees are waived it is with the understanding that the costs of treatment are the responsibility of the LHD.
5 FEES AND CHARGES

Ineligible patients who have not been determined eligible for treatment at no charge under section 3 of this document must be charged for all services as scheduled, or if not scheduled on a full cost recovery basis.

Scheduled fees charged by the health service are set out in the appropriate schedules and advised by the NSW Ministry of Health at least annually, these include:

- *Health Services Act 1997* - Scale of Fees for Hospital and other Health Services – NSW policy
- Pension Based Scale of Fees - Charging Arrangements and Scale of Fees – NSW policy
- Health Records and Medical/Clinical Reports – NSW policy
- Pharmaceutical charges for hospital outpatients – NSW Information bulletin
- Fee for Cremation Certificates Issued by Salaried Medical Practitioners of Public Hospitals – NSW information bulletin
- Ambulance Service – Charges – NSW policy
- Prostheses Rebate list – national schedule

In lieu of further information, full cost recovery may be determined by cost of item +17% on costs. Policy documents and guidelines can be found on the [NSW Health policy page](#).

5.1 Fees for hospital, medical and diagnostic services

5.1.1 Admitted patients

**Accommodation and related services - for all gazetted rates refer to the** current Policy Directive titled *Health Services Act 1997* - Scale of Fees for Hospital and other Health Services.

- Asylum seekers are charged a scheduled rate
  - Charges are raised applying the same rules as a Medicare eligible private patient (i.e. pharmacy included)
- Specific classes of Insured Visa holders are charged at the gazetted rate as per the [Schedule of Fees & Charges Summary](#)
  - Charges are raised applying the same rules as a Medicare eligible private patient in a shared room (i.e. pharmacy included)
- All other chargeable Medicare ineligible patients are billed a gazetted rate covering accommodation in a shared room, meals, nursing care and inpatient dressings as required
  - Rates are adjusted for critical care, sub-acute care, maintenance dialysis and hospital in the home
  - Inpatient pharmacy items must be charged at a full cost recovery rate
- Surgically implanted prostheses must be charged at a full cost recovery rate

**Medical and diagnostic services**

- Work and Student visa holders covered by private insurance, OSHC or OVHC should be charged up to the equivalent applicable Medicare Benefits Schedule (MBS) fee
- All other ineligible patients should be charged up to the current AMA rates for medical consults and diagnostics
- If the patient is admitted but not seen by a specialist with rights of private practice, or the VMO is not prepared to accept the Medicare Ineligible patient as a private patient, then the patient should be charged the daily ineligible treatment fee in lieu of specialist billing being raised.

92(8/12/16)
5.1.2 Non-admitted patients (outpatient) (Please refer Chapter 1 (1.3))

The following applies to all Medicare Ineligible non-admitted patients who are not eligible for treatment at no charge under section 3 of this document.

Where no specific schedule exists, the AMA scheduled rate or the scheduled (gazetted) flat rate per Occasion of Service (OOS) may be used for charging purposes. Charges must be raised and paid prior to each service.

- Emergency department services and diagnostics per OOS
- Outpatient services for nursing and day care must be charged at the scheduled flat fee per OOS
- Allied health services must be charged at the scheduled rate
- Patients must be regarded as private patients for medical and diagnostic services provided by doctors with rights of private practice.
- Patients treated by doctors without rights of private practice (i.e. ED) must be charged at the scheduled flat fee per OOS
- Outpatient pharmacy items must be charged according to the schedule
- Dressings, aids and equipment for mobility, communication, respiratory function or self-care should only be supplied if no other supplier is available and must be charged at a full cost recovery rate
- Requests for medical records or cremation certification must be charged according to the schedules.

5.1.3 Determining Occasion of Service (OOS)

Where the flat fee is being charged there may be more than one OOS per episode.

- Pathology will always have a minimum of 2 OOS (collection and testing). If more than one area of pathology testing is required then one collection OOS for each type of collection, e.g:
  - Blood collection or other forms of venessection
  - Swabs
  - Faeces, semen or sputum collection.

And one collection OOS for each area of testing:
  - Histopathology / Cytopathology
  - Chemical pathology
  - Genetics
  - Haematology
  - Immunopathology
  - Microbiology.

- Imaging: each type of imaging is counted as a separate OOS
  - X-ray
  - CT scan
  - Nuclear medical scans
  - MRI scans
  - Ultrasound.

- Consult: normally only one consult OOS will be applied to each episode however if a multidisciplinary approach is required each speciality may raise a charge.
5.1.4 Services provided as part of an Emergency Department non-admitted patient episode

- Where patient is only seen in the emergency department the scheduled flat fee will apply to each OOS
- The consult flat fee should be charged prior to the patient being treated but urgent clinical assessment and treatment should not be delayed for this
- All other OOS must be charged either by the service providing (according to the section above) or by ED prior to the patient leaving the facility

5.2 Charges for patient transport

Primary Transport (from site of accident or emergency to hospital)

- All persons are responsible for the cost of their primary Ambulance transport.

Inter-hospital transport (transport for continuation of treatment)

- Medicare Ineligible patients eligible for treatment at no charge under section 3 of this document will not have patient transport charges raised against them for inter-hospital transport.
- Medicare Ineligible Visa holders with private, OSHC or OVHC will have patient transport charges raised by the health service, to their insurer, for inter-hospital transport costs.
- Asylum seekers who have had agreed costs accepted will have transport charges raised by the health service, to their insurer or organisation, for inter-hospital transport costs.
- All other Medicare Ineligible patients will have charges raised by the health service for inter-hospital transport.

Transport for repatriation (transport to patient’s residence or place of the patient’s choosing)

- Patient transport should not be used for these purposes, arrangements such as taxi or private transportation should be used and payment for these services will be the patient’s responsibility. If, in exceptional circumstances, patient transport is used, then charges must be paid upfront by the patient.

NOTE: All charges will be raised in accordance with the rates set in the NSW Health Policy directive Ambulance Service – Charges.

5.3 Remuneration to specialists

5.3.1 Inpatients

If the patient is only admitted to the ED or the VMO is not prepared to accept the Medicare Ineligible patient as a private patient, the health service will pay VMOs who provide service to these patients on the same basis as payment for eligible public admitted patients and charge the daily medical treatment fee.

5.3.2 Outpatients

- For Medicare Ineligible persons who are eligible for treatment at no charge under Section 3 of this document, the health service will pay VMOs who provide medical and diagnostic services to on the same basis as payment for a public patient.
- The health service will pay VMOs who provide medical services to Medicare Ineligible ED only non-admitted patients on the same basis as payment for Medicare eligible ED only non-admitted patients.
- Services provided by salaried specialists to these patients are part of their employment by the health service and no additional payment is required.
6 WORKING WITH THE DEPARTMENT OF HUMAN SERVICES AND IMMIGRATION

6.1 Reporting Medicare fraud
Most people are honest and use Medicare fairly, but if you have information about someone who is misusing Medicare it is important to contact the Department of Human Services.

Medicare fraud includes:
1. Making Medicare claims for services that were not provided
2. Using someone else's Medicare card
3. Using an invalid concession card
4. Forging prescriptions for PBS medicines.

To report suspected Medicare fraud, call 131 524 or fill out the Reporting suspected Medicare fraud form

6.2 Reporting immigration fraud
The following are examples of Immigration and Citizenship offences or fraud, it is important to report suspected fraud.

Immigration fraud includes where you suspect a person:
• Should maintain adequate health insurance due to visa class but person is uninsured
• Has overstayed their visa and does not hold a valid visa to remain in Australia
• Is working illegally (for example, a tourist visa holder who is working)
• Deliberately lied on their visa application or provided false documents to the department
• Is on a student visa but is not studying
• Is visiting Australia to promote extremist ideologies, advocate violence as a means to an end, or to vilify a segment of the community
• Ows a debt to the Australian Commonwealth government.

To report suspected immigration fraud call 1800 009 623 or fill out the Reporting Immigration fraud form

PRINCIPLES FOR THE MANAGEMENT OF TUBERCULOSIS IN NEW SOUTH WALES
(PD2014_050)


PURPOSE
This policy sets out the mandatory principles for the provision of Tuberculosis (TB) services in New South Wales (NSW).

TB Services are required to operate in accordance with this policy in conjunction with the current relevant guidelines for the prevention and control of tuberculosis in NSW, which reflect best practice for the clinical and public health management of TB.

(PD2014_050)
MANDATORY REQUIREMENTS

All staff must adhere to these principles. All services related to the screening, care and management of people with active, latent, or suspected TB are available at no charge to patients within the NSW Public Health system. The treatment for people with active TB is to be administered by directly observed treatment.

IMPLEMENTATION

Chief Executives must ensure that:
• The principles and requirements of this policy are applied, achieved and sustained.
• Relevant staff are made aware of their obligations in relation to the Policy Directive.
• Documented procedures are in place to support the Policy Directive.

Clinicians:
• Must comply with this Policy Directive.

5 CHARGING FOR TB RELATED SERVICES

Provision of TB services free of charge to the patient
All services related to diagnosis and treatment of suspected or proven TB (active or latent) are available at no charge to patients within the NSW public health system. This includes the provision of services for TB-related investigations, care and treatment.

This policy applies to (but is not limited to) the following:
• All Australian residents, including prison inmates and persons in juvenile detention centres.
• Migrants and refugees referred by the Commonwealth and/or State Health Departments or their nominated delegates.
• Persons who are ineligible for Medicare benefits.
• Temporary residents or overseas visitors.
• Asylum seekers.
• Persons without legal status in Australia.

This policy applies regardless of whether the person attends with or without a referral from another health care provider.

Investigation
All clinical, laboratory and other investigations for cases, or suspected cases, of TB (active or latent) carried out through admitted patient and non-admitted patient services (including ambulatory care services) in NSW public hospitals and health facilities must be provided free of charge to the patient.

Treatment and medication
All medications related to the treatment of active or latent TB provided through admitted patient and non-admitted patient services (including ambulatory care) in NSW public hospitals and health facilities must be provided free of charge to the patient.

Medication and other treatments required for ensuring that TB treatment can be tolerated and/or completed without side effects must be provided free of charge to the patient.
Investigations required for patient monitoring prior to and during treatment, such as blood chemistry, audiometry and visual acuity, carried out through admitted patient and non-admitted patient services (including ambulatory care services) in NSW public hospitals and health facilities must be provided free of charge to the patient.
TB prevention
The provision of TB prevention services through admitted patient and non-admitted patient services (including ambulatory care) in NSW public hospitals and health facilities must be provided free of charge to the community and patients. These services include contact tracing assessments (TSTs, CXR and clinical evaluation), and professional and community education.

Circumstances where charging for TB services is permitted
Local Health Districts may apply a fee for services in the specific situations listed below. However, issues surrounding financial remuneration should not delay investigations, care, or treatment for persons with TB.

Occupational screening for students and new healthcare workers
Students and new health service employees who require screening for TB in accordance with the policy directive, PD2011_005 Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases.

Occupational screening for existing healthcare workers
Employers (in both the public and private sectors) of healthcare workers are responsible for meeting the cost of occupational screening programs related to TB, including TST. The principle for charging employers for occupational screening is one of cost recovery.

Occupational screening (other than healthcare workers)
Any worker or group of workers requiring occupational screening for TB, unless this is related to contact screening, in which case it must be provided free of charge.

Immigration detention
Where TB Services are provided to a person held under Commonwealth immigration detention, including persons in community detention, the local health district may charge the Commonwealth Department of Immigration through its contractor at the appropriate ineligible patient rate.

BCG vaccination
TB Services may elect to charge patients a service fee for BCG vaccination.

Referral to private providers
Where a public health organisation initiates investigations (on behalf of a patient) with a private practitioner or service, the public health organisation is responsible for meeting the cost of the service or investigations and the patient is not responsible for meeting these costs. Local health districts should have mechanisms in place for the reimbursement of private practitioners.

Medicare benefits
Medicare benefits cannot be paid for professional services related to the care and treatment of TB provided for public patients in public health facilities funded by either the State or Commonwealth Health Department unless the Federal Minister for Health has directed that Medicare benefits are to be paid.
Services related to investigations, care, treatment, screening and BCG vaccination provided within the public health system cannot be billed to Medicare.
For a Medicare benefit to be payable for a patient in a public hospital, the patient must be classified as a private patient, at the time the service was rendered.

78(18/12/14)
ADMITTED PATIENT ELECTION PROCESSES FOR NSW PUBLIC HOSPITALS (PD2018_029)

PD2018_029 rescinds PD2005_221

PURPOSE

This policy directive updates PD2005_221 Admitted Patient Election Processes for NSW Public Patients – Revised to fully align with the National Health Reform Agreement 2011 (NHRA) in particular Schedule G (Business Rules for the National Health Reform Agreement) and other clauses. This Directive will also provide guidance on the changes to election processes to be applied to NSW public hospital admissions.

MANDATORY REQUIREMENTS

Facilities across NSW health are obliged to adhere to these election processes to ensure that the requirements of the NHRA are met.

Hospitals are to:

- ensure that all patient election forms include a statement that all eligible persons have the choice to be treated as either public or private patients;
- that an election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of or as soon as possible after admission and must be in accordance with the minimum standards set out in the NHRA;
- ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent;
- only interview Mental Health patients after capacity has been determined by an appropriate healthcare professional

IMPLEMENTATION

Local Health Districts/Speciality Health Network Chief Executives are to ensure that the requirements of this Policy Directive are communicated to appropriate staff. Directors of Finance, Revenue Managers and Hospital Administration Staff are responsible for the operational compliance of this policy directive.

1. BACKGROUND

1.1 About this document

- This Policy Directive has been written to update PD2005_221 with appropriate references to the National Health Reform Agreement 2011 (NHRA), National Healthcare Agreement 2012 and related Agreements to ensure compliance with the National Standards for Public Hospital Admitted Patient Election processes.
- The NHRA requires that all States provide eligible persons with the right to receive, free of charge as public patients, services that are currently or historically provided by public hospitals, and must ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent.
- It is a requirement of the NHRA Schedule G – Business Rules for the National Health Reform Agreement that an eligible patient on admission will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Election processes (unless a third party has entered into an arrangement with the hospital or the State to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient.

104(09/08/18)
Information for patients in NSW hospitals concerning the election process is also included in this document (general principles).

This Policy Directive refers to the election processes to be applied to mental health admissions to declared mental health facilities in NSW as defined in the Mental Health Act 2007.

This Policy Directive is for all staff who are involved in the election process for admitted patients.

1.2 Key definitions

Eligible Person: means an Australian resident or an eligible overseas representative.

Public Patient: means an eligible person who receives or elects to receive a public hospital service free of charge.

1.3 Legal and legislative framework

- National Health Reform Agreement 2011
- Health Insurance Act 1973 (Cth)
- Mental Health Act 2007 (NSW)
- Health Records and Information Privacy Act 2002 (NSW)
- Privacy Manual for Health Information NSW Health

2 ADMITTED PATIENT ELECTION INFORMATION – NSW

2.1 Patient Election General Principles

All eligible persons have the choice to be treated as either public or private patients in NSW public hospitals whether they hold private health insurance or not. By completing an election form the patient (or their legally authorised representatives) makes an election to be a public or private patient. A private patient has a choice of doctor, subject to their doctor having admitting rights at the hospital. Choice occurs even where only one doctor (including the doctor on call) has admitting rights at the hospital.

The decision must be freely made based on accurate information and informed financial consent. Where possible, the patient/legally authorised representatives should endeavour to determine if there will be any out of pocket expenses during the admission by discussing this with an appropriate hospital employee, doctor(s) and their health fund. Hospital employees will not direct patients or their legally authorised representatives towards a particular choice.

Elections by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as practicable after, admission.

Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as part of the patient’s treatment and will be provided free of charge.

Patients electing to use their private health insurance will be asked to sign an inpatient election form allowing NSW Health to disclose health information relevant to their claim. The National Private Patient Hospital Claim form’s disclosure statement must also be signed. By signing these documents, the patient/legally authorised representatives agrees to permit NSW health to disclose health information in keeping with the Health Records and Information Privacy Act 2002 to their insurer or other parties in order to obtain payment. It is expected that NSW Health staff will advise patients of this disclosure requirement.

Once made, this election can only be changed due to unforeseen circumstances.
Where it is appropriate to change an election due to unforeseen circumstances, that change must not be retrospectively backdated to the date of admission. In the event that an admitted patient or their legally authorised representatives do not make an election, these patients will be treated as public patients and the hospital will choose the doctor until such time as an election is made. This is called a “deferred election”. Examples of circumstances where this may occur are:

a) emergency admissions after hours in hospitals where staff are not available to organise the completion of the election form until the following working day

b) where the patient is experiencing some or all of the following:
   - inability to understand/speak English
   - where the patient lacks decision making capacity for an election decision and the legally authorised representatives are not present or available (after reasonable attempts to contact them) to make the decision on the patient’s behalf
   - unconsciousness
   - severe pain
   - shock
   - dementia; or
   - cognitive disability

When a valid election is made that election can be considered to be for the whole episode of care, commencing from admission.

The transfer of privately insured patients to hospital in the home (HITH) is considered to be “unforeseen circumstances”. The change in patient status is effective from the date of the change onwards. These patients can therefore be reclassified to non-charge at the time of transfer to HITH.

2.2 Workers/Other Compensation/Compulsory Third Party insurance

Even though a patient makes an election at the time of admission, if at some later date the patient is found to be eligible for compensation under Workers Compensation, Compulsory Third Party insurance, or under any other type of arrangement (and therefore not eligible under Medicare arrangements), the patient will be reclassified as compensable from the time of admission and charged accordingly.

2.3 Capacity to make an election decision

There is a legal presumption that every adult has capacity. Therefore, a patient’s election decision will be binding unless it has been established that they do not have the capacity to make that decision. Capacity must be assessed by an appropriate healthcare professional.

Mental health patients admitted as voluntary patients, or detained as involuntary patients, under the Mental Health Act 2007 do not necessarily lack capacity to make election decisions. Health Practitioners will need to consider on a case by case basis whether or not the mental illness or mental disorder suffered by the person is affecting their capacity to make a valid election decision. Administrative staff, prior to interviewing, must confirm the patient’s capacity to make an election decision with the health practitioner. Further information about capacity to make decisions or supported decision-making can be found on the websites of the NSW Public Guardian, the NSW Trustee and Guardian and the NSW Civil and Administrative Tribunal (NCAT). Additionally, please see the NSW Department of Justice’s Capacity Toolkit at: http://www.justice.nsw.gov.au/diversityservices or call the Information & Support Branch of the Public Guardian.
3 NATIONAL STANDARDS FOR PUBLIC HOSPITAL ADMITTED PATIENT ELECTION PROCESSES

In accordance with the NHRA, Schedule G24-G30, States and Territories public hospital admitted patient election processes for eligible persons should conform to the national standards.

4 SCHEDULE G: NATIONAL STANDARDS FOR PUBLIC HOSPITAL ADMITTED PATIENT ELECTION PROCESSES G24 – G30 (NHRA)

4.1 Public Hospital Admitted Patient Election Forms

G24. States/Territories agree that while admitted patient election forms can be tailored to meet individual State or public hospital needs, as a minimum, all forms will include:

a) a statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in clause G3 of Schedule G – Business Rules for the NHRA. This clause states that “Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State.”

b) a private patient may be treated by a doctor of his or her choice and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation must be admitted as a private patient (note: eligible veterans are subject to a separate agreement);

c) a statement that a patient with private health insurance can elect to be treated as a public patient;

d) a clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for nursing home type patients):

   i. will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and

   ii. are treated by the doctor(s) nominated by the hospital;

 e) a clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:

   i. will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;

   ii. may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and

   iii. are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital;
f) evidence that the form was completed by the patient or legally authorised representative before, at the time of, or as soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee;

g) a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:

   i. patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
   ii. patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
   iii. patients whose social circumstances change while in hospital (for example, loss of job);

h) in situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission;

i) it will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in this Schedule apply;

j) a statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision;

k) a statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement may result in the refusal of their health fund to provide benefits; and

l) where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

4.2 Multiple and Frequent Admissions Election Forms

G25. A State or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specified period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.

4.3 Other Written Material Provided to Patients

G26. Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross reference to the admitted patient election form in any such written material.
4.4 Verbal Advice Provided to Patients

G27. Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.

G28. Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election.

G29. To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.

G30. Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

104(09/08/18)

TRANSFER OF PATIENT FROM PUBLIC HOSPITAL TO PRIVATE FACILITIES
(PD2005_096)

Following the recommendation of the Health Care Complaints Commission, all Area Health Services are requested to ensure public hospitals have a written policy and checklist relating to the making of referrals to private health facilities and the provision of verbal and/or written information to patients and their families where:

a. patients are uninsured or are awaiting the outcome of a third party insurance claim to pay for their private medical treatment; or
b. patients have a mental incapacity to enter into contracts regarding charging arrangements for private medical treatment

This will enable clarification of the liability and charging arrangements, if applicable, for the patients.

37(10/01)
2. NON-CHARGEABLE

These patients must:
• be Australian residents or other eligible persons under Medicare
• elect to be treated by a doctor nominated by the hospital and
• elect to be accommodated in a shared room (single room accommodation without charge can continue to be provided on grounds of medical need).

An Australian resident is defined as “a person who is ordinarily resident in Australia”. Migrants to Australia from the date of arrival and overseas residents with approval to stay in Australia for a period in excess of six months are also regarded as eligible persons.

Whilst a person is classified as a non-chargeable patient in a recognised hospital in New South Wales, the “recognised hospital system” is responsible for providing all services necessary for the care and treatment of that patient.

However, in certain circumstances it could be more convenient to refer a patient to the private rooms of a medical practitioner for services not available at a hospital, e.g. certain diagnostic and radiology services. In these circumstances, the hospital is responsible for engaging the services of the private practitioner and is, therefore, responsible for meeting any costs involved. A similar situation exists where a person other than a visiting practitioner, e.g. optometrist, physiotherapist, etc. is called to a hospital to attend a “hospital” patient.

A Non-Chargeable Patient:
• Will not be charged for accommodation, diagnostic, medical, nursing or other services:
  a) by the hospital where admitted;
  b) by the hospital to which transferred for further care as an inpatient; it is expected that if one recognised hospital does not have the facilities necessary for the care and treatment of a patient, the patient should be referred (and if necessary transferred) to another recognised hospital which has the necessary facilities.
  c) by the hospital to which the patient was referred for a diagnostic or clinical procedure without being admitted as an inpatient, including the referral of a specimen for pathological examination without the patient having to visit that hospital; or

  (In respect of (c) above the hospital providing the service would render a charge to the hospital referring the patient but would not register the patient as a non-inpatient.)
• Will be formally admitted at each hospital where inpatient care is provided to him/her and will sign a separate form of election at each hospital.
• Will have post-discharge care carried out in an out-patient clinic or a doctor’s rooms depending on circumstances.

**ONCE A PATIENT WHO IS A POTENTIAL DONOR HAS BEEN DECLARED BRAIN DEAD THE POTENTIAL DONOR SHOULD BE CLASSIFIED AS NON-CHARGEABLE**
(PD2005_341)
PRISONERS – PROVISION OF MEDICAL SERVICES (Excerpt of PD2016_024)

PD2016_024 rescinds PD2005_0527

Excerpt of PD2016_024 - Health Services Act 1997 – Scale Of Fees For Hospital And Other Health Services

All New South Wales prisoners are entitled to free inpatient and non-inpatient services in New South Wales public hospitals.

When the required services are not available at the public hospital to which the prisoner is admitted as an inpatient, or attends as a non-inpatient the following arrangements apply:-

1.1 Inpatient Services

Neither the prisoner, nor the Justice and Forensic Mental Health Network is to be charged for accommodation, diagnostic, medical, nursing or other services provided by:

- The public hospital where admitted
- The public hospital to which transferred for further care as an inpatient
- The public hospital to which referred for a diagnostic or clinical procedure without being admitted as an inpatient
- A private medical practitioner (in their rooms), for services not available at a public hospital.

In these circumstances, the referring public hospital is responsible for meeting any costs involved.

1.2 Non-Inpatient Services

Neither the prisoner, nor the Justice and Forensic Mental Health Network is to be charged for non-inpatient services provided by:

- The public hospital initially attended by prisoner
- The public hospital to which referred, if services not available at the initial public hospital
- A private medical practitioner (in their rooms), for services not available at a public hospital.

In these circumstances, the original hospital that the prisoner attended is responsible for meeting any costs involved.
3. “CHARGEABLE”

A. GENERAL

Shared (Own Doctor) - Patients who elect in writing to nominate a doctor who will be responsible for their care and treatment but who do not elect single accommodation. They will be charged by the hospital at Standard Ward rate even if single accommodation is provided through medical necessity. They will also be charged by attending medical officers for services rendered. After 35 days they may be reclassified as “Nursing Home Type” patients.

Single (Own Doctor) - Patients who elect in writing to nominate a doctor who will be responsible for their care and treatment but who also elect single accommodation. They will be charged by the hospital at the single room rate if single accommodation is provided but this charge will reduce to the Standard Ward rate if single accommodation is not available. They will also be charged by attending medical officers for services rendered. After 35 days they may be reclassified at “Nursing Home Type” patients.

Own Doctor - A patient who is admitted as a chargeable inpatient (own doctor) at one hospital and who receives some part of his/her care at another hospital without being admitted as an inpatient at the other hospital is to be regarded as having received all his/her care as a chargeable inpatient (own doctor) within the public hospital system. That would allow the chargeable inpatient (own doctor) to be charged by his/her attending medical practitioners for services rendered in any public hospital during any one episode of illness.

The following explanations should clarify the concept.

A chargeable patient: (own doctor)
- The patient will have a private contract for care by the doctor selected and with other doctors whom the patient and doctor select to assist in the patient’s care (except for hospital resident medical staff).
• Will be charged hospital fees by the hospital to which he/she is admitted as an inpatient and by any other hospital to which he/she is transferred and admitted as an inpatient.

• Will be charged for prosthesis.

• Will be formally admitted at each hospital, the admission procedure to include completion of separate forms of election with undertakings to pay hospital fees.

• Will be formally discharged, at the time of transfer, from the hospital to which originally admitted.

• The patient post-discharge care will ordinarily be carried out by the doctor selected in his or her consulting rooms.

• If referred in person to another hospital for a diagnostic or clinical procedure but not admitted as an inpatient at that other hospital, will not be charged a fee by the second hospital but the attending medical practitioner will be entitled to render an account for clinical services. The second hospital will raise accounts on behalf of medical practitioners for diagnostic services and on behalf of staff clinicians. (The patient so referred would not be registered as a non-inpatient of the second hospital.)

• The visiting medical practitioners attending the patient at the hospital where he/she is admitted or to which transferred as an inpatient for further treatment would also render accounts for professional services. For diagnostic services, the accounts will be raised by the hospital on behalf of the medical practitioners.

• If a specimen collected from a private inpatient is sent to another hospital for pathological examination that hospital will raise accounts on behalf of the pathologist reporting on the examination.
• Ineligible patients are “private”, i.e. they must elect a doctor, except in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.

• Ineligible patients are to be billed for all clinical/diagnostic services provided by VMO’s, HMO’s and salaried staff specialists exercising their right of private practice, or by the hospital (See treatment fee – section page 2.5.1) in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.

• Accommodation charges are not to be raised in respect of ineligible unqualified babies. (96/49)

• Charges to be raised for the direct cost (plus related on -costs) of drugs. (98/67)

• Charges are to be raised for surgically implanted prostheses.

• The dates of admission and discharge are to be counted as one day with the date of admission being counted as that day (i.e. the 24 hour counting for compensable patients, does not apply to ineligible patients).

Ineligible patients are also to be charged, at a separate rate as gazetted from time to time, for accommodation in designated Intensive Care Units or coronary Care Units. (92/55)

See separate Norfolk Island residents provisions.

In respect of Ineligible Patients the Department requires that all hospitals adopt a policy of:

Obtaining an assurance of payment from all foreign patients before treatment is provided. This assurance may take the form of:

• credit card imprint (credit limits to be verified)
• cash to cover estimated cost
• bank cheque to cover estimated cost
• personal guarantee from Australian citizen whose bona fides are verified
• other initiatives to ensure that payment for the services is not lost to the hospital.

Where such an assurance of payment is not forthcoming, the foreign patient is to be informed that they will receive only the minimum and necessary medical care to stabilise their condition. This provision is not intended to impinge on the medical or legal obligations of medical officers in the treatment of ineligible patients. (96/49)

See also page 2.5 for further details.
C. COMPENSABLE PATIENTS

Compensable patients are those patients who are eligible to claim compensation/damages for hospital charges under workers compensation, third party (no charges raised for accommodation and diagnostics), Public Liabilities Insurance or such other compensation that may apply. In such cases, patients who believe they are compensable patients are asked to sign a Compensable Patient Declaration. All such compensable patients on initial admission are classified as private patients of the Doctor nominated by the Hospital or of the Doctor nominated by the patient. However, as approximately 3% of compensable cases do not proceed, compensable patients are also asked to make, on initial admission, an election as to whether they wish to be a private chargeable patient or a hospital non-chargeable patient if their compensation claim is not successful. (DETAILED PROCEDURES ARE CONTAINED LATER IN THIS SECTION.)

D. VETERANS’ AFFAIRS

See Veterans’ Affairs Section as to conditions and charges.

E. NURSING HOME TYPE

Patients who are accommodated for periods of 35 days or longer and in respect of whom certificates of “acute care need” are not issued. If they elect to be treated by hospital nominated doctors, the only charge will be by the hospital at the Nursing Home Type rate. If they nominate a doctor, they will be charged by the hospital at the Nursing Home Type Who Elect To Be Treated By Doctor Of Choice rate and by attending medical practitioners for services rendered. (DETAILED PROCEDURES ARE CONTAINED LATER IN THIS SECTION.)

F. DAY ONLY ADMISSIONS

(Charges and Benefits for private “day only” procedures in recognised public hospitals.) (96/7)

Detailed lists of band items and general instructions, as contained in the Commonwealth Department of Health, Housing and Community Services “DAY ONLY PROCEDURES MANUAL” are contained from page 2.100 of this Manual. (Attachment K)

As well as the instructions contained in the Commonwealth Manual the undermentioned matters are to be noted:

The current distinction made by hospitals between non-inpatient and day only patients should be maintained. Under the Medicare Agreement no charge (other than for pharmaceuticals) can be raised for non-inpatients. None of the arrangements outlined applies to non-inpatients.
1. CATEGORIES OF CHARGES AND BENEFITS

The charges are introduced within 4 “Bands” to classify procedures undertaken on a “day only” basis. The rates are effective in New South Wales for recognised public hospitals and are gazetted from time to time.

- Band 1 Rate as gazetted from time to time
- Band 2 Rate as gazetted from time to time
- Band 3 Rate as gazetted from time to time
- Band 4 Rate as gazetted from time to time

The classification, in general terms, is based on the procedure provided and on the type and level of anaesthesia required (if any) and the time spent by the patient in the operating theatre. The more complex the procedure, the higher the charge and benefit level:

Where the patient was admitted for more than one “day only” procedure to be performed on the same day, the patient should be classified according to the “day only” procedure that attracts the higher benefit (but only one of the four bands can be claimed for that day).

In an effort to limit the possibility of hospitals claiming same day benefits for procedures traditionally undertaken on an outpatient or non-inpatient basis the Type C Exclusion List (a list of Medicare Benefit Schedule items excluded from basic benefit payment for day only procedures) has been developed. However, if the appropriate medical practitioner believes that a patient warrants admission the completion of the “Day Only Procedure Certification” component, (Sections 4 & 5) of the 1830 form will enable benefit payment.

Practitioners may, under the legislation (para. 4B[b]) National Health Act) want to upgrade Type C professional attention to Type B professional attention under Section 4C(2) of the National Health Act. In such circumstances the practitioner may certify that:

a) because of the medical condition of the patient, it would be contrary to accepted medical practice NOT to provide day only treatment; or
b) because of the special circumstances specified in the certificate, it would be contrary to accepted medical practice NOT to provide day only treatment.

These procedures, when undertaken on a day only basis, will be claimed as Band 1 items.
It should be noted that the Exclusion List is **not** just a list of outpatient procedures. It also includes procedures which, in the normal course of events, should not be undertaken within the day only arrangements for the patient’s own safety.

With effect from 1 August 1991, dental procedures (performed on a day only basis) without a MBS item number will be classified according to anaesthetic type and time in theatre. If band 1 then classify as band 1B other.

### 2. IMPLICATIONS FOR HOSPITALS

The legislation has removed the requirement that a patient must occupy a bed in order to qualify as a day only admission.

However, basic table benefits for same day patients will **only** be payable where patients are formally admitted to a hospital or registered freestanding day hospital facility and receive professional attention by or under the supervision of a medical practitioner.

There will be occasions when an inpatient receives, as part of wider treatment, a procedure listed in Band 1. This will **not** necessitate use of the new “day only” forms, but hospitals should ensure that the HC.21 claim form clearly shows that the Band 1 procedure was only part of a wider treatment program, necessitating overnight stay.

Similarly, there will be occasions where a patient is initially admitted on a “day only” basis to a public hospital but, due to medical/social/environmental circumstances, he/she requires an overnight stay. In these cases, Form 1830 must accompany the HC.21 claim form submitted to the health insurance fund if the patient is a Band 1. If a Band 2, 3 or 4 patient stays overnight, form 1830 is not applicable, this patient is admitted as a normal inpatient.

The “four hour rule” no longer applies, and patients may only be admitted as a “day only admission” if:

a) they receive a procedure under Bands 1A, 1B (excluding Type “C” procedures), 2, 3 or 4 as specified on Pages 2.109 to 2.112 of Attachment K; or

b) they receive a Type C procedure as specified on Pages 2.113 to 2.183 of Attachment K **AND** the attending medical practitioner has certified on Form 1830 as to the patient’s medical condition or special circumstances requiring admission. See special provisions for non-elective public patients (part 5).
3. IMPLICATIONS FOR DIFFERENT CATEGORIES OF PATIENTS

Public Patients - The provisions in Attachment K should be applied but no charges raised. (See also part 5 as well.)

Private Chargeable Patients - These new charges apply regardless of whether the patient is privately insured.

Ineligible Patients - Ineligible patients receiving day only procedures are to be charged the full inpatient daily charge for an Ineligible patient. (Any private doctors’ fees would be the responsibility of the patient.)

Compensable Patients - should be charged at the inpatient compensable rates as gazetted in the NSW Government Gazette.

Veterans’ Affairs Patients - Patients in respect of whom the Department of Veterans’ Affairs will meet hospital costs should be billed in the same way as other private “day only” procedure patients.

4. FORMS TO BE USED

The “Day Only” Procedure Form (1830) is to be completed for privately insured patients and for all patients where certification for Type C professional services is undertaken. (93/112)

Form HC.21 must accompany Form 1830 when hospitals claim on health insurance funds. Hospitals should place orders for additional HC.21 forms with:

Government Printing Service
PO Box 256
Regents Park NSW 2143
Telephone: (02) 9743-8777
Facsimile: (02) 9743-8588

Health funds have agreed to accept Form 1830 in conjunction with Form HC.21, as the only “official” forms to be used. Note, Medibank Private have their own claim form.

Form 1830 is in Duplicate form. The first copy is to be attached to the patient’s claim form, HC.21, and forwarded to the patient’s health fund. The second copy is to be retained by the facility. There is no need for the medical practitioner to retain a copy.
5. GENERAL (94/64)

Section 1. Determination of Same Day Admission Status

The following questions have been developed to assist in the determination of admission status for patients presenting for a same day procedure, at public hospitals in NSW. To be of maximum benefit, the questions need to be addressed in the sequence in which they are presented:

a) Is the patient going to receive a same day medical, surgical or diagnostic service as specified in Band 1a?

These procedures are specifically set out in the Day Only Procedures Manual on pages 11 to 15.

<table>
<thead>
<tr>
<th>If yes</th>
<th>Same Day Admission - Band 1a</th>
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b) Is the patient going to receive a same day medical, surgical or diagnostic service as specified in Band 1B Type C - Professional Attention Procedures?

These procedures are specifically set out in the Day Only Procedures Manual on pages 16 to 70.

Please note that if a patient is going to receive a number of services during one presentation to a hospital then the patient can only be admitted without certification if one of the procedures is not on the Band 1b - Type C exclusion list. If all the procedures are on the exclusion list then, no matter how many procedures the patient receives in one presentation, certification is required before the patient can be admitted.

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</table>
INPATIENTS

Will the Admitting Medical Practitioner/Director of Emergency Department (refer to Section II for details) certify that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient (for example, remote location, no-one at home to care for patient)?

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<tr>
<th>If yes</th>
<th>Same Day Admission - Band 1b.Type C</th>
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Please note it is understood that health funds will only remunerate at the Band 1 level for certified B and 1b.Type C procedures, no matter what type of anaesthesia or theatre time was involved. This may have specific implications for paediatric patient admissions.

<table>
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<tr>
<th>If no</th>
<th>Patient cannot be recorded as an admission and should be classified as a non-inpatient.</th>
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c) Is the patient going to receive a same day surgical or diagnostic service as specified in Bands 2, 3 or 4?

These procedures are determined on the basis of anaesthetic type and theatre time as set out in the Day Only Procedures Manual on page 11.

Please note that, given the definition of Bands 2, 3 and 4, any procedure listed in Bands 1a and 1b. Type C in the Day Only Procedures Manual must be classified as a Band 1 procedure no matter what the anaesthetic type or theatre time associated.

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<tr>
<th>If yes</th>
<th>Same Day Admission - Band 2,3 or 4</th>
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</table>
d) Is the patient going to receive a medical, surgical or diagnostic service that requires same day admission but is not listed in bands 1a or 1b. Type C and does not involve anaesthesia or time in theatre?

Required same day procedures that are not listed in bands 1a or 1b Type C and do not involve anaesthesia or time in theatre (e.g. some dental services) should be classified as band 1b other.

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<tr>
<th>If yes</th>
<th>Same Day Admission - Band 1b. Other</th>
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<tbody>
<tr>
<td>If no</td>
<td>Patient cannot be recorded as an admission and should be classified as a non-inpatient.</td>
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Requirement for admission should be determined by the Admitting Medical Practitioner or Director of Emergency Department and based on the patient’s need for hospital inpatient services rather than the significance of the resources utilised.

Section II. Certification of Band 1B. Type C Same Day Admissions

The Commonwealth has determined that procedures specified in band 1b type c have been traditionally undertaken in ambulatory settings (e.g. outpatients, medical practitioner's rooms, emergency rooms) and as such do not usually warrant admission to hospital. However, the Commonwealth does recognise that there may be circumstances that warrant the admission of patients receiving such services.

All patients (public, private, compensable, ineligible, other) who are admitted for a same day medical, surgical or diagnostic service as specified in Band 1b Type C - Professional Attention Procedures require certification that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Please note that, although different certification requirements exist for various patient groups (refer below), a medical practitioner (e.g. admitting, director of emergency department) is required to sign the certificate forms in all instances.
6. Specific Certification Requirements (94/64)

a) Non-Elective Admission

i. Public Patient Certification

Background

In general terms, patients are admitted to public hospitals on either an elective (i.e. booked) or non-elective (i.e. unbooked) basis, with the majority of non-elective admissions presenting at the emergency department of a hospital.

The NSW Health Fees Procedure Manual (pp. 2.100 -) details the current same day procedure arrangements. These were likewise incorporated into the admission criteria specified in the Medicare Agreement 1993 - 1998. It has been acknowledged, however, that these arrangements were developed with particular reference to elective admissions and did not give full consideration to the admissions typically generated through hospital emergency departments.

The specific nature of emergency department activity makes adherence to the requirements of these same day arrangements, problematic. Given the immediacy of decision making, the specific patient casemix, current organisational arrangements and present status of information systems available in most hospital emergency departments, it is difficult for the admitting medical practitioner to determine the admission status of a patient in a timely manner.

The majority of the problems being experienced in emergency departments tend to be centred around the Band 1b.Type C exclusion list. It has been recognised that:

- admitting medical practitioners in emergency departments appear to be having difficulty determining whether the procedure(s) the patient is to undergo is on the Band 1b.Type C exclusion list or not.
- the Band 1b.Type C exclusion list does not allow adequate recognition of the patient casemix of emergency departments. A significant number of routine procedures performed in emergency departments are captured by the Band 1b.Type C exclusion list.
- adherence to the certification requirements associated with the Band 1b.Type C exclusion list are creating excessive administrative burden on emergency department staff.
To facilitate effective adherence to and consistent application of the admission criteria for public hospitals in NSW, the certification requirements for public patient admission for non-elective same day procedures have been modified. The following requirements are to be followed.

All public patients admitted on a non-elective basis (i.e. unbooked) to a public hospital for a same day medical, surgical or diagnostic service, as specified in Band 1b Type C, are to be listed on Public Patient Non-Elective Band 1b.Type C Certification Forms (Pro forma attached) to be completed daily.

The decision to admit a patient for a non-elective same day procedure should be made by the Admitting Medical Practitioner or Director of Emergency Department (where appropriate) and based on the patient’s need for hospital inpatient services rather than the significance of the resources utilised. However, given the lack of precision in the current admission criteria and the inability of the Band 1b.Type C exclusion list to allow adequate recognition of the patient casemix of emergency departments, a degree of discretion is allowed in determining the specified reason for admission.

It is anticipated that in the longer run a refined set of same day admission criteria will be developed for emergency department non-elective patients that allows adequate reflection of the inpatient activity of public hospital emergency departments.

The Public Patient Non-Elective Band 1B.Type C Certification Form

The Public Patient Non-Elective Band 1b.Type C Certification Form has been primarily developed to enable public hospital emergency departments to effectively certify public patients admission for non-elective Band 1b.Type C procedures (Pro forma attached) without the additional administrative burden of completing a Form 1830 for every admitted patient.

Although the form can be tailored to suit the needs of individual departments, the following information must be collected for each patient:

- Medical record number
- Patient name
- Patient age
- Specified reason for admission
- MBS item number
A Public Patient Non-Elective Band 1B. Type C Certification Form must be completed for each day (for each area where non-elective admissions take place) and be signed by the appropriate Admitting Medical Practitioner or Director of the Emergency Department within 48 hours of that day (i.e. patient admission).

The forms must list all public patients who were admitted on a non-elective basis for a same day medical, surgical or diagnostic service listed in Band 1b Type C.

Completed forms should be stored in such a way so as to facilitate any future audit of patient records.

ii. Private Patient Certification

All Private patients (i.e. chargeable, compensable, ineligible) who are admitted on a non-elective basis to a public hospital for a same day medical, surgical or diagnostic service, as specified in Band 1b.Type C, require the admitting medical practitioner to complete a Form 1830 (including Sections 4 and 5). This form must accompany a Form HC.21 when hospitals claim on health insurance funds.

Please note all private patients admitted for same day procedures require the completion of a Form 1830.

b) Elective Admissions

All patients (i.e. public, private, compensable, ineligible, other) who are admitted on an elective basis (i.e. booked) to a public hospital for a same day surgical or diagnostic service, as specified in Band 1b Type C, require the admitting medical practitioner to complete a Form 1830 (including Sections 4 and 5).

Please note that when completing a Form 1830, for private patients receiving a Band 1b.Type C procedure, care must be taken to ensure that the reasons for admission are clearly stated in section 5 to allow health funds to identify the special circumstances requiring the patient to be admitted.
## DAY ONLY PROCEDURES

### PUBLIC PATIENT NON-ELECTIVE BAND 1B. TYPE C CERTIFICATION FORM

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I certify that admission of the patients listed on this form was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Medical Officer: Name

Signature

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<th>MEDICAL RECORD NUMBER</th>
<th>SURNAME</th>
<th>GIVEN NAME(S)</th>
<th>AGE</th>
<th>SPECIFIED REASON FOR ADMISSION</th>
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4. COMPENSABLE CHARGEABLE

5 General

1) Where there is reasonable evidence that a person would be entitled to claim for compensation or damages in respect of an injury, illness or diseases, e.g. Public Liability Workers’ Compensation, that person should be classified as “Compensable” and accounts raised at the rates gazetted in the Government Gazette. (This applies to patients from other States as well.) Motor Vehicle Third Party cases are compensable but accounts are not raised on insurers.

SEE PAGE 49 FOR RATES OF CHARGE.

Hospitals should render accounts on the appropriate insurance company. It should be noted that accounts are not to be sent to the Government Insurance Office or other insurers in respect of Third Party Cases.

2) Accounts for clinical services provided by visiting medical officers, or staff specialists with rights of private practice, should be rendered on the appropriate insurance company by, or on behalf of, those officers.

3) Accounts for diagnostic services provided by visiting medical officers, or staff specialists with rights of private practice, should not be rendered on any insurance company or the patient. The hospitals are responsible for remunerating practitioners for these services.

4) Should a patient’s claim for compensation or damages fail, or an award for compensation or damages not include a component in respect of hospital charges, the patient’s classification should be reassessed as CHARGEABLE OR NON-CHARGEABLE according to the election made by the patient at the time of admission. The hospital should cancel the accounts issued by the hospital in accordance with (2) above, and:
   a) Issue an account at the Chargeable rate.
   b) Not issue any account for accommodation or medical charges if the patient is eligible under Medicare and elected hospital doctor and shared ward accommodation.
   c) Issue accounts to the patient for diagnostic services provided during the period of accommodation as a compensable patient if the patient is classified as chargeable. Such accounts can only be issued if the salaries or visiting specialist who performed the services is still a salaried or visiting specialist of the hospital.
5) Fees collected in respect of accounts for diagnostic services raised under 4(c) above, should be paid into the trust account of the salaried or visiting specialist concerned, and distributed on the same basis as fees collected in respect of services to other private inpatients. However, where a hospital has already paid the salaried or visiting specialist for his/her services, the hospital should transfer from the trust account an amount equal to that amount already paid in respect of these services.

6) a) Compensable patients will be formally admitted to each hospital where they are inpatients and registered as non-inpatients at each hospital where they receive non-inpatient care.

b) Will, if transferred from the hospital where admitted to another hospital for diagnostic or clinical procedure without being admitted as an inpatient at the second hospital, be charged hospital fees only by the hospital where admitted. (The hospital where the diagnostic or clinical procedure was performed in the above circumstances should make a charge to the hospital which referred the patient. For practical purposes the charge should be that gazetted for an outpatient occasion of service, in respect of a compensable patient of the hospital providing the service.)

c) Will be charged separately by attending medical practitioners at both the referring hospital and the hospital to which referred.

7) a) In respect of accommodation charges for ALL compensable patients, a “day” will be a period of 24 consecutive hours commencing from the time of the patient’s admission to a hospital and each successive period of 24 hours thereafter is an additional day.

b) In accordance with this definition, accommodation charges for all compensable patients should be raised for each “day” as defined above, with any part of a day being charged as a full day.

8) Commonwealth provisions in respect to compensable patients take precedence over State provisions. The Commonwealth provisions only allow for a standard daily charge with the bed days for admission and discharge being one day. Hospitals should continue raising accounts at the “compensable rate”, e.g. in a workers’ compensation patient of Australia Post.
INTRODUCTORY:

The following instructions apply to persons admitted as a result of Motor Accidents on and from 1 July 1989.

For persons attending as a result of Motor Accidents prior to that date, their insurer should be identified and if the GIO, their statistics should be included in the Transcover Section of the Monthly Report.

If an insurer other than the GIO, an account at the compensable rate should be issued on that insurer and their statistics recorded in the Other Compensable Section of the Monthly Report.

The Motor Accidents Act 1988 requires that there must be, in relation to every motor vehicle used upon a public street, a policy of insurance in a prescribed form which is issued by an authorised insurer and which insures the owner and any person driving the vehicle (with or without the authority of the owner) against liability which may be incurred in respect of death or bodily injury caused by, or arising out of the negligent use of the vehicle.

The Motor Accidents Act 1988 or Third Party Insurance covers all occupants of the motor vehicle (whether registered or not or whether the driver is licensed or not) except the driver at fault. If a single vehicle accident the driver of the vehicle is not covered.

Overseas visitors if driving or the occupant of a NSW registered vehicle which is not at fault are covered under the Motor Accidents Act 1988. If an overseas visitor is driving and is at fault he/she is not covered by the Act and is subject to charges at the ineligible rate. An overseas visitor who is the occupant, but not the driver, of a vehicle at fault is covered under the provisions of the Motor Accidents Act 1988.

Since 1983 the Department of Health has had a bulk billing arrangement with the GIO for the payment of hospital costs of persons hospitalised or attending for non-inpatient treatment as a result of motor accidents. (See Attachment J for Pre 1989 Procedures.)

This arrangement, which did away with the need for hospitals to render individual accounts with the insurers for persons hospitalised or attending for non-inpatient treatment as a result of motor accidents became obsolete with the introduction of the Motor Accidents Act on 1 July 1989 for persons injured in motor accidents on a from midnight 30 June 1990.

Visiting Medical Officers and staff specialists under schemes “B”, “C” and “D” are to render accounts in respect of clinical services. NO ACCOUNTS ARE TO BE RAISED IN RESPECT OF DIAGNOSTIC SERVICES.

The Motor Accidents Act 1988, unlike its predecessor, allows insurers other than the GIO to participate in the third party (personal injury) insurance industry.

Because of the benefits of bulk billing to the Areas/Hospitals in eliminating the need to render and follow-up individual claims and to the Department itself, through the continuity of cash flow, the Department has arranged for the continuation of the bulk billing arrangements by accredited compulsory third party insurers.

Insurers will pay a lump sum to the Department provided that, amongst other things, the Department requires Area Health Services and Public Hospitals “to obtain and maintain specified patient information to the extent that they are reasonably able to obtain it”.

13(5/92)
In the case of inpatients on admission, or as soon as possible thereafter, the information to be collected and filed for audit purposes within the Area Health Service/Public Hospital, is as follows:

(a) name of injured party;
(b) whether the injured party was a pedestrian, passenger, driver or rider;
(c) whether the injured party was the driver of a motor vehicle involved in a single motor vehicle accident;
(d) place of the motor accident;
(e) registration number of motor vehicles;
(f) date of the motor accident;
(g) whether the police attended the scene of the motor accident; and
(h) name of the hospital where the treatment, whether as an inpatient or non-inpatient, is provided.

To assist in the provision of the required information a Compulsory Third Party Patients Declaration and Election form which has been approved by the NSW Motor Accidents Insurers’ Committee, the Australian Medical Association and the Department, is at Attachment H and this is to be used. Areas/Hospitals should print sufficient copies for their own use and note that the form must be printed in accordance with that pro forma.

5.2.1 AUDIT OF RECORDS

The NSW Motor Accidents Insurers’ Committee has at this stage, agreed not to undertake an audit of records, or a sample thereof, maintained by Area Health Services/Public Hospitals subject to:

(i) the provision of an audit certificate by the Auditor-General in respect of Net Operating Costs, Total Bed Days/Occasions of Service and Bed Days/Occasion of Service for persons occasions admitted under the provisions of the Motor Accidents Act, and

(ii) the supply of monthly statistics relating to Bed Days/Occasions of Service for persons admitted under the provisions of the Motor Accidents Act and Total Bed Days/Occasions of Service.
The data requirements are as indicated in the “Audited Annual Return” and the information to complete this return is available from the DOHRS reports:

3.4.3.C00S  By Accounting Classification
3.4.3.D  Inpatient Accounting Bed Days

Bed day records and non-inpatient occasions of service directly affect the Bulk Billing Agreement and particular attention must be paid to the accuracy of dissection of these records for road accident cases.

Bed day and non-inpatient records for persons admitted or attending from road accidents occurring from midnight 30 June 1989 and having a claim against a third party insurer under the *Motor Accidents Act* must be recorded against the *Motor Accidents Act* Section of the Monthly Report.

“Transcover” statistics record bed days of cases of patients admitted as a result of road accidents that occurred between 1 July 1983 and 30 June 1989 and whose current admission or stay in hospital is attributable to that accident. Bed days of patients whose accident occurred prior to 1 July 1983 should be recorded against Other Compensable.

### 5.2.2 LONG TERM INPATIENTS

The NSW Motor Accident Insurers’ Committee has expressed concerns that their Agent (the Motor Accidents Authority of New South Wales) is not being advised of all patients who will be in hospital for a minimum of 35 days either as single admission or through multiple admissions as a result of the one accident.

For long term patients, which in this context, means patients who will be in hospital for a minimum of 35 days either as a single admission or through multiple admissions as a result of the one accident, the Department has agreed to undertake the following:

On or before the 35th day (preferably as early as possible if patient’s condition suggests it will be a long stay) of inpatient service, the Area/Hospital will obtain the additional information detailed below and send a copy of the Declaration/Election Form (which is filed for audit purposes) and the information to the licensed insurers’ agent which is The Motor Accidents Authority of New South Wales, 139 Macquarie Street, Sydney, 2000.

(i) basic injuries;
(j) whether the patient has lodged a claim under the Act and if so, with whom.
The additional information may be sent by letter when referring the copy of the declaration/election form. The insurers’ representative has also asked that a copy of the Ambulance Report, if available, be forwarded with the additional information and the copy of the Declaration/Election Form. This report should be filed with the patient’s medical record.

In respect of non-inpatient services, the Department has agreed to request Areas/Hospitals to identify CTP compensable persons on registration, and to record as they occur the number of non-inpatient services provided. The information collected on registration must be filed for audit purposes and the declaration/election form is to be used for this purpose.

The insurers have agreed that certain services will be excluded from the agreement.

The excluded services are clinical services provided at Areas/Hospitals by a medical practitioner exercising his right of private practice and certain rehabilitation services to be agreed between the parties. The agreement recognises that self-funding rehabilitation units established at Areas/Hospitals will be entitled to charge for their services. Apart from these excluded services, no charge shall be made to insurers in respect of inpatient or non-inpatient services provided during the relevant period to CTP compensable persons (the bulk billing agreement will cover such charges).

The Department’s standard monthly report forms will collect details of bed days and occasions of service in respect of CTP patients.

5.2.3 ACCESS TO MEDICAL RECORDS

From time to time insurers will request the Area/Hospital to forward information which relates to a compensation claim for a patient for whose hospital and medical costs the insurer is responsible.

A form, a copy of which is at Attachment II, has been designed for this purpose and is produced under the authority of the Motor Accidents Act.

In supplying data Areas/Hospitals are reminded of the provisions contained in the Patient Matters Manual (Chapter 9) regarding confidentiality of medical records and release of information.

It will be noted that for insurance purposes a PHOTOCOPY of the patient’s consent will suffice - Areas/Hospitals should not therefore request the insurers to send original consent forms.
5.2.4 CHARGES FOR MEDICAL RECORDS

Charges should be made to the Third Party Insurer where the records requested are a Summary of Injuries. (See charges for Medical Records)

It is important that statistics in respect of accidents occurring on or after 1 July 1989 (Motor Accidents Act 1988) be recorded and reported separately from those occurring prior to 1 July 1989 (Transcover).
**WORKERS’ COMPENSATION CLAIMS**

The *Workers’ Compensation Act 1987*, repealed the *Workers’ Compensation Act 1926*, to provide for payment for hospital treatment of injured workers at the cost to hospitals of providing the treatment, as estimated and notified in the Government Gazette. Hospitals should have copies of the Act and Regulations.

Fees are to be raised by each hospital at the relevant rates. Fees chargeable by each hospital as estimated and notified by the Minister for Health in the Government Gazette and are advised each year by Departmental Notice. This applies even though the injuries requiring hospitalisation or outpatient treatment were sustained prior to the effective date.

The fees specified in respect of inpatients are “all-inclusive” and hospitals are not to raise charges for any specific service provided, e.g. Radiology, Pathology, Theatre, EEG’s, ECG’s, Plasters, Splints.

As soon as possible after admission details should be obtained from the patient, in respect of date of injury, employer, name of insurance company and claim number if possible.

Under the Act, there is now no limit on the charges which may be raised by hospitals in a defined period for outpatient attendance. Fees should be raised for the full period of hospitalisation and a claim made accordingly.

For accounting purposes, charges raised based on the inpatient fees specified are to be recorded in full as being for “accommodation”, whilst the outpatient charges are to be recorded in full as being for “attendance”.

Whilst separate charges will not be raised, hospitals are to continue to maintain in their statistical records separate figures on services provided to Workers’ Compensation patients, viz. X-Rays, Pathology, etc. In addition, hospitals are to keep a memorandum record of all outpatient registrations and attendances of Workers’ Compensation patients.

Where a Workers’ Compensation outpatient attends more than one clinic or department during a visit to a hospital, including day hospital, each such attendance is to be regarded as a separate attendance and charged accordingly, (e.g. A Workers’ Compensation patient who attended the Casualty Clinic and the X-Ray Department of a hospital during the one visit would be regarded as having two attendances and charged accordingly).

As an indicator in respect to injured employees the undermentioned chart is to be applied.

<table>
<thead>
<tr>
<th><strong>Injured Employee</strong></th>
<th><strong>Charge Applicable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth Employee</td>
<td>WCC Rate</td>
</tr>
<tr>
<td>Australian Seaman</td>
<td>WCC Rate</td>
</tr>
<tr>
<td>Interstate Employee Injured in NSW</td>
<td>CC Rate</td>
</tr>
<tr>
<td>Interstate Employee Injured Outside NSW</td>
<td>Normal Accommodation Rate</td>
</tr>
<tr>
<td>NSW Employee Injured Outside NSW</td>
<td>WCC Rate</td>
</tr>
</tbody>
</table>
 PD2018_024 rescinds PD2017_018 which rescinded PD2016_024

PURPOSE

This Policy Directive provides the key policy aspects and rates in relation to public hospital accommodation for chargeable patients.

MANDATORY REQUIREMENTS

Hospital accommodation charges are to be raised for all chargeable patients as detailed in this Policy Directive and attached Procedures. Hospital accommodation rates from 1 July 2018 are advised in the attached Procedures.

Hospitals are to:

- Inform patients of all applicable accommodation charges
- Verify private insurance status of patients
- Ensure prepayment arrangements are made on admission for ineligible patients and for eligible patients who will incur a co-payment / excess.

Bulk billing arrangements apply for all Motor Vehicle Compulsory Third Party (MV CTP) and Lifetime Care and Support (LTCS) patient services (except for services provided by designated Brain and Spinal Injury Rehabilitation units) under the Purchasing Agreement for NSW Health Services to Motor Accident Vehicle Patients. The NSW Ministry of Health administers the charging of these patients based on hospital / facility activity data recorded and conveyed via the Health Information Exchange (HIE) and agreed rates of charge and disseminates this revenue to LHDs as appropriate. Hospitals / facilities / LHDs are to ensure MV CTP and LTCS activity is accurately identified and coded to ensure that appropriate charging occurs.

The Commonwealth Government will assume full responsibility for Norfolk Island from 1 July 2016. As a consequence, the vast majority of Norfolk Island residents will become Medicare eligible from 1 July 2016 and will be issued with a Medicare card. Further advice is provided in “Section 5 Norfolk Island Residents” of this Policy Directive.

IMPLEMENTATION

Local Health District / Specialty Health Network Chief Executives are to ensure that the requirements of this Policy Directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

Staff can access the State-wide Revenue Toolkit at http://staterevenue.wsha.nsw.gov.au for further information on policy application and implementation.

1. BACKGROUND

1.1 About this document

This Policy Directive updates key charging policy aspects and rates in relation to public hospital accommodation for chargeable patients. The advised rates are effective from 1 July 2018. This document replaces PD2017_018.
Vehicle Accident Compulsory Third Party (MVA) and Lifetime Care and Support (LTCS) patients this occurred from 1 July 2012 and for Workers Compensation and Other Compensable patients from 1 April 2014.

Compensable patient other service categories (sub and non-acute services and non-admitted patient services (except Emergency Departments) will transition from their current charging arrangements (per diem and occasion of service) to case mix over the next few years.

The Commonwealth Government will assume full responsibility for Norfolk Island from 1 July 2016. As a consequence, the vast majority of Norfolk Island residents will become Medicare eligible from 1 July 2016 and will be issued with a Medicare card. Further advice is provided in “Section 5 Norfolk Island Residents” of this Policy Directive.

1.2 Legal and legislative framework

The advised fees (with the exception of fees relating to Workers Compensation patients) are gazetted by order under the Health Services Act 1997.

The advised fees in relation to Workers Compensation patients are gazetted by order under the Workers Compensation Act 1987.

2. PRIVATE PATIENTS (Overnight Stay)

<table>
<thead>
<tr>
<th></th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Room</td>
<td>357</td>
</tr>
<tr>
<td>Single Room</td>
<td>752</td>
</tr>
</tbody>
</table>

The shared room rate applies for private patients in single rooms where:

- The patient elects shared ward accommodation, but only single ward accommodation is available
- The patient elects shared room accommodation, but due to clinical reasons is located in single ward accommodation.

The single room rate applies for private patients where:

- The patient is accommodated at his / her request in a single room or as a sole occupant of a shared room.

Public hospitals are to undertake the following procedures in order to ensure full payment of accommodation charges:

- Admission staff must inform eligible patients with health insurance who wish to elect to be a private patient that their health insurance policy may require a patient co-payment / excess.
- To reduce administrative effort, patients from whom co-payment / excess is required or patients who elect to be private and who do not have private health insurance, payment arrangements are to be made on admission in the form of:
  - Credit card imprint (credit limits to be verified)
  - Cash to cover estimated cost
  - Bank or personal cheque to cover estimated cost.
- On discharge, credit card imprints should be completed with the due amount and adjustments made in respect of cash advances / cheques.
- Where for any reason payment is not finalised on admission or upon discharge, existing procedures for the recovery of outstanding hospital accounts should be followed.
3. PRIVATE PATIENTS (Same Day Patient)

<table>
<thead>
<tr>
<th>Band</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>259</td>
</tr>
<tr>
<td>Band 2</td>
<td>290</td>
</tr>
<tr>
<td>Band 3</td>
<td>318</td>
</tr>
<tr>
<td>Band 4</td>
<td>357</td>
</tr>
</tbody>
</table>

Band 1, 2, 3, or 4 per diem rates apply as appropriate, in accordance with the complexity of the procedure provided, the type and level of anaesthesia required (if any) and the time spent by the patient in the operating theatre.

4. INELIGIBLE PATIENTS

Excluding persons admitted to a public hospital under the Asylum Seeker Assistance Scheme.

Ineligible patients (e.g. overseas patients) are not eligible for free hospital treatment. Reciprocal Health Care Agreement arrangements are to apply where appropriate.

4.1 Worker Visa holders 401, 403, 408, 416, 420, 457 & 485 and Student Visa holders 500, 570 to 576 and 580

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>Inpatient - Critical Care</td>
<td>3,340</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Inpatient – Other than critical care</td>
<td>1,344</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Inpatient</td>
<td>564</td>
</tr>
<tr>
<td></td>
<td></td>
<td>316</td>
</tr>
</tbody>
</table>

Critical Care for the purpose of this document is defined as patients treated in the following units: intensive care units (ICU), paediatric intensive care units (PICU), neonatal intensive care units (NICU), psychiatric intensive care units, neonatal special care nurseries, coronary care units (CCU) and high dependency units (HDU).

4.2 Other than Worker and Student Visa holders stipulated in 4.1 (above)

4.2.1 Acute Admitted Patient Services – All Hospitals

<table>
<thead>
<tr>
<th></th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care – first 21 days per episode</td>
<td>5,830</td>
</tr>
<tr>
<td>Critical Care – over 21 days</td>
<td>3,340</td>
</tr>
<tr>
<td>Other Inpatient – first 21 days per episode</td>
<td>2,298</td>
</tr>
<tr>
<td>Other Inpatient – over 21 days</td>
<td>1,344</td>
</tr>
</tbody>
</table>

- In counting the days in Critical Care – first 21 days per episode and Other Inpatient – first 21 days per episode, stand alone. For example if a patient is in Critical Care for 25 days and then Other Inpatient (non-critical care) for a further 30 days – charge would be 21 days at $5,830 plus 4 days at $3,340 plus 21 days at $2,298 plus 9 days at $1,344. If the same patient then returned to Critical Care for a further 2 days (same episode) the charge would be a further two days at $3,340.

- Critical Care for the purpose of this document is defined as patients treated in the following units: intensive care units (ICU), paediatric intensive care units (PICU), neonatal intensive care units (NICU), psychiatric intensive care units, neonatal special care nurseries, coronary care units (CCU) and high dependency units (HDU).
4.2.2 Sub-Acute and Non-Acute Admitted Patient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>Inpatient</td>
<td>1,344</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Inpatient</td>
<td>564</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Inpatient</td>
<td>316</td>
</tr>
</tbody>
</table>

4.3 Non-Inpatient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>Non-Inpatient</td>
<td>143</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Non-Inpatient</td>
<td>100</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Non-Inpatient</td>
<td>100</td>
</tr>
</tbody>
</table>

The rates of charge are as per the above occasion of service rates as appropriate to the hospital classification or in relation to Staff Specialists or Visiting Medical Officers up to Australian Medical Association (AMA) rates.

4.4 Ineligible Inpatient Treatment Fee

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>354</td>
</tr>
</tbody>
</table>

The above per diem fee is applicable under the following circumstances:-

Emanating from the provision of indemnity cover for doctors treating public patients in NSW public hospitals was the need to introduce a treatment rate in relation to ineligible inpatients when treated by a VMO / HMO as a public patient, pursuant to clause 5.2 of the VMO / HMO explanation document for the ‘Public Patient Indemnity (PPI) Cover’.

In the normal course an ineligible inpatient is treated as a private patient by a VMO / HMO who charges the patient for services provided, in which case PPI cover will not be provided to the VMO / HMO. In addition to the VMO / HMO charge, the public health organisation (PHO) raises the applicable gazetted accommodation fee (sections 4.1 and 4.2 above) on the ineligible inpatient for his / her period in hospital.

However, where the PHO requires a VMO / HMO to treat an ineligible inpatient under the service contract (including call backs) as a public patient in a public hospital, PPI cover will be provided to the VMO / HMO. In this situation the VMO / HMO cannot raise a charge on the ineligible patient and the VMO is paid by the PHO for services provided at the appropriate VMO rate (sessional, FFS, RDA). The PHO will continue to raise the applicable gazetted accommodation fee for the ineligible inpatient’s period in hospital, however the ineligible inpatient is now not charged by the VMO / HMO with the medical costs now being borne by the PHO.

As a result a daily treatment charge (irrespective of the number of treating practitioners) was introduced from 1 July 2002. The treatment charge applies to ineligible inpatients (in addition to the current applicable accommodation charge) in situations where the ineligible inpatient receives medical treatment under arrangement with a PHO rather than an individual practitioner.

The above principles also apply to Salaried Medical Practitioners (SMP’s)(except Level 1 who are covered for civil liability in regard to all work performed including their treatment of private patients), in circumstances where they are directed as part of their employment arrangements to treat an ineligible inpatient. In these circumstances the SMP (Levels 2-5) will not be entitled to raise a fee on the ineligible inpatient.

It would be expected that VMO / HMOs and SMPs in the normal course will treat ineligible inpatients as private, in which case the Ineligible Inpatient Treatment Fee will not apply.

Where a VMO / HMO has chosen not to participate in the TMF Contract of Liability Coverage arrangements, they cannot be provided with PPI cover to treat an ineligible inpatient as part of the VMO contract. These VMO’s can only treat ineligible inpatients as private and are to hold appropriate insurance cover for all patients treated in a public hospital.
4.5 **Ineligible Patient - Hospital In The Home (HITH)**

HITH services provide acute and post-acute care to patients residing outside hospital, as a substitution or prevention of in-hospital care. The place of residence may be permanent or temporary.

- **Substitution** - The defining feature is that if not receiving the HITH service, the patient would require hospitalisation or a longer stay in hospital.
- **Prevention** – Care that does not immediately substitute inpatient care, however it is provided as preventative option to avoid an imminent hospital admission or readmission.

HITH care is short-term and preferably interdisciplinary, including doctors, nurses and allied health practitioners.

4.6 **Ineligible Patient Dialysis – All Hospitals**

4.7 **Ineligible Patients – Policy aspects**

- Ineligible patients are "private", that is they must elect a doctor except in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.
- Ineligible patients are to be billed for all clinical/diagnostic services provided by VMOs / HMOs and salaried staff specialists exercising their right of private practice or by the hospital (treatment fee-section 4.4 above) in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.
- Accommodation charges are not to be raised in respect of ineligible unqualified babies.
- Charges are to be raised for surgically implanted prostheses.
- Charges are to be raised for the direct cost (plus relevant on-cost) of drugs.
- Charges are to be raised at cost recovery for all other services provided in relation to a patient’s episode of care
- The dates of admission and discharge are to be counted as one day, with the date of admission being counted as that day (i.e. the 24 hour counting for compensable patients, does not apply to ineligible patients).
- In relation to section 4.2 (other than Worker Visa holders 457 and 485 and Student Visa holders 570 to 576) hospitals are to obtain an assurance of payment from this category of ineligible patients before treatment is provided. This assurance may take the form of:
  - Credit card imprint (credit limits to be verified)
  - Cash to cover estimated cost
  - Bank cheque to cover estimated cost
  - Personal guarantee from Australian citizen whose bona fides are verified
  - Other initiatives to ensure that payment for the services is not lost to the hospital.

Where such an assurance of payment is not forthcoming, the ineligible patient is to be informed that they will receive only the minimum and necessary medical care to stabilise their condition. This provision is not intended to impinge on the medical or legal obligations of medical officers in the treatment of ineligible patients.

104(03/07/18)
5. NORFOLK ISLAND RESIDENTS

5.1 Medicare Eligible Norfolk Island residents

As with all Medicare eligible persons these patients have the choice to elect to be treated as either a public (non-chargeable) or private (chargeable) patient.

For private patients, charges are to be raised in accordance with section 2 Private Patient (overnight stay) and 3 Private Patient (same day patient) of this Policy Directive.

It is imperative that from 1 July 2016 the “Financial Class” for these patients reflects their Medicare eligible status. Thus public patients should be coded to the appropriate “Medicare Card Holder – Hospital Doctor” (public) financial class while private patients should be coded to the appropriate “Medicare Card Holder – Elected Doctor” (private) financial class. Note that the specific “Overseas Visitor – Norfolk Island” Financial Class codes are not to be used from 1 July 2016.

The Commonwealth has undertaken to reimburse the cost of providing mainland hospital services to Medicare eligible Norfolk Island residents. These patients will be identified via a combination of the appropriate Medicare eligible financial class and Norfolk Island resident postcode.

5.2 Medicare Ineligible Norfolk Island residents

Charges are to be raised on the patient in accordance with section 4.1 (Ineligible Patient - admitted) and section 4.3 (ineligible Patient – non inpatient) accommodation charges of this Policy Directive.

It is imperative that from 1 July 2016 the “Financial Class” for these patients reflects the appropriate Ineligible patient status.

5.3 Norfolk Island resident - Compensable patients

Charges are in accordance with section “7 Compensable Patient Accommodation Charges” of this Policy Directive.

It is imperative that from 1 July 2016 the “Financial Class” for these patients reflects the appropriate Compensable patient status.

6. PATIENTS ADMITTED TO A PUBLIC HOSPITAL UNDER THE ASYLUM SEEKERS ASSISTANCE SCHEME

$ per day

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Room</td>
<td>630</td>
</tr>
<tr>
<td>Single Room</td>
<td>939</td>
</tr>
<tr>
<td>One Day Admission (Bands 1, 2, 3 or 4)</td>
<td>538</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1890</td>
</tr>
</tbody>
</table>

7. COMPENSABLE PATIENTS ACCOMMODATION CHARGES

7.1 Acute Admitted Patient Services – All Hospitals

The patient episode reflecting the applicable AR-DRG version 9.0 grouping aligned to the National Weighted Activity Unit (NWAU(18)) with adjustments applied as applicable in accordance with the Independent Hospital Pricing Authority (IHPA) publication National Efficient Price Determination 2018-2019. The NWAU(18) is adjusted to reflect that Visiting Medical Officers (VMOs) and Staff Specialists bill separately for compensable admitted patients. The removal of assessed VMO and Staff Specialist costs reduces each NWAU by 11% creating an adjusted NWAU (18) for the purposes of charging this category of compensable patients. The NWAU is rounded to the nearest 3 decimal places multiplied by

The National Efficient Price (NEP) of $5,012 as determined by the Independent Hospital Pricing Authority (IHPA).

104(03/07/18)
7.2 Emergency Department (ED) Admitted Patient Services – All Hospitals, excluding EDs of small rural hospitals not collecting nor required to collect patient level data

The ED episode reflecting the applicable URG version 1.4 or UDG version 1.3 grouping aligned to the National Weighted Activity Unit \((NW\text{A}U(18))\) with adjustments applied as applicable in accordance with the IHPA publication \textit{National Efficient Price Determination 2018-2019}.

The \(NW\text{A}U(18)\) is adjusted to reflect that Visiting Medical Officers (VMOs) and Staff Specialists bill separately for compensable admitted patients. The removal of assessed VMO and Staff Specialist costs reduces each NWAU by 11\% creating an \textit{adjusted NWAU (18)}, which is applicable for the purposes of charging ED admitted compensable patients. The NWAU is rounded to the nearest 3 decimal places multiplied by

\[ \text{The National Efficient Price (NEP) of } \$5,012 \text{ as determined by the Independent Hospital Pricing Authority (IHPA).} \]

7.3 Emergency Department (ED) Non-admitted Patient Services – All Hospitals, excluding EDs of small rural hospitals not collecting nor required to collect patient level data

The ED presentation reflecting the applicable URG version 1.4 or UDG version 1.3 grouping aligned to the National Weighted Activity Unit \((NW\text{A}U(18))\) with adjustments applied as applicable in accordance with the IHPA publication \textit{National Efficient Price Determination 2018-2019}. The NWAU is rounded to the nearest 3 decimal places multiplied by

\[ \text{The National Efficient Price (NEP) of } \$5,012 \text{ as determined by the Independent Hospital Pricing Authority (IHPA).} \]

7.4 Emergency Department (ED) of small rural hospitals not collecting nor required to collect patient level data

Per occasion of service at set rates per section 7.6 of this Policy Directive.

7.5 Sub-Acute and Non-Acute Admitted Patient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>Inpatient</td>
<td>1,181</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Inpatient</td>
<td>496</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Inpatient</td>
<td>278</td>
</tr>
</tbody>
</table>

- The above charges are inclusive of diagnostic costs.

7.6 Non-Inpatient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>Non-Inpatient</td>
<td>125*</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Non-Inpatient</td>
<td>88*</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Non-Inpatient</td>
<td>88*</td>
</tr>
</tbody>
</table>

The amounts shown (*) are the rates of charge for each occasion of service (excluding physiotherapy, chiropractic & osteopathy services, psychology & counselling services and exercise physiology services – see section 7.7 to 7.9) as appropriate to the hospital classification or the maximum amount payable under the relevant WorkCover practitioner fees order. The fees orders, which generally link to AMA rates, cover Medical Practitioners, Surgeons and Orthopaedic Surgeons. Links to the Orders are advised below:-


### 7.7 Non-Inpatient Physiotherapy Service Charges

**Normal Practice**

<table>
<thead>
<tr>
<th>Item</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA001</td>
<td>94.10</td>
</tr>
<tr>
<td>PTA002</td>
<td>79.70</td>
</tr>
<tr>
<td>PTA003</td>
<td>142.00</td>
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**Home Visit**

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**Other**

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</table>

The above rates do not apply in relation to Motor Vehicle CTP patients.

### 7.8 Non-Inpatient Psychology Service Charges

<table>
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The above rates do not apply in relation to Motor Vehicle CTP patients.

### 7.9 Non-Inpatient Exercise Physiology Service Charges

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</table>

The above rates do not apply in relation to Motor Vehicle CTP patients.
7.10 Dialysis – All Hospitals (per non-admitted session) $ per session 666

8. VETERANS’ AFFAIRS PATIENTS

NSW Health manages bulk billing on behalf of recognised public hospitals under Agreement with the Department of Veterans’ Affairs.

Thus from 1 July 1993, recognised public hospitals no longer raise accounts against DVA for the cost of accommodation of DVA patients.

9. OUTREACH SERVICES PATIENTS

The *Private Health Insurance Act 2007* abolished the Outreach default benefit payable for hospital in the home type services.

10. ACCOMMODATION & MEALS CHARGES FOR PARENTS, RELATIVES OR FRIENDS OF PATIENTS

**Accommodation Only** (excluding meals) $ per night

- Maximum charge where accommodation is provided in a self-contained unit (including own kitchen and bathroom facilities). 48
- Maximum charge per person for accommodation other than self-contained accommodation 24

**Meals** $ per meal

- Maximum per meal per person and no greater than rates applicable to hospital employees 8

The Chief Executive has the discretion to reduce or waive these charges based on the level/standard of accommodation provided or financial hardship.

11. PATIENTS IN MEDICAL ASSESSMENT UNITS AND OTHER SHORT STAY UNITS

Where such a patient is admitted on one day and discharged on a subsequent day, the admitted shared rate is to be raised in relation to private patients.

Where such a patient is admitted and discharged on the same day, the following charging rules apply in relation to private patients:

- Hospital to claim benefit under Medicare Benefits Schedule (MBS) from Medicare (75%) and Health Fund (25%) for medical services (including diagnostic services).
- Where the day only criteria for Band 1 is satisfied, and the appropriate medical practitioner completes the “Type C Exclusion” exemption (Day Only Procedure Certification), hospital to invoice Health Fund the Same Day - Band 1 rate.

12. PRISONERS – PROVISION OF MEDICAL SERVICES

All New South Wales prisoners are entitled to free inpatient and non-inpatient services in New South Wales public hospitals.

When the required services are not available at the public hospital to which the prisoner is admitted as an inpatient, or attends as a non-inpatient the following arrangements apply:

104(03/07/18)
12.1 Inpatient Services
Neither the prisoner, nor the Justice and Forensic Mental Health Network is to be charged for accommodation, diagnostic, medical, nursing or other services provided by:

- The public hospital where admitted;
- The public hospital to which transferred for further care as an inpatient;
- The public hospital to which referred for a diagnostic or clinical procedure without being admitted as an inpatient;
- A private medical practitioner (in their rooms), for services not available at a public hospital.

In these circumstances, the referring public hospital is responsible for meeting any costs involved.

12.2 Non-Inpatient Services
Neither the prisoner, nor the Justice and Forensic Mental Health Network is to be charged for non-inpatient services provided by:

- The public hospital initially attended by prisoner
- The public hospital to which referred, if services not available at the initial public hospital
- A private medical practitioner (in their rooms), for services not available at a public hospital.

In these circumstances, the original hospital that the prisoner attended is responsible for meeting any costs involved.

13. BABIES – CHARGES IN RESPECT OF NEWBORNS

13.1 Qualified Babies
Qualified babies are deemed to be a patient of the hospital (inpatient service) and are those babies that meet the following criteria:-

- A newly-born child who occupies an approved bed in an intensive care facility in a hospital receiving special care services, and
- Each child in excess of one where there are two or more newly born children of the same mother in a hospital (note that all the children are qualified babies if they meet the criteria above).

Parents must make an election on behalf of the baby to be public (non-chargeable) or private (chargeable).

13.2 Unqualified Babies
The baby should be classified as ‘non-chargeable’ whilst unqualified, however if a baby becomes qualified for any part of the period of stay the rules relating to qualified babies apply but only for the period of qualification.

Medical / Diagnostic services are non-chargeable where provided by a hospital appointed doctor or where a service provided by a private practitioner has been organised by the hospital as part of the overall service to an unqualified baby. However where a parent / guardian requests to have an unqualified baby examined by a private medical practitioner of their choice, the parent / guardian can be billed for these services. A Medicare rebate of 85% of the scheduled MBS fee then applies as the Commonwealth regards these services as being provided to a privately referred non-inpatient as an unqualified baby and not as an inpatient service.
14. CLASSIFICATION OF VICTIMS OF CRIME PATIENTS

Victims of crime are unable to claim expenses under the *Victims Compensation Act 1996* for hospital treatment as the Act does not confer a right to compensation. Therefore when an inpatient or non-inpatient presents at a public hospital as a victim of crime they are not to be classified as compensable.

The exception to these general principles would be those persons who are the victim of crime for which they are entitled to claim some form of compensation (eg worker’s compensation). In these instances the person would be classified as a compensable patient and charges raised accordingly.

Medicare eligible victims of crime inpatients may elect to be treated as either public (non-chargeable) or private (chargeable) with usual policies to apply.

Medicare ineligible (overseas visitors) victims of crime (confirmed by police) who present at a NSW public hospital and treatment is provided by a hospital nominated doctor, no hospital / medical charges are to be raised, otherwise charging arrangements for ineligible patients apply.
NURSING HOME TYPE PATIENTS AND THE NATIONAL ACUTE CARE CERTIFICATE (PD2016_011)

PURPOSE
This Policy Directive advises requirements in relation to administration of the Nursing Home Type Patient (NHTP) contribution and the National Acute Care Certificate (NACC).

MANDATORY REQUIREMENTS
All public hospitals are required to comply with the attached procedures.

Patients who remain in a public hospital bed after 35 days must have their care type assessed by a medical practitioner and the need for continuing hospital level care documented in the patient’s medical record prior to day 35. In addition for Private and DVA patients a NACC must be issued by a medical practitioner to certify the need for continuous hospital level care beyond 35 days.

A key change advised in this policy is that NACC’s are no longer required for Public patients.

Patients no longer requiring hospital level care beyond 35 days must have their care type changed to Maintenance Care and financial class to NHTP.

Fees are to be raised for NHTP’s consistent with the attached procedures.

IMPLEMENTATION
Local Health District / Speciality Health Network Chief Executives are to ensure that the requirements of this Policy Directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

Staff can access the State-wide Revenue Toolkit at http://staterevenue.wsahs.nsw.gov.au for further information on policy application and implementation.

1 BACKGROUND

1.1 About this document
This Policy Directive advises requirements in relation to administration of the Nursing Home Type Patient (NHTP) contribution and the National Acute Care Certificate (NACC).

This policy does not apply to Motor Accident Third Party, Workers Compensation, Other Compensable or Ineligible patients.

Patients who remain in a public hospital bed after 35 days continuous care at one or more hospitals and no longer require hospital level care, i.e. the patient only requires nursing care and accommodation as an end in itself, are charged a daily NHTP contribution as determined by the Commonwealth Department of Health.

Inpatient accommodation rates payable by Private Health Insurers (PHI) for Private patients and Department of Veterans Affairs (DVA) for DVA patients are reduced once the patient is deemed to be subject to the NHTP contribution. For this reason, if the Private or DVA patient remains in need of hospital level care following 35 days continuous care, a NACC certificate is required by PHI and DVA to provide certification and justification for continuation of the higher inpatient accommodation rate.

87(5/5/16)
1.2 Key definitions

In this policy directive:-

- Hospital Level Care, refer to section 2.1 of this document.
- Continuous care, refer to section 2.2 of this document.
- Nursing Home Type Patient (NHTP) refers to a patient who has been in one or more hospitals (public or private) for a period of more than 35 days continuous care, and who is not deemed to be receiving hospital level care (i.e. the patient only requires nursing care and accommodation as an end in itself).
- National Acute Care Certificate (NACC) refers to a document required by private health insurers (PHI) and the Department of Veterans Affairs (DVA) to certify a patient’s need for long term hospital level care.
- Maintenance Care, refer to Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care (PD2014_010).

1.3 Legal and legislative framework

These procedures are in line with requirements from the National Health Reform Agreement 2011, Private Health Insurance (Benefit Requirements) Rules 2011 and the Pension Based Fees - Charging Arrangements and Scale of Fees.

2 NURSING HOME TYPE PATIENT (NHTP)

NHTP refers to a patient who has been in one or more hospitals (public or private) for a continuous period of more than 35 days, with a maximum break of no greater than seven days, who is not deemed to be receiving hospital level care (i.e. the patient only requires accommodation and nursing care, as an end in itself).

A patient no longer requiring hospital level care beyond 35 days must have their care type assessed and evidenced by documentation in the patient medical record prior to day 35. Hospital administration staff must be notified of this change. The patient’s care type must be changed to Maintenance Care and the patient must be fully informed of all changes and charges seven days prior to the financial class being changed to Nursing Home Type (NHTP).

Should a patient’s care type be changed to Maintenance Care prior to day 35 the patient’s financial classification does not change to NHTP until day 36.

If a patient classified as NHTP subsequently requires hospital level care this must be evidenced by documentation in the patient medical record to support a change in care type and financial classification.

In the case of Private and DVA patients a NACC must be issued. Following the period of hospital level care the patient must have a care type change back to Maintenance Care and a financial classification change back to NHTP.

2.1 Guidelines for assessing Hospital Level Care

Hospital Level Care includes active, inpatient treatment which is clinically necessary for the intensive optimal management of acute conditions, effective management of exacerbations of symptoms in a chronic condition or where outpatient treatment has been ineffective in a chronic condition, or for life support.

The need for hospital level care refers to those patients whose medical condition requires medical and nursing care which is intensive, active and requires regular monitoring in an inpatient setting. In the context of this policy, hospital level care does not refer to treatment being provided to those patients whose medical condition has become stabilised, and the treatment and management being provided is of a routine and/or supportive nature.
Rehabilitation is considered part of hospital level care if it is being provided by a hospital with rehabilitation facilities and appropriately qualified personnel in order to improve a patient’s functional capacity to a level that will enable the patient to be returned to his or her environment. It does not include ongoing supportive therapy.

Hospital level care includes treatment during the post-operative recovery period, including the treatment of any post-operative complications and/or complications arising from any diagnostic or therapeutic procedure.

Some terminally ill patients in hospitals may be considered as needing hospital level care. This will depend on the level of active medical intervention.

Patients remaining in hospital while awaiting nursing home placement should not be considered as requiring hospital level care.

In evaluating the need for hospital level care the following factors should be considered:

• Does the patient require care which should be provided in an acute hospital bed?
• Does the condition of the patient require treatment and investigation procedures which are unavailable in a nursing home?
• Is the treatment being given likely to further improve the patient in the short term with the intention of returning the patient to his or her previous environment?
• Is the degree of improvement consistent with the time interval between initiation and completion of treatment?
• The relationship between the degree of improvement in the patient’s condition and the nature of the treatment provided.

2.2 How to calculate continuous care

In the event of readmission to a hospital within seven days, or transfer between hospitals, the previous related inpatient periods will be regarded as contributing towards the period of 35 days continuous care. The date of discharge is not to be counted as one of the seven days. The seven days commences from the day after discharge or on leave.

The periods of leave are not counted towards the 35 day qualifying period; therefore, a patient who has been in hospital for 20 days and then leaves the hospital for 3 days will start at day 21 when returning to hospital. Similarly, where a patient is discharged and a period of more than seven days elapses before readmission, the previous stay in hospital will not be counted.

If a patient is transferred from one hospital to another, all relevant documentation of the patient’s prior length of stay must be provided to the admissions department of the hospital to which the patient is transferred. This is to determine the total length of stay.

In cases where the patient’s length of stay in hospital has been broken by periods of less than seven days, this will require all relevant admission and separation dates from the previous hospital be forwarded to the new hospital. Private hospitals will be asked to supply this information for all transfers to public hospitals.

The acute care calculator is available on the NSW Health Revenue Toolkit Tools & Resources intranet page.
NHTPs are required to pay a patient contribution (fee) as set by the Commonwealth Department of Health. The patient contribution fee is uninsurable and charged as a daily rate to the patient.

The rates are reviewed in March and September each year in line with Australian pension / benefit adjustments.

Pension patients may be eligible for various assistance payments such as single pension and rent assistance depending on their individual circumstance. Patients should be referred to the Department of Human Services for current details and application information.

NHTP rates can be found in the current policy directive titled Pension Based Fees – Charging Arrangements and Scale of Fees.

2.4 Patient Communication

Patients must be informed verbally and in writing at least seven days prior to their financial classification change to NHTP and commencement of charging the daily patient contribution. A sample letter can be found on the NSW Health Intranet Revenue Toolkit tools and resources page (Attachment 2).

Once patients have been given notification and all information related to the associated fee they should be asked to sign a Nursing Home Type Patient – Accommodation Contribution Agreement (Attachment 3).

3 PUBLIC PATIENT

A NACC is not required for public patients requiring the continuance of hospital level care beyond 35 days. The patients care type must be assessed by a medical practitioner and the need for continuing hospital level care documented in the patient medical record prior to day 35.

Public patients no longer requiring hospital level care beyond 35 days must also have their care type evidenced by documentation in the patient medical record and be brought to the attention of administration staff as soon as possible. The patient’s care type must be changed to Maintenance Care as at the day of assessment, and the financial class changed to Public-Nursing Home Type from day 36.

For Public NHTPs a patient contribution (fee) applies as per section 2.3 of this document.

4 PRIVATE AND DEPARTMENT OF VETERANS AFFAIRS (DVA) PATIENTS AND THE NATIONAL ACUTE CARE CERTIFICATE

All Private and DVA patients requiring hospital level care beyond 35 days must have their care type assessed and the need for continuing hospital level care documented in the medical record prior to day 35.

In addition, a NACC must be issued by a medical practitioner to certify to the PHI and DVA the need for continuous hospital level care beyond 35 days and every 30 days thereafter as long as the Private or DVA patient requires hospital level care.

For Private patients the original copy of each completed NACC should be forwarded with accounts to the Private Health Insurer (PHI) as soon as possible to ensure continuation of payment at the acute care accommodation rate. A copy of the NACC is to be kept with the patient records.

The PHI needs to be informed of any changes which may affect the processing or consideration of a NACC (e.g. revised prognosis or death of a patient). If the doctor forms the opinion that the patient no longer requires hospital level care, the PHI needs to be informed that the NACC has been revoked.

For DVA patients the original NACC must remain with the patient record and is to be supplied to DVA upon request.
Private and DVA patients no longer requiring hospital level care beyond 35 days must have their care type evidenced by documentation in the patient health record and be brought to the attention of administration staff as soon as possible. The patient’s care type must be changed to Maintenance Care and financial class to Private-Nursing Home Type or DVA-Nursing Home Type.

For Private and DVA NHTPs a patient contribution applies as per section 2.3 of this document. For Private patients an additional charge (difference between “Patient Contribution” and “Patient Contribution plus Fund Benefit” rates) is recoverable from the patient’s health fund.

If a patient classified as Private or DVA NHTP subsequently requires hospital level care, a NACC must be issued to support a change in care type and financial classification. Following the period of hospital level care, unless a NACC is issued the patient must have a care type change back to Maintenance Care and a financial classification change back to NHTP.

A new HC.21 form should be issued each time a private patient is reclassified to or from the NHTP patient category.

4.1 Guidelines for issuing a National Acute Care Certificate

The NACC must only be completed by the treating registered medical practitioner who must provide a prognosis and his/her opinion of the probable duration of further acute care. Allied health and nursing professionals involved in the care of the patient may assist with section 3 of the NACC but cannot certify the certificate. The NACC may be completed up to 14 days in advance of the commencement of the period covered in the NACC and may be completed retrospectively in exceptional cases.

4.2 Absence of Acute Care Certificates - Charges to Patients

When a Private or DVA patient is considered to be legitimately in need of hospital level care but the doctor has not completed a NACC, the patient should not be charged the patient contribution until it is determined by the Director of Medical Services, or similar delegation, that the classification of “NHTP” is warranted. Every effort should be made to ensure that NACCs are completed.

5 PAYMENT METHODS AND DEBT RECOVERY

5.1 Payment Method

All patients have the right to decide the method of payment of the NHTP contribution. Direct debit is the preferred payment option (Attachment 4).

Only in exceptional circumstances will the Commonwealth Department of Human Services overrule a patient’s choice of payment method. When a pensioner patient refuses to pay the required contribution, there is a provision for the hospital to apply for guardianship if it is shown to be in the best interests of the patient.

5.2 Debt Recovery

Where for any reason payment is not made, Local Health District debt recovery procedures for the recovery of outstanding hospital accounts should be followed, in accordance with NSW Treasurer’s Direction 93/4 Recovery of debts owed to the State.

If the patient is not in receipt of a pension and genuinely considers themselves disadvantaged by the daily contribution fee, an application form for financial hardship can be found on the NSW Health Intranet Revenue Toolkit forms page.
Attachment 1: National Acute Care Certificate

### Section 1 – Particulars of Patient and Hospital (to be completed by Hospital, Doctor or Patient)

<table>
<thead>
<tr>
<th>Patient’s Surname</th>
<th>Given Names</th>
<th>Address</th>
<th>Postcode</th>
</tr>
</thead>
</table>

Date of Birth / Gender M / Full Name of Hospital

Health Fund Name Membership Number

Date of original admission being the date from which the patient has been continuously an overnight patient in this or any other hospital(s), without a break of more than seven days.

### Section 2 – Patient Authorisation (to be completed by Patient, Parent, Guardian or Power of Attorney)

I, authorise the Hospital/Health Service, to complete this certificate and release to my health fund or funding agency health information relevant to the conditions that required acute care during the certified period including confidential and personal identifying and non-identifying information to confirm whether acute treatment has been provided and to verify the claims necessary to process the payment of accounts for treatment or diagnostic tests as described in Section 3 below.

Signature Relationship Date

### Section 3 – Certification of Patient’s Medical Condition (to be completed by and/or certified by treating doctor)

I, Telephone No.

 certify that the above patient:

[ ] no longer requires acute care; OR
[ ] required/will require acute care for at least the period commencing and ending (no later than 30 days from commencement).

Treatment type during the certified period (tick the appropriate box):

[ ] Psychiatric [ ] Acute Medical [ ] Acute Surgical [ ] Palliative Care [ ] Hospital in the Home
[ ] Rehabilitation [ ] Other (specify)

Has the patient had an ACAS (ACAT) assessment during the certified period [ ] Yes [ ] No

Please state the condition(s) that required acute care during the certified period:
### Section 3 – Certification of Patient’s Medical Condition (cont.)

Please document the services or interventions that describe the acute care provided to the patient in the certified period.

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<tr>
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<tr>
<td>Allied Health</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>

If the patient has not been discharged, please state the prognosis and opinion of probable duration of the continuing need for acute care (to be completed by the treating doctor):

________________________________________________________________________________________________________________________________________________________

I confirm the information documented in Section 3 of this acute care certificate is accurate.

Signature of treating doctor ____________________________________________

Name of treating doctor ____________________________________________ (please print)

Date: _____ / _____ / 87(5/5/16)
Attachment 2: Sample notification letter for Nursing Home Type Patients

AUD: «PatientID»
«PatientTitle» «PatientForename» «PatientSurname»
«PatientAddressLine1»
«PatientSuburb» «PatientState» «PatientPostCode»

Dear «PatientTitle» «PatientSurname»

**RE: Accommodation Contribution**

Your attending clinician has determined that you will no longer require hospital level care from *(insert: the end date in the acute care certificate)*, and as a result you will be reclassified as a Nursing Home Type patient. This change in classification will not affect your entitlements to hospital services, the quality of care received, or the professional relationship between you and your attending clinician.

For the remainder of your stay, as a Nursing Home Type patient, you will be charged an accommodation contribution of $XX.XX per day. This accommodation contribution is determined by NSW Health and the Commonwealth Department of Health.

We are able to offer direct debit facilities from your nominated bank account as a convenient way to pay your contribution. Please find the direct debit form attached. If you have appointed someone to handle your finances, please advise our hospital administration staff.

We recommend you contact Centrelink or the Department of Veterans Affairs to advise them of changes in your circumstances and to determine your eligibility for additional benefits, such as rent assistance.

The accommodation contribution still applies if you hold private health insurance and have elected to be treated as a private patient. Note that your private health fund will also be charged a daily Nursing Home Type Patient fee.

Should you have any concerns about the above charges, or require any further information or assistance, please contact our hospital administration staff. Please complete and return the attached Accommodation Contribution Agreement to confirm that you have read and understood this advice.

Yours sincerely,

Health Service Manager
«FacilityName»
Attachment 3: Sample Nursing Home Type Patient – Accommodation Contribution Agreement

Nursing Home Type Patient - Accommodation Contribution Agreement

Patient

I, «PatientForename» «PatientSurname», of «PatientAddressLine1» «PatientAddressLine2» «PatientSuburb» «PatientState» «PatientPostCode», confirm that I have received and understood the advice given to me in relation to Nursing Home Type Patient reclassification and associated fees (Accommodation Contribution). I understand that I am responsible for the Accommodation Contribution. The reasons for the contribution, as well as direct debit options, have been explained to me.

Signature ___________________________ Date_________________

Or authorised representative (on behalf of patient)

I, __________________________________________________________________
of  _________________________________________________________________

have received and understood the information given to me in relation to Nursing Home Type Patient reclassification and fees for «PatientForename» «PatientSurname», of «PatientAddressLine1» «PatientAddressLine2» «PatientSuburb» «PatientState» «PatientPostCode»,

I am the patient’s authorised representative in relation to finance matters. My appointment as representative has been discussed with the Health Service Manager and appropriate documentation to evidence my appointment as authorised representative has been provided.

Signature ___________________________ Date _________________

Relationship to patient __________________________________________________
Attachment 4: Sample Direct Debit Request Service Agreement

| [YOUR] Local Health District  
| Direct Debit Request Service Agreement |

For your convenience, [YOUR] Local Health District is pleased to offer the option to pay health service fees by direct debit against your nominated bank account.

There will be no additional cost incurred by entering into this agreement. The Local Health District will bear the expense of any financial institution transaction fees associated with this process.

**Direct Debit Process**

By completing the *Direct Debit Request Form*, you authorise the Health District to debit your nominated bank account and transfer funds to the Health District bank account.

Funds will be transferred on a fortnightly basis as stipulated on the *direct debit request form*. The payment amount shall be the daily patient contribution fee calculated at the fortnightly amount.

At the end of each month a *Statement of Account* detailing the charges raised for that month and the fees transferred during that month will be available on request from the Central Revenue Unit.

**Alteration of Direct Debit Arrangements**

Where a variation (deferment, alteration or cessation) to the agreed arrangements is to be made by either party, 14 days written notice is to be provided detailing the proposed change before the variation may be effected. Such written advice will detail the reason for the variation, the new payment amount and the effective date.

Customers seeking to alter a direct debit arrangement should forward their written advice to:

[YOUR] Local Health District  
Finance Division – Central Revenue Unit  
[PO Box XXXX]  
[TOWN NSW POSTCODE]

**Dispute Resolution Process**

Should there be any reason to dispute or seek clarification of any debit item made against your account all such requests should be directed to the [YOUR] Local Health District, Central Revenue Unit in the first instance.

Please contact the Central Revenue Unit during business hours on [XX XXXX XXXX]

**Your Responsibilities**

It is your responsibility to ensure that sufficient funds are available in your nominated account on the payment day as per the agreement. Please note that where insufficient funds lead to a direct debit item being returned, a charge may be applied to your account by the financial institution.

*Direct debit* is not available on all account types. If uncertain, please confirm your account details with your financial institution before completing a *Direct Debit Request*.

**Where Payment Date falls on a weekend or public holiday**

Where an agreed payment date falls on a day which is not a business day, the direct debit will occur on the next available business day.
Debit Items Returned Unpaid
[YOUR] Local Health District will advise you, in writing, of any rejections on the next business day following the debit item rejection.

Privacy Policy Statement
All bank account and personal details provided by you for the purpose of entering into a Direct Debit Request will be held on a strictly confidential basis.

The information provided will be used for the sole purpose of initiating a direct debit against your nominated bank account in accordance with the terms of the agreement.

[YOUR] Local Health District undertakes not to disclose or release to any person or organisation the details provided in the Direct Debit Request without your written consent.

Where a financial institution seeks information or clarification of account details in relation to a claim made on it relating to an alleged incorrect or wrongful debit item, [YOUR] Local Health District will provide such details as necessary to correct or complete the direct debit transaction.

[YOUR] Local Health District
Please contact the Central Revenue Unit for all information relating to Direct Debit Requests.

Mailing address:  
[YOUR] Local Health District  
Finance Division – Central Revenue Unit  
[PO Box XXXX  
[TOWN NSW POSTCODE]  

Tel: [XX XXXX XXXX]  
Fax: [XX XXXX XXXX]
Residents' Authority

(Name of Resident)  «PatientForename» «PatientSurname»
«PatientID»

I, [Name of Debit User], APCA User ID No [XXXXXXX]

authorise [YOUR] Local Health District to arrange for funds to be debited from my/our account at the financial institution below and as prescribed below through the Bulk Electronic Clearing.

This authorisation is to remain in force in accordance with the terms of the Service Agreement.

Resident / Power of Attorney

Details of the Account to be Debited (All details must be supplied)

Name of the Financial Institution

Account Name

BSB Number  Account number  Branch Name

Payment Details

The payment is for Accommodation Contribution

Payment Options

I/We request that you debit my/our account in accordance with our Agreement and subject to the following conditions:

- Maximum amount to be debited $  
- Frequency of Debit Fortnightly  
- First payment date / /  
- Final payment date / /  

NOTE: Customers are asked to consult with the Finance Division - Central Revenue Unit to ascertain/confirm the amount to be debited and the commencement date for the purposes of this request.

I/We also authorise the following:

1. The debit user to verify the details of the abovementioned account with my/our Financial Institution.

2. The financial Institution to release information allowing the Debit User to verify the above mentioned account.

Financial Institution Consent

Signature

Date  / /  

Signature

Date  / /  
## Attachment 5: Implementation checklist

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<thead>
<tr>
<th>LHD/Facility:</th>
<th>Date of Assessment:</th>
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### IMPLEMENTATION REQUIREMENTS

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<th>Requirement</th>
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<th>Full compliance</th>
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INPATIENTS

PROVISION OF PUBLIC HEALTH ORGANISATION SERVICES TO ELIGIBLE VETERANS 2014/15 – 2020/21 (PD2018_039)

PD2018_039 rescinded PD2005_506. PD2005_505 is obsolete, content removed.

PURPOSE

The NSW Ministry of Health has a new funding agreement with the Department of Veterans’ Affairs (DVA) for public health organisation services provided to eligible veterans. The purpose of this Policy Directive is to outline the DVA funding arrangements, data reporting and other administrative requirements of the funding agreement. This Policy Directive provides advice to health service staff on the administrative processes to be undertaken, including documentation and obtaining DVA financial authorisation.

MANDATORY REQUIREMENTS

This Policy Directive applies to Local Health Districts and other NSW public health organisations providing admitted and non admitted services to eligible veterans and their dependants.

IMPLEMENTATION

Local Health Districts and other relevant NSW public health organisations are to ensure that the requirements of the Policy Directive are communicated to appropriate staff.

PROCEDURES

CONTENTS

1 BACKGROUND

1.1 About this document
1.2 Key features of funding arrangement

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2.1 Who is eligible
2.2 Determining eligibility for funding under this agreement
2.3 DVA authorisation for treatment

3 FUNDING ARRANGEMENTS

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3.2 Services funded
3.3 Fees
   3.3.1 Services billed to DVA
   3.3.2 Patient charges
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3.5 New technology
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4 SERVICE PROVISION & ADMINISTRATIVE ARRANGEMENTS

4.1 Admissions
4.2 Convalescent and Respite Care
4.3 Long stay and nursing home type patients
4.4 Medications
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4.6 Complaints
4.7 Ex-Service Organisation (ESO) visits

5 REPORTING
1 BACKGROUND

1.1 About this document
The NSW Ministry of Health and the Department of Veterans’ Affairs (DVA) have agreed on the 2014/15 – 2020/21 funding arrangements for public health organisation services provided to eligible veterans. Eligible veterans include veterans, their dependants, war widow(er)s, members of Peacekeeping Forces, Australian mariners and persons from overseas who are entitled to treatment under an arrangement with another country. The term ‘veteran’ will be used in this document to refer to all individuals with entitlement to DVA funding of health services. This Policy Directive outlines the funding arrangements for Local Health Districts (LHDs), relevant Specialty Health Networks and St Vincent’s Health Network. It also advises of the reporting and administrative requirements of the agreement.

1.2 Key features of funding arrangement

- DVA has implemented national public hospital purchasing arrangements based on the funding model developed by the Independent Hospital Pricing Authority

- 2014/15 – 2019/20 funding to LHDs will continue to be based on the previous arrangements:
  - Admitted activity funded using the service categories in the NSW Costs of Care Standards 2006/07
  - Non admitted activity block funded

- 2020/21 funding to LHDs will be activity based using National Weighted Activity Units (NWAU)
2 ELIGIBILITY

2.1 Who is eligible

• Individuals eligible for DVA funding of treatment will usually be issued with a DVA Health Card:
  o Gold Card: covers all health conditions
  o White Card: covers specific health conditions

• Some individuals may be provided with a written authorisation for treatment by DVA

• In emergency situations, DVA may fund admitted patient services where a Vietnam veteran or their dependant presents requiring urgent medical attention and the veteran or their dependant does not have a DVA Health Card

Some individuals will be issued with an Orange Card. This provides entitlement to access Repatriation Pharmaceutical Benefits Scheme (RPBS) medications only.

2.2 Determining eligibility for funding under this agreement

Gold card holders: do not need to seek prior DVA authorisation for treatment. Refer to Section 2.3 for exceptions.

White card holders: hospitals should seek DVA financial authorisation if it is unclear whether the condition being treated is covered by DVA.

Orange card holders: are not entitled to DVA funding for treatment at a public hospital. The orange card provides access to RPBS medications only.

A veteran will not be funded under this agreement if:
  o they elect to be treated as a public patient
  o they elect to be a private patient, using their private health insurance
  o they are eligible for compensation other than under DVA legislation

Further information regarding patient election and compensation is at Section 4.1.1.

2.3 DVA authorisation for treatment

A hospital should seek prior financial authorisation from DVA:

  i) where there is some doubt about a patient’s eligibility for treatment; or
  ii) where the admission relates to:
      a. surgical/medical procedures not listed on the Medicare Benefits Schedule
      b. insertion or use of a prosthesis not on the Australian Government Department of Health Prostheses List at the time of arranging the procedure
      c. a specific treatment that has previously been advised requires authorisation (eg cosmetic surgery); or
  iii) for access to respite care in a Multi-Purpose Service (MPS)

Hospitals should contact DVA on ph. 1800 550 457. The DVA contact number for respite care authorisation is ph. 1300 550 450.

Authorisation is no longer required for convalescent care or for respite care in public hospitals. See Section 4.2 for further details.
3 FUNDING ARRANGEMENTS

3.1 LHD funding

3.1.1 2014/15 – 2019/20 financial years

The Ministry will continue to fund admitted services using the service categories in the NSW Costs of Care Standards 2006/07. Acute services will be funded on a casemix weighted basis and sub & non acute and mental health services funded on a per diem basis. Updated pricing information has been provided to all LHDs.

Non admitted services will continue to be block funded.

3.1.2 2020/21 financial year

Both admitted and non admitted services will be funded on an ABF basis. The Ministry of Health will work with LHDs in the preceding financial years to manage the transition.

3.2 Services funded

Public health organisation services funded by DVA under this agreement are:

i) admitted patient treatment, including Hospital in the Home programs
ii) emergency treatment provided by recognised Emergency Departments and Emergency Services
iii) non admitted patient occasions of services that are classified as a Tier 2 clinic (excluding privately referred non inpatients’ services – see Section 3.3.1b)
iv) other services that could be reasonably considered a public hospital service in accordance with the Independent Hospital Pricing Authority’s General List and A17 List

From 2015/16 onwards prices for admitted services include payment for inter-facility transport (excluding secondary aeromedical retrieval) and payment for surgically implanted prostheses. Hospitals are not to bill DVA separately for prostheses.

Non admitted services funding covers all medical, nursing, diagnostic and allied health services, except where provided to a veteran who is a privately referred non inpatient. Charges that can be raised for admitted and non admitted services are outlined in Section 3.3.

3.3 Fees

3.3.1 Services billed to DVA

a) Medical services

Prices for admitted patient services do not include payment for services provided by medical practitioners with a right of private practice, including diagnostic services. Hospitals are to bill DVA, via Medicare, for these services.

b) Privately referred non inpatients

Hospitals are to bill DVA for medical, specialist and diagnostic services provided to veteran privately referred non inpatients.

c) Patient contribution – ex-Prisoners of War and Victoria Cross recipients

DVA will pay the basic daily care fee patient contributions for ex-Prisoner of War and Victoria Cross recipient nursing home type patients. Hospitals are to obtain approval from DVA (ph. 1800 550 457) and then claim from Medicare, using item number NH05.
3.3.2 **Patient charges**

Veterans are not to be charged directly for services provided under this agreement except:

i) for non clinical personal services including telephone and television

ii) where Commonwealth legislation provides for charges. Currently this allows charges to be raised for:

a. the patient contribution for nursing home type patients (see Section 3.3.1c for exceptions)

b. the PBS co-payment for medication provided to veterans as non admitted patients

3.4 **Subcontracting of services**

The agreement recognises that public hospitals may occasionally subcontract treatment services to a private hospital or day procedure centre (DPC). If the private hospital or DPC has a contract with DVA, DVA will pay the private hospital directly for services provided to a veteran. The public hospital will not receive DVA funding. A list of contracted private hospitals and DPCs can be found at https://www.dva.gov.au/sites/default/files/files/providers/hospitals/private-hosp.pdf.

3.5 **New technology**

DVA recognises that treatment not currently listed on the MBS, PBS or Commonwealth Prostheses List may be clinically appropriate for a veteran. To obtain DVA funding the hospital must seek prior financial authorisation from DVA.

3.6 **High cost admitted patient care**

The agreement recognises that in rare cases the cost of treatment may significantly exceed the DVA funding provided. DVA will consider, on a case by case basis, an adjustment in payment for additional costs (not including nurse specialling) based on clinical need.

If a hospital considers that such a case exists, the claim should be submitted to the Director, Policy and Funding Reform, Government Relations Branch, NSW Ministry of Health. DVA will only consider claims that are submitted by the Ministry of Health within 3 months of the veteran’s discharge.

4 **SERVICE PROVISION & ADMINISTRATIVE ARRANGEMENTS**

4.1 **Admissions**

4.1.1 Policies and Procedures

Admissions should be in accordance with NSW Health policies and procedures, including Policy Directive PD2017_015 “NSW Health Admission Policy”. DVA may review submitted records to ensure that admissions are compliant with NSW policy and procedures and the terms of the agreement. Hospitals should contact the Director, Policy and Funding Reform, Government Relations Branch, NSW Ministry of Health if they have any concerns about whether the criteria for admission are met.

4.1.2 Election

Hospitals should use their best endeavours to ensure that an admitted patient election form is completed within 2 days of admission. A copy of the form must be retained for audit purposes.

Veterans electing to be treated as a DVA patient are entitled to services provided on a private patient basis, that is:
i) choice of doctor, subject to the doctor having practising rights at the hospital
ii) shared accommodation
iii) if medically necessary, private accommodation

Veterans can also access private accommodation if it is available and if the veteran or the veteran’s private health insurer agrees to pay the difference in cost between private and shared accommodation.

If it is anticipated that a veteran will be eligible for compensation, other than under DVA legislation, the veteran should be classified as compensable rather than DVA. The veteran can elect to be treated as DVA should the compensation claim fail. DVA will only fund a failed compensation episode if the record is submitted to DVA by February of the following calendar year.

4.2 Convalescent and Respite Care

DVA financial authorisation is no longer required for veterans accessing convalescent care in a public hospital or MPS.

DVA financial authorisation is no longer required for veterans accessing respite care in a public hospital. Unless exceptional circumstances apply, respite care cannot directly follow an acute or subacute admission where there has been no discharge home of the patient.

Prior DVA authorisation is required for veterans accessing respite care in an MPS. The MPS should use its best endeavours to reclassify the patient from a hospital patient to a residential aged care patient as soon as a residential aged care bed becomes available. No funding is provided for residential aged care patients under this agreement.

4.3 Long stay and nursing home type patients

A National Acute Care Certificate (NACC) should be issued for veteran admissions where hospital level care is required beyond 35 days. The NACC, certified by a medical practitioner, should be kept on the patient’s file for audit purposes.

Long stay veterans reclassified to nursing home type patients (NHTP) should have a discharge plan developed, including an assessment by an Aged Care Assessment Team where appropriate. If a veteran is receiving NHTP care in an MPS, the veteran should be reclassified to a residential aged care recipient as soon as a residential aged care bed becomes available. No funding is provided for residential aged care patients under this agreement.

4.4 Medications

Medication reviews should be undertaken for veteran admissions in accordance with NSW Health policy and procedures, noting that medication reviews may not always be possible for admissions of 48 hours or less. The reviews are to be undertaken by a pharmacist or authorised prescriber (other than the treating doctor).

Hospitals should contact the Veterans’ Affairs Pharmaceutical Advisory Centre on ph. 1800 552 580 (operates 24 hours a day) for financial authorisation or any RPBS queries.

4.5 Transfer of Care

4.5.1 Discharge planning and discharge summary

Transfer of care should be in accordance with NSW Health policy and procedures, including Policy Directive PD 2011_015 “Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals”. Hospitals should use their best endeavours to provide a discharge summary to the veteran’s referring doctor, and general practitioner if the GP is not the referring doctor, within 48 hours
of discharge. DVA may ask hospitals to provide a copy of the discharge planning protocols in the hospital, together with documentation relating to a veteran’s discharge.

A veteran may be enrolled in DVA’s Coordinated Veterans’ Care (CVC) program. If a hospital becomes aware that a veteran is enrolled in the CVC program, the hospital should use its best endeavours to ensure that the veteran’s GP or Nurse Coordinator receives a copy of the discharge plan and, if appropriate, is involved in the implementation of the plan.

4.6 Complaints

DVA will refer complaints about the quality of service, in writing, to the LHD involved. DVA and LHD will work together to resolve the issue. Complaints management should be in accordance with NSW Health Policy Directive PD2006_073 “Complaint Management Policy”.

Should complaints not be resolved within 35 days, DVA will raise the matter formally with the Ministry of Health. DVA acknowledges that some delays may be experienced that are beyond the LHD’s control, for example where awaiting findings from the Coroner.

4.7 Ex-Service Organisation (ESO) visits

During an admission a veteran may wish to receive a visit from an ESO representative. Hospitals should use their best endeavours to facilitate visits when the veteran has completed the ESO visit leaflet. A copy of the pro forma ESO visit leaflet, which is to be adapted for local use, can be found at http://internal.health.nsw.gov.au/sd/igfs/dva/.

5 REPORTING

Under the agreement, the Ministry of Health is required to submit data to DVA. The Ministry will submit electronic data on each veteran treated in a public health organisation via DVA’s HOTSPUR Portal, a secure on-line web based interface for data transfer. The data specifications from 1 July 2015 will be as per IHPA Data Request Specifications https://www.ihpa.gov.au/what-we-do/data-specifications for the relevant financial year for admitted, emergency, non-admitted and aggregate file types.

In addition to the IHPA ABF Data Request Specification, DVA will require the following specifications for admitted episodes of care:

- Admission time;
- Separation time;
- DVA File Number;
- Surname of Entitled Person; and
- Given name of Entitled Person
- DRG

In addition to the IHPA ABF Data Request Specification, DVA will require the following specifications for patient level Non-admitted and Emergency Department care:

- DVA File Number;
- Surname of Entitled Person; and
- Given name of Entitled Person
DVA payments are reflective of the actual activity reported. Failure to provide accurate and complete identifiable patient information will result in rejection of records by DVA and will impact on the DVA payments. As part of the reconciliation process, LHDs will be requested to verify inpatient records that cannot be matched against the data collection held by DVA.

If an LHD agrees that a returned record is not eligible for DVA funding, the payment status should be reclassified. Veterans will have nominated an alternative election (public or private patient) on the admitted patient election form. To enable funding as a public or private patient the LHD should reclassify the record by the following dates:

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Data reclassification completed [LHD]</th>
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</thead>
<tbody>
<tr>
<td>1 July – 31 December</td>
<td>1st week of April</td>
</tr>
<tr>
<td>1 January – 30 June</td>
<td>1st week of October</td>
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If an LHD believes that a returned record is eligible for DVA funding, further information should be provided to allow resubmission of the record to DVA. While most corrected records will have been resubmitted prior to this date, LHDs are requested to resubmit the final corrected records to the Ministry by 30 March of the following calendar year. As advised below, the final date for the Ministry to resubmit records to DVA is 30 April of the following calendar year.

The DVA Data Submission timelines are outlined in the table below:

<table>
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<tr>
<th>Reporting Period</th>
<th>Data submission to MOH completed [LHD]</th>
<th>Data submitted to DVA [MOH]</th>
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<tbody>
<tr>
<td>1 July – 31 December</td>
<td>1 Feb</td>
<td>28 Feb</td>
</tr>
<tr>
<td>1 January – 30 June</td>
<td>2 Aug</td>
<td>31 Aug</td>
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</table>

The final acceptance date for data resubmission to DVA is 30 April of the following calendar year and the final reconciliation is to be completed by the Ministry and DVA before 30 May of that year.
PD2006_062 (Reporting of Department of Veterans' Affairs (DVA) Non Admitted Patients to DOHRS) rescinded by PD2011_067 (Non-Admitted Patient Activity) which was rescinded by PD2012_037 (Non-Admitted Patient Activity) which was rescinded by PD2013_010 (Non-Admitted Patient Activity Reporting Requirements). The link for this Policy Directive is http://www.health.nsw.gov.au/policies/pd/2013/PD2013_010.html

THIS PAGE UPDATED 2 SEPTEMBER 2013.
B. ACCOMMODATION CHARGES

1. GENERAL

Basically it is intended that a person admitted as an inpatient or registered as a non-inpatient of a public hospital shall be regarded as a patient of the public hospital system and not as a patient of a particular hospital for the purpose of rendering charges where appropriate.

Public hospital accommodation charges are GST-free under section 38-20 of the GST Act except for taxable services, e.g. cosmetic surgery not covered by Medicare (refer section 38-7 of the GST Act). Where public hospital accommodation is provided for a taxable supply there is to be no grossing up of the approved bed day charge, however, 1/11th is payable as GST. (PD2012_022)

SINGLE ROOM CHARGE FOR PRIVATE PATIENTS

Patients may elect either shared or single accommodation. However, single rooms are to be allocated primarily on the basis of medical need, and only those not required for this purpose can be allocated to persons desiring such accommodation.

It is expected that for the majority of private patients requesting and receiving treatment in a single room a patient co-payment will be required to fully recover the accommodation fees.

The Department advises public hospitals to undertake the following procedures in order to ensure full reimbursement of accommodation fees. (PD2015_022):

• Admission staff must inform eligible patients with health insurance who wish to elect to be a private patient that health insurance policy may require a patient co-payment/excess.

• To reduce administrative effort, patients from whom a co-payment/excess is required or patients who elect to be private and who do not have private health insurance, payment arrangements are to be made on admission in the form of:
  - credit card imprint (credit limits to be verified)
  - cash to cover estimated cost
  - bank or personal cheque to cover estimated cost

• On discharge, credit card imprints should be completed with the due amount and adjustments made in respect of cash advances/cheques.

• Where for any reason payment is not finalised on admission or upon discharge, existing procedures for the recovery of outstanding hospital accounts should be followed.
The shared room rate applies for private patients in single rooms where:
• the patient elects shared ward accommodation, but only single ward accommodation is available
• the patient elects shared room accommodation, but due to clinical reasons is located in single ward accommodation.

In respect of any day on which the patient is on leave for the whole twenty four (24) hours of the day no fees should be charged or Hospital Benefits claimed, for that day.

Patients whilst on leave of absence, who return to hospital for treatment for periods of less than twenty four (24) hours are to be charged, and their Hospital Benefits claimed, for that day.

FOR LEAVE PROVISIONS SEE GLOSSARY “LEAVE”.

For the definition of what constitutes a one day admission refer to the Statistics and Definitions Section of these guidelines. Refer Day Only Procedures on page 2.16 for charging arrangements.

Patient’s accommodation should not be dependent upon whether or not the patient is receiving free treatment, nor on the method of payment for medical treatment chosen.

Public hospitals are not to pay contributions to health funds on behalf of patients, however, they may assist patients in maintaining their health insurance coverage, e.g. through contacting relatives, etc.

When raising accounts for fees the date of admission and discharge are to be counted as one day with the date of admission being counted as that day. Ineligible (overseas visitors) are to be charged on the same basis.

Where telephones are provided for patients, each hospital should assess an appropriate charge.

Hospitals should not require payment in advance in respect of hospital charges except for ineligible patients and co-payment in respect to single rooms, see page 2.63.

No “charge” is to be raised against an inpatient in respect of any pharmaceutical preparation.
2. CHARGES IN RESPECT OF NEWBORN BABIES (PD2018_024)

PD2018_024 extract

BABIES – CHARGES IN RESPECT OF NEWBORNS

Qualified Babies

Qualified babies are deemed to be a patient of the hospital (inpatient service) and are those babies that meet the following criteria:

- A newly-born child who occupies an approved bed in an intensive care facility in a hospital receiving special care services, and
- Each child in excess of one where there are two or more newly born children of the same mother in a hospital (note that all the children are qualified babies if they meet the criteria above).

Parents must make an election on behalf of the baby to be public (non-chargeable) or private (chargeable).

Unqualified Babies

The baby should be classified as ‘non-chargeable’ whilst unqualified, however if a baby becomes qualified for any part of the period of stay the rules relating to qualified babies apply but only for the period of qualification.

Medical / Diagnostic services are non-chargeable where provided by a hospital appointed doctor or where a service provided by a private practitioner has been organised by the hospital as part of the overall service to an unqualified baby. However where a parent / guardian requests to have an unqualified baby examined by a private medical practitioner of their choice, the parent / guardian can be billed for these services. A Medicare rebate of 85% of the scheduled MBS fee then applies as the Commonwealth regards these services as being provided to a privately referred non-inpatient as an unqualified baby and not as an inpatient service.
4. CLAIMS ON REGISTERED HOSPITAL BENEFIT ORGANISATIONS

Instructions in this part apply to hospitals recognised under the Health Insurance Act.

At the time of admission to hospital the patient’s classification should be ascertained, i.e.
1) Non-chargeable.
2) (Single-hospital doctor) - (patient elects to be treated by doctors nominated by the hospital but requests and is granted single room accommodation.
3) Single/shared - private doctor. (Patient elects to be treated by doctor nominated by himself/herself.)
4) Compensable (third party, workers’ compensation, etc.). This over-rides the other classifications.
5) Ineligible.
6) Veterans’ affairs.
7) Nursing home type.

Recognised hospitals will issue Certificates of Hospitalisation on Form HC.21 to private patients who are covered by health insurance. An insured patient who has paid the hospital account, on presenting his Certificate of Hospitalisation to his registered hospital benefits organisation, will receive from that organisation the benefits to which he/she is entitled (list of registered organisations is attached).

At the same time the hospital should write an account through the Invoice and Fees Journal for the full amount of hospital fees.

NOTE: If the patient has been hospitalised for some considerable time, accounts should have been raised at least at quarterly intervals. In such circumstances the debit raised at the time of submission of claim would be for balance of period of hospitalisation up to date of discharge.

The hospital should only claim from the organisation, benefits up to the amount of the patient’s hospital account.

5.3.1 Certificates of Hospitalisation - HC.21

The following instructions should be followed:

- A Certificate of Hospitalisation is to be issued only to or in respect of a contributor, or the dependant of a contributor to a registered hospital benefit organisation who is a qualified hospital inpatient.
- The “Certificate of Hospitalisation” section must be completed in all details and signed by a hospital official. The approval number of the hospital must be inserted in the space provided. That part of the form headed “TO BE COMPLETED BY CONTRIBUTOR” is to be completed and signed by the contributor or spouse.
- One certificate is usually sufficient to cover the full period of hospitalisation. However, in the event of long-term hospitalisation progressive certificates may be issued, provided that subsequent certificates issued do not cover any part of a period already covered by a prior certificate of hospitalisation. Where progressive certificates are issued and the hospitalisation is continuous the discharge date of the preceding certificate should be repeated as the admission date on the current certificates. Separate HC.21’s are to be issued in respect to Nursing Home Type patients.
• HC.21 forms may be sent by mail to patients when it is not possible to complete the form in hospital, but this should only be done in exceptional circumstances.
• Certificates bearing alterations or corrections to the dates and period of hospitalisation should not be issued, but should be cancelled and retained by the hospital.
• The “Nature of Illness” provision in the Certificate of Hospitalisation portion of the form should include the diagnosis determined from hospital’s records at date of discharge, or at the date thereafter of preparation of the form.
• Where the benefit is assigned to the hospital the authority portion of the claim form must be signed by the contributor or spouse.
• Accounts/receipts and patient’s fund contribution book, where required (e.g. in the case of MBF) must accompany all claims.
• All accounts should be raised and claims submitted for the date of admission not the date of discharge.

Before patients are discharged, hospitals should endeavour to obtain contribution books and group agency certificates, and all information necessary for the completion of the Certificates of Hospitalisation, Form HC.21. Immediately on discharge, the appropriate documents should be sent to the registered organisations. This will help to reduce the amount of outstanding fees. Failure to claim promptly has, in the past, resulted in hospitals being deprived of the use of large sums owing to them in fees.

Before claiming on a benefits organisation, care should be taken that the Certificate of Hospitalisation is complete in all respects; this includes answers to the questions regarding workers’ compensation and third party, and completion of the authority to pay benefits to the hospital. If a Certificate of Hospitalisation is not properly completed, the benefits organisation may reject it.

A detailed statement of the hospital’s account must accompany the Certificate of Hospitalisation and contribution book. Under the National Health Act, benefit organisations are required to have the hospital’s account before paying a claim. The account will be sent to the patient by the organisation when it is no longer required.

It is most important that no duplicates of Form HC.21 should be issued unless the original is lost (say in the mail). In this case the original certificate marking etc. should be noted as cancelled and a duplicate issued. Failure to observe this requirement may lead to accounts being paid more than once in respect of the same period of hospitalisation. This matter should be brought constantly to the notice of staff concerned with the preparation of Certificates of Hospitalisation.

In the past, difficulty has been experienced with:
a) frequent illegibility of hand-writing of the hospital official who fills in the HC.21 forms; and
b) omission of answers to the questions “Is the patient still in hospital?” and “was the patient the sole occupant of the room?”.

In order to over this problem, it is suggested that the staff responsible for the completion of the forms be asked to print clearly in BLOCK LETTERS and to ensure that the questions mentioned in (b) above are answered.

There should be no circumstances under which a patient or health fund contributor should be asked to sign a blank form which can be used to claim hospital/medical benefits.
Claims Register

Claims submitted to registered organisations should be recorded in a register under the following headings:

- Claim Number (this should be hospital’s own sequence).
- Name of Patient.
- HC.21 Number.
- Name of Fund.
- Fund Claim, Number of Days at (Rate).
- Date sent to Fund.
- Date Paid.
- Remarks.

In addition to providing ready access to details of claims submitted the purpose of this register is to facilitate the follow-up of outstanding claims.

Points

- Health insurance funds will now be obliged, as a condition of registration, to pay claims within two months of lodgement.
- The original and pink copy of the Acute Care Certificate (3B) should be forwarded to the patient’s health fund in respect of patients in hospital for over 35 days.

HOSPITAL BENEFITS ORGANISATIONS OPERATING IN NSW

1. AMA Health Fund Limited.
2. Amalgamated Metal Workers and Shipwrights Union Health Care, Ltd.
3. Army Health Benefits Society.
4. Coats Patons Employees Mutual Benefits Society and Hospital and Medical Benefits Association.
5. Cessnock District Hospital Contribution Fund.
6. Commercial Banking Company Health Society.
8. Government Employees Medical and Hospital Club.
9. Grant United Order of Oddfellows Friendly Society of NSW
11. Hospitals Contribution Fund of Australia.
12. Independent Order of Oddfellows in the State of NSW
13. Lysaght Hospital and Medical Club.
14. Medical Benefits Fund of Australia Ltd.
INPATIENTS

INPATIENTS  2.84

16. NIB Health Funds Ltd.
17. New South Wales Teachers’ Federation Health Society.
18. NSW Railway and Transport Employees Hospital Fund.
19. Phoenix Welfare Association Ltd.
20. Reserve Bank Health Society.
21. Sydney Morning Herald Hospital Fund.
23. Western District Health Fund.
24. Wollongong Hospital and Medical Benefits Contribution Fund.

5. PARENTS, RELATIVES, FRIENDS (PD2018_026)

It has been a long standing policy of the Ministry of Health that where circumstances permit, the parents, a relative or a friend of patient should have the opportunity of staying with the patient in hospital if such attendance makes a real contribution to the treatment program of the patient. For example, in the case of hospitalised children, it is obvious that it is in their best interests to have a parent present with them whenever possible.

Where suitable facilities exist, relatives or friends may be offered accommodation with the patient particularly where the patient is acutely ill.

<table>
<thead>
<tr>
<th>Accommodation Only (excluding meals)</th>
<th>$ per night</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum charge where accommodation is provided in a self contained unit (including own kitchen and bathroom facilities).</td>
<td>$48</td>
</tr>
<tr>
<td>maximum charge per person for accommodation other than self contained accommodation.</td>
<td>$24</td>
</tr>
</tbody>
</table>

Individuals who stay with a patient in a hospital that provides self contained unit accommodation will be given the opportunity to access accommodation other than self contained accommodation and be charged accordingly.

<table>
<thead>
<tr>
<th>Meals</th>
<th>$ per meal</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum per meal per person and no greater than rates applicable to hospital employees.</td>
<td>7</td>
</tr>
</tbody>
</table>

The Chief Executive have the discretion to reduce or waive these charges based on the level/standard of accommodation provided or financial hardship.
Current Accommodation and Meal charges for Parents, Relatives or Friends of Patients are deemed to be GST free, based upon the benchmark values contained in DEWRSB (Department of Employment, Workplace Relations and Small Business) advice No. 1999/7.

NB Further details are contained in section 3.3 (pages 22 to 24) of the “NSW Health - Finance and Commercial Services - Tax Reform - GST Manual” which is available on the NSW Health Intranet.

The Chief Executive has the discretion to reduce or waive these charges based on the level/standard of accommodation provided or financial hardship.

The fee will not attract benefits from either the Commonwealth or registered hospital benefit organisations and HC.21 forms must not be issued for the accommodation. The charge is to be recorded as Miscellaneous Income (Other) and not as patient fees. Further, days where such accommodation is provided are to be excluded from hospital statistics and morbidity details. It is recognised that at times hospitals may have insufficient accommodation available to allow all members of the family and friends to stay at the hospital. In that event, hospital authorities should use their discretion very carefully to ensure that parents and very close relatives of patients are able to utilise the available facilities.

Emergency accommodation is available in the War Memorial Hospital, Waverley, for the spouses of country patients hospitalised in any Sydney Hospital as well as ambulant outpatients being treated at a public hospital. $40 for a twin, $35 for a single. Most of these charges are met under IPTAAS arrangements.

**Babies Admitted with Ill Mothers During Lactation (Baby Boarder)**

Breast fed infants who are admitted to hospital with their mothers (when the mother becomes ill during lactation) are to be charged $3.00 per day if the mother is classified as chargeable.
POLICE FORCE MEMBERS INJURED ON DUTY – HOSPITAL CHARGING ARRANGEMENTS (PD2010_008)

PURPOSE

To advise the hospital charging arrangements that are to apply in relation to members of the police force who are injured on duty and attend a public hospital for treatment/hospitalisation.

This policy does not apply to members of the police force who are injured on duty in circumstances which entitle them to compensation under the Motor Vehicles (Third Party Insurance) Act and choose to claim under that entitlement.

MANDATORY REQUIREMENTS

The Police Department has 2 separate policies in relation to its police officers who are injured on duty, which differ with respect to coverage and benefits depending upon when the injured officer joined the force:

Officers who joined the police force on or after 1 April 1988

These officers are subject to the provisions of the Workers’ Compensation Act 1987 and accordingly the legislation, policies and procedures set in place by WorkCover apply (eg injured officers are required to complete the Workers’ Compensation claim form).

Allianz is the Police Department’s Worker’s Compensation insurer.

In respect to these officers presenting at a public hospital for treatment, fees are to be invoiced to Allianz at the applicable gazetted Worker’s Compensation admitted patient per diem rate or non-admitted patient occasion of service rate. The exception is where injuries are sustained as a result of a motor vehicle accident. In such cases, consistent with Workers’ Compensation legislation, the accommodation and occasion of service fees are covered under the MAA Bulk Billing Agreement arrangements.

The attending medical practitioner accounts should also be submitted to Allianz.

Officers who joined the police force prior to 1 April 1988

These officers are covered by the “Hurt on Duty” scheme. Medical treatment/hospitalisation rates are in accord with Workers’ Compensation legislation.

Allianz has been appointed by the Police Department to manage this scheme.

In respect to these officers presenting at a public hospital for treatment, fees are to be invoiced to Allianz at the applicable gazetted Worker’s Compensation admitted patient per diem rate or non-admitted patient occasion of service rate.

In addition, the treating hospital is to advise to Allianz the following patient details:

Surname
Given Names
Police Serial Number
Date of Treatment (non-admitted)
Date of Admission and Date of Discharge (admitted)
Reason for Treatment
The attending medical practitioner accounts should also be submitted to Allianz.

**Allianz**

As indicated above Allianz is the Police Department’s Insurer in relation to both of the above groups. Hospital accounts and Medical Practitioner accounts should be sent to:

Allianz Australia  
GPO box 4056  
Sydney NSW 2001  
Phone: 1300788946  
Fax: 1300788942

**IMPLEMENTATION**

This policy directive is effective immediately and applies to all public hospitals in NSW. Area Health Service Chief Executives are to ensure that the requirements of this policy directive are communicated to all appropriate staff.

Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this policy directive.

### 5.3.3 DEFENCE FORCE PERSONNEL - HOSPITAL ACCOMMODATION CHARGES

The fee charging procedure is as follows:

1. The defence force member and his/her dependants can elect to be treated as either a public or a private patient.
2. If the election is for treatment as a public patient, then no charges are raised.
3. If the election is for treatment as a private patient, then fees are raised at the shared ward accommodation rate.
4. If the defence force member has a notification from his/her unit that the Department of Defence accepts responsibility for the hospitalisation, the member is treated as private shared and the account referred back to the unit.
5. If there is no such notification, any account for private treatment is raised against the member and, if the member considers that the Department of Defence is responsible for the hospitalisation, he/she refers the account to the Department for payment. If the Department does not accept responsibility, the member must meet the cost. If covered by a private health fund the member should claim through that fund.
6. Dependents are not covered by the Department of Defence but may be covered by one of the Defence Force Health Funds which are private health funds.
7. **AFTER CARE - PAYMENT FOR MEDICAL SERVICES WHERE TREATMENT IS PROVIDED BY MORE THAN ONE DOCTOR AT FEE FOR SERVICE HOSPITALS**

In general, the fee specified for each of the operations listed in the Medical Benefits Schedule Book contains a component for the consequential after-care customarily provided by the surgeon. It is expected that in the case of the discharge of “hospital” patients, the patient will present for follow-up care to the Outpatient or Casualty Department.

Where hospital patients are transferred from one recognised hospital under the fee-for-service system to another following an operation, or where it is necessary for the after-care in a recognised fee-for-service hospital to be carried out by a medical practitioner other than the surgeon, the Department has decided that:

a) arrangements may be made between individual hospitals and visiting medical officers in regard to the apportioning of after-care when the surgeon delegates after-care to another doctor. As a guideline medical benefits may be apportioned on the basis of 75% for the operation and 25% (of the modified fee) for the after-care; and where the benefit is apportioned between two or more medical practitioners, no more than the 100% of the benefit for the procedure will be paid.

b) in respect of closed fractures where the after-care is delegated to a doctor at a place other than a place where the initial reduction and immobilisation takes place, benefit may be apportioned on a 50:50 basis rather than on a 75:25 basis suggested for surgical operations.

Where a hospital patient is transferred from a recognised sessional hospital to a fee-for-service hospital (or vice versa) following an operation, the appropriate portion of the fee should be paid to the visiting medical officer at the fee-for-service hospital. No direct payment would be made to the medical officer in the sessional hospital, as payment for the service would be included in normal sessional payments.
7. AMBULANCE TRANSPORT CHARGES

1. Hospitals ordering ambulance transport of patients should be responsible for transport charges raised in the following circumstances:
   (a) where it is necessary for a patient of a recognised hospital in New South Wales to be transported to another recognised hospital (in New South Wales) which has facilities necessary for that patient’s treatment, and where those facilities are not available at the first hospital;
   (b) where a patient of a New South Wales recognised hospital is transported for specialised treatment, to a hospital in another State the New South Wales hospital is responsible for both the forward and return journey ambulance transport charges. Similarly, New South Wales hospitals are not responsible for the ambulance transport costs of interstate patients transported to a New South Wales public hospital for treatment. (91/44)
   (c) where a patient referred to in (a) above is returned to the hospital from which previously transferred. The hospital transferring the patient back and ordering the ambulance transport is responsible for the transport charges and not the hospital to which the patient is being transported.
   (d) where a patient of a recognised hospital in transported to a psychiatric hospital for tests not available at the recognised hospital and where the nearest recognised hospital with facilities to undertake the tests is further away, provided ‘the patient returns to the recognised hospital;
   (e) where it is necessary for a patient of a recognised hospital to be transported to a private diagnostic service, which has facilities not available at the hospital, and where the nearest recognised hospital with such facilities is further away, provided the patient returns to the recognised hospital.

2. Individual insurance companies are responsible for transport charges raised for Compensable patients in respect of primary response transports, ie ambulance transports from the accident site to a NSW public hospital. See the Veterans Affairs section of this Manual in respect of Veterans’ Affairs patients.

3. In all other cases the patient should be responsible for any charges raised for ambulance transport.

Generally the abovementioned provisions would apply to inpatients only. However, there may be instances where a non-inpatient has to be transported to another hospital for admission. In these instances the abovementioned provisions would apply but they would, of course; be rare.

4. Health areas are to note that there exists a reciprocal arrangement between the Capital Territory Health Commission and the NSW Department of Health whereby:
   a) Accounts for inter-hospital ambulance transport of Australian Capital Territory residents both to and from public hospitals in Canberra and New South Wales would be paid by the Capital Territory Health Commission; and
   b) Accounts for inter-hospital ambulance transport of NSW residents between this State and the ACT should be paid by the NSW public hospital to which or from which the patients were transported.

Accounts received for Capital Territory residents which are considered to have been issued for transports of convenience or transports to private hospitals or establishments should be referred back to the ACT Health Authority for action (88/36).
AMBULANCE SERVICE – CHARGES (PD2018_026)

PD2018_026 rescinds PD2017_017 which rescinded PD2016_021

PURPOSE
This Policy Directive provides the key principles and rates for ambulance service charges, including inter-hospital charges payable by Local Health Districts (LHDs) under the Ambulance Partnership Agreement and is effective on and from 1 July 2018.

MANDATORY REQUIREMENTS
Ambulance Services charges as described in the attached procedures are to be applied by all LHDs from 1 July 2018.

IMPLEMENTATION
LHD Chief Executives are to ensure that the requirements of this policy directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

6 BACKGROUND

1.1 About this document
This Policy Directive provides the key principles and rates for ambulance service charges, including inter-hospital charges payable by Local Health Districts (LHDs) under the Ambulance Partnership Agreement and is effective on and from 1 July 2018.

1.2 Key definitions
In this Policy Directive:

- **“primary emergency service”** means the provision of ambulance services by road ambulance, fixed wing aircraft or helicopter or a combination of these, from the scene of an accident, illness or injury to a public hospital or other destination nominated by the Ambulance Service of NSW

- **“primary non-emergency service”** means an ambulance road service that is booked no later than 6pm on the day prior to service delivery with the Service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the primary emergency service charge will apply. [All services provided by a dedicated Patient Transport vehicle, where available, irrespective of time of booking or time of transport, are classified as “non-emergency services”]

- **“inter-hospital emergency service”** means the provision of ambulance services by road ambulance, fixed wing aircraft or helicopter or a combination of these, from one public hospital to another public hospital

- **“inter-hospital non-emergency service”** means an ambulance road service that is booked no later than 6pm on the day prior to service delivery with the service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the inter-hospital emergency service charge will apply. [All services provided by a dedicated Patient Transport vehicle, where available, irrespective of time of booking or time of transport, are classified as “non-emergency services”]
INPATIENTS 2.91

- **“treat-not-transport service”** – means a service where a patient is provided with ambulance services at the scene of an accident, illness or injury and does not require ambulance transport to a health facility or any other destination.

- **“standby services”** – means a service where an ambulance or ambulances are required to stand by at scenes such as industrial accidents for the purpose of providing services to emergency workers or others at the scene of the incident. Neither transport nor treatment may be required.

1.3 Legal and legislative framework

The advised fees are gazetted by order pursuant to section 67L of the Health Services Act 1997.

2 FEES

2.1 Primary emergency service

The fee by road ambulance and / or fixed wing ambulance and / or helicopter shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of $382 callout, plus an additional charge of $3.44 for each kilometre or part thereof, provided that such total fee shall not exceed $6,258.

2.2 Primary non-emergency service

The fee by road ambulance shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of $301 callout, plus an additional charge of $1.86 for each kilometre or part thereof, provided that such total fee shall not exceed $6,258.

2.3 Inter-hospital emergency service

The fees by ambulance shall be charged as follows:

- Road ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of $646 callout, plus an additional charge of $6.45 for each kilometre or part thereof, provided that such total fee shall not exceed $6,047.

- Fixed wing ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of $3,983 callout, plus an additional charge of $1.86 for each kilometre or part thereof (road travel associated with fixed wing cases is charged at the $6.45 for each kilometre or part thereof), provided that such total fee shall not exceed $6,047.

- Helicopter - on a time basis calculated pursuant to section 4 on the scale of $6,837 for the first thirty (30) minutes or part thereof, with any further period charged at a rate of $149.63 per six (6) minutes or part thereof.

- Charges for road or fixed wing transport under this sub-section shall be paid by the hospital or health service sending the person being transported. However in the case of helicopter transport under this sub-section, the transport fee shall be apportioned equally between the hospital or health service sending the person being transported and the hospital or health service receiving that person.

104(11/07/18)
2.4 Inter-hospital non-emergency service

The fee by ambulance shall be charged as follows:

- Road ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of $296 callout, plus an additional charge of $1.83 for each kilometre or part thereof, provided that such total fee shall not exceed $6,047. Charges under this sub-section shall be paid by the hospital or health service sending the person being transported.

2.5 Treat-not-transport service

The fee shall be calculated in accordance with the primary emergency service fee scale (sub-section 2.1).

2.6 Standby service fee

This fee is payable by the owners of premises or vehicles involved in dangerous incidents or events where an ambulance is required to be present (for example at chemical spills or other industrial accidents), shall be calculated in accordance with:

- The primary emergency service fee scale (sub-section 2.1) for the first hour or part thereof (provided that such total fee shall not exceed $6,258); and in addition
- $53.91 for every 15 minutes after the first hour
- Note that a treat-not-transport service provided by an Ambulance standby service is covered in the standby service fee provided the treatment is related to the event. However, the provision of a ‘primary emergency service’ emanating from a standby dangerous incident or event shall be deemed as such and a fee, calculated in accordance with sub-section 2.1, applicable.

3 CALCULATION OF TRANSPORT KILOMETRES

The total number of kilometres for the provision of services by ambulance (or ambulances) shall be calculated by determining the total number of kilometres that are travelled by road or, in the case of transportation by fixed wing aircraft or helicopter, that would have been travelled by road had no fixed wing aircraft or helicopter been available, in accordance with the distance:

- From the base ambulance station nearest to the location where the person was picked up / treated by ambulance, to that pick up / treatment location; and
- From that pick up location (where transport occurs), to the place where that person disembarked from the ambulance (or, where more than one ambulance was used in the transport, disembarked from the last ambulance used in that transport); and
- From that place of disembarkation / location of treatment, to the base ambulance station referred to in the first dot point of this section.

4 CALCULATION OF TRANSPORT TIME FOR HELICOPTERS (INTER-HOSPITAL)

The number of minutes for a service by helicopter (other than a primary response service) shall be calculated from the time the helicopter engine or engines are turned on, or, if the engines are already on, the time at which the helicopter is dispatched by an air ambulance controller, to the time the helicopter engine or engines are turned off at the helicopter’s operational base, or the time at which the helicopter is otherwise dispatched by an air ambulance controller or other authority.
5 CHARGING CRITERIA

- Where two or more persons are transported / treated concurrently by the same ambulance or ambulances, each person shall be charged a fee calculated in accordance with sub-sections 2.1, 2.2, or 2.5 as appropriate to that transport.
- The dot point immediately above shall not apply when two or more persons are transferred concurrently by ambulance (or ambulances) between any public hospitals in New South Wales.
- Ambulance attendances at sporting and recreational fixtures are to be on the basis of cost recovery. A treat-not-transport service provided by an Ambulance in attendance at sporting and recreational fixtures is covered in the attendance fee. However, in the case of the provision of a primary emergency service at sporting and recreational fixtures a fee shall be calculated in accordance with sub-section 2.1.
- Budget supplementation is not available to fund any increased costs resulting from this Policy Directive with such costs to be met from within existing allocations.
- The above rates are applicable in relation to NSW ambulance services provided to Residents of NSW (Primary) and Public Hospitals in NSW (Inter-hospital).
- Residents of other States or Territories shall be charged full cost recovery as follows:

<table>
<thead>
<tr>
<th>Primary</th>
<th>Road</th>
<th>Fixed Wing</th>
<th>Helicopter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency</td>
<td>Non Emergency</td>
<td>Emergency</td>
</tr>
<tr>
<td>Call-Out</td>
<td>$'s</td>
<td>$'s</td>
<td>$'s</td>
</tr>
<tr>
<td>Variable Rate</td>
<td>748</td>
<td>301</td>
<td>748</td>
</tr>
<tr>
<td>Max. Charge</td>
<td>6.75</td>
<td>1.86</td>
<td>6.75</td>
</tr>
<tr>
<td>Max. Charge</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

6 GOODS AND SERVICES TAX (GST)

6.1 GST-free

Ambulance Services are GST-free under section 38-10 of the GST Act where the service is provided to a person as part of their treatment. Ambulance Services deemed GST-free are as follows:

- Primary emergency service
- Primary non-emergency service
- Treat-not-transport service.

6.2 Taxable supply

Ambulance Services are a taxable supply (subject to GST) and accordingly GST must be added to the rates advised in this Policy Directive in respect of:

- Inter-hospital emergency services
- Inter-hospital non-emergency services
- Standby services
- Ambulance attendances at sporting and recreational fixtures.
NSW NEWBORN AND PAEDIATRIC EMERGENCY TRANSPORT SERVICES (NETS) CHARGES (PD2018_025)

PD2018_025 rescinds PD2017_016 which rescinds PD2016_020

PURPOSE
This Policy Directive provides the key principles and rates for NETS charges, including Inter Hospital Charges payable by Local Health Districts (LHDs) under the Ambulance / NETS Partnership Agreement and is effective on and from 1 July 2018.

MANDATORY REQUIREMENTS
NETS charges as described in the attached procedures are to be applied by all LHDs from 1 July 2018.

IMPLEMENTATION
LHD Chief Executives are to ensure that the requirements of this policy directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

1 BACKGROUND

1.1 About this document
This Policy Directive provides the key principles and rates for NETS charges, including Inter Hospital Charges payable by Local Health districts (LHDs) under the Ambulance / NETS Partnership Agreement and is effective on and from 1 July 2018.

1.2 Key definitions
In this Policy Directive:-

• “Primary emergency service” means the provision of NETS services by road, fixed wing aircraft or helicopter or a combination of these, from a private hospital to a public hospital or other destination nominated by NETS
• “Primary non-emergency service” means a NETS road service that is booked no later than 6pm on the day prior to service delivery with the service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the primary emergency service charge will apply
• “Inter-hospital emergency service” means the provision of NETS services by road, fixed wing aircraft or helicopter or a combination of these, from a public hospital to another public hospital
• “Inter-hospital non-emergency service” means a NETS road service that is booked no later than 6pm on the day prior to service delivery with the service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the inter-hospital emergency service charge will apply.
1.3 Legal and legislative framework

The advised fees are gazetted by order pursuant to section 69 of the Health Services Act 1997.

2 FEES

2.1 Primary emergency service

The fee by road and / or fixed wing service and / or helicopter shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of $382 callout, plus an additional charge of $3.44 for each kilometre or part thereof, provided that such total fee shall not exceed $6,258.

2.2 Primary non-emergency service

The fee by road shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of $301 callout, plus an additional charge of $1.86 for each kilometre or part thereof, provided that such total fee shall not exceed $6,258.

2.3 Inter-hospital emergency service by NETS

The fees shall be charged as follows:-

- Road service - on a kilometre basis calculated pursuant to section 3, on the scale of $646 callout, plus an additional charge of $6.45 for each kilometre or part thereof, provided that such total fee shall not exceed $6,047.

- Fixed wing service - on a kilometre basis calculated pursuant to section 3, on the scale of $3,983 callout, plus an additional charge of $1.86 for each kilometre or part thereof (road travel associated with fixed wing cases is charged at the $6.45 for each kilometre or part thereof), provided that such total fee shall not exceed $6,047.

- Helicopter service - on a time basis calculated pursuant to section 4 on the scale of $6,837 for the first thirty (30) minutes or part thereof, with any further period charged at a rate of $149.63 per six (6) minutes or part thereof. Charges for road or fixed wing transport under this sub-section shall be paid by the hospital or health service sending the person being transported. However in the case of helicopter transport under this sub-section, the transport fee shall be apportioned equally between the hospital or health service sending the person being transported and the hospital or health service receiving that person.

2.4 Inter-hospital non-emergency service by NETS

The fee shall be charged as follows:-

- Road ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of $296 callout, plus an additional charge of $1.83 for each kilometre or part thereof, provided that such total fee shall not exceed $6,047. Charges under this sub-section shall be paid by the hospital or health service sending the person being transported.
3  **CALCULATION OF TRANSPORT KILOMETRES**
The total number of kilometres the provision of NETS services shall be calculated by determining the total number of kilometres that are travelled by road or, in the case of transportation by fixed wing aircraft or helicopter that would have been travelled by road had no fixed wing aircraft or helicopter been available, in accordance with the distance:

- From the NETS base nearest to the location where the patient was picked up or treated by the NETS service and
- From that pick up location (where transport occurs), to the place where that patient disembarked from the NETS transport and
- From that place of disembarkation (or where no transport occurs, from the treatment location), back to the NETS base referred to in the first dot point of this section.

4  **CALCULATION OF TRANSPORT TIME FOR HELICOPTERS (INTER-HOSPITAL ONLY)**
The number of minutes for a NETS service by helicopter (other than a primary response service) shall be calculated from the time the helicopter engine or engines are turned on, or, if the engines are already on, the time at which the helicopter is dispatched by an air ambulance controller, to the time the helicopter engine or engines are turned off at the helicopter’s operational base, or the time at which the helicopter is otherwise dispatched by an air ambulance controller or other authority.

5  **CHARGING CRITERIA**

- Where two or more persons are transported / treated concurrently by the same NETS service, each person shall be charged a fee calculated in accordance with sub-sections 2.1 and 2.2 as appropriate to that transport
- The dot point immediately above shall not apply when two or more patients are transferred concurrently by a NETS service between any public hospital in New South Wales
- Budget supplementation is not available to fund any increased costs resulting from this policy directive with such costs to be met from within existing allocations
- The above rates are applicable in relation to NETS services provided to NSW Public Hospitals (Inter-hospital) and NSW Private Hospitals (Primary)
- Residents of other States or Territories shall be charged full cost recovery as follows:-

<table>
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</tr>
<tr>
<td>Max.Charge</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

6  **GOODS AND SERVICES TAX (GST)**

NETS Services are a taxable supply (subject to GST) and accordingly GST must be added to the rates advised in this policy directive
PD2018_023 rescinds PD2017_020 which rescinded PD2016_022

PURPOSE
This Policy Directive provides the key policy aspects and fees schedule in relation to brain injury rehabilitation services provided by the state-wide network of the Brain Injury Rehabilitation Program (BIRP) units for compensable patients.

MANDATORY REQUIREMENTS
Applicable BIRP accommodation fees are to be raised for compensable patients as detailed in this policy and attached procedures.

The BIRP fees advised herein are effective from 1 July 2018 and apply only to compensable patients admitted to an inpatient BIRP rehabilitation unit or an inpatient Transitional Living Unit and compensable non-inpatient services.

Non-compensable patients admitted to BIRP Units will be covered under the National Health Reform Agreement.

For compensable patients with traumatic brain injury who are inpatients in a NSW public hospital, other than a designated Inpatient BIRP Rehabilitation unit or an inpatient Transitional Living Unit, the bulk billing arrangements under the Purchasing Agreement for NSW Health Services to Motor Accident Patients will apply in relation to MAA Compulsory Third Party patients and ‘Compensable Patients’ billing arrangements will apply in relation to other classes of compensable patients e.g. Workers’ Compensation and Other Compensable patients.

IMPLEMENTATION
Local Health District / Speciality Health Network Chief Executives are to ensure that the requirements of this Policy Directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

104(03/07/18)
1 BACKGROUND

1.1 About this document

This Policy Directive advises the key charging policy aspects and updates the fees in relation to brain injury rehabilitation services provided by the state-wide network of Brain Injury Rehabilitation Program (BIRP) units for compensable patients requiring rehabilitation services. The advised fees are effective from 1 July 2018. This document replaces PD2017_020. LHDs / hospitals / facilities are to raise invoices against insurers as appropriate.

1.2 Legal and legislative framework

The advised fees are gazetted under the Health Services Act 1997 and Workers Compensation Act 1987.

2 DESIGNATED BIRP UNITS

2.1 Designated Inpatient BIRP Rehabilitation units - the daily bed rate for compensable inpatients can only be charged by the following units:

- Westmead
- Liverpool
- Royal Rehabilitation Centre, Sydney.

2.2 Designated Inpatient Transitional Living Units and non-inpatient services - the daily bed rate / non-inpatient rate can only be charged by the following units:

- Westmead Hospital Brain Injury Rehabilitation Service
- Liverpool Hospital Brain Injury Rehabilitation Unit
- South West Brain Injury Rehabilitation Service
- Southern Area Brain Injury Service
- Hunter Brain Injury Service
- Dubbo Brain Injury Rehabilitation Program
- New England Brain Injury Rehabilitation Program
- Mid West Brain Injury Rehabilitation Program.

2.3 Designated Units for non-inpatient services - the non-inpatient rate can only be charged by the following units:

- Children’s Hospital Westmead
- Sydney Children’s Hospital
- Illawarra Brain Injury Service
- Mid North Coast Brain Injury Rehabilitation Service
- Northern Brain Injury Rehabilitation Service.

3 INPATIENT BIRP REHABILITATION UNITS AND INPATIENT TRANSITIONAL LIVING UNITS

There are three categories that apply to patients in Inpatient BIRP Rehabilitation Units and Inpatient Transitional Living Units. The BIRP unit will nominate the most appropriate category classification for a patient and identify the proposed classification on the rehabilitation plan submitted to the Insurer, and update the classification in the progress reports. Insurers may seek clarification of the classification if necessary in the course of reviewing the rehabilitation plans and progress reports.

Category A applies to patients who are being assessed for or receiving active rehabilitation.
Category B applies to patients who are not on an active rehabilitation program but who are resident in a BIRP facility. These patients are receiving nursing and/or personal care assistance, regular monitoring of their medical condition, medical care and case management as appropriate. This category includes but is not limited to patients who are admitted for respite care or patients who have finished their rehabilitation program and are waiting for a transfer, placement or appropriate accommodation elsewhere.

Category X is for the rare patient who requires an extremely high level of support such as two to one care. It is only to be used in very specific circumstances, for instance where the patient has severe or extreme behavioural problems and cannot be managed without constant close supervision, generally requiring temporary additional staffing.

4 FEES FOR DESIGNATED UNITS

4.1 Inpatient BIRP Rehabilitation Units

<table>
<thead>
<tr>
<th>Category</th>
<th>Daily Bed Rate</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Category X</td>
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4.2 Inpatient Transitional Living Units

<table>
<thead>
<tr>
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<tr>
<td>Category A</td>
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<tr>
<td>Category B</td>
<td>$439</td>
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</table>

4.3 Non-Inpatient Services Including Outreach

Charged at the cumulative rate of $85 per half-hour. The fee shall not be greater than the equivalent of 5 hours per day of non-inpatient care.

4.4 Outpatient Medical Clinical Appointments

4.4.1 Medical Consultation – New - applies to a new patient referred for medical assessment by an attending medical officer and are charged at the standard rate of $293.

4.4.2 Medical Consultation – Review - applies to follow-up appointments of a patient by an attending medical officer and are charged at the standard rate of $146.

4.5 Reports

The charging for reports is in accordance with the rates set out in Information Bulletin IB2017_035 (or as amended periodically), subject to the fees policy set out in PD2006_050. Reports that are part of the rehabilitation process such as rehabilitation plans, progress reports and case closures will be charged at the same half hourly rate as non-inpatient services.

4.6 Group Activities

4.6.1 Group Activities - qualified - applies to those group activities directly supervised by a qualified allied health clinician and are charged at the cumulative half hour rate of $54.

4.6.2 Group Activities - unqualified - applies to those group activities not directly supervised by a qualified allied health clinician and are charged at the cumulative half hour rate of $39.
PD2018_022 rescinds PD2017_021 which rescinded PD2016_023

PURPOSE

This Policy Directive provides the key charging policy aspects and rates for designated units in relation to patients accepted into the Lifetime Care & Support (LTCS) Scheme by the LTCS Authority.

The LTCS Authority of NSW (Level 7, 321 Kent Street, Sydney 2000), a statutory authority established under the Motor Accidents (Lifetime Care and Support) Act 2006, is responsible for the administration of the LTCS Scheme.

The Scheme provides lifelong treatment, rehabilitation and attendant care services to people who sustain a spinal cord injury, a moderate to severe brain injury, multiple amputations and severe burns or blindness from a motor accident in NSW. The Scheme commenced in relation to children under 16 years of age who are injured in a motor accident from 1 October 2006 and in relation to adults from 1 October 2007.

The Scheme is a “no-fault” scheme which means that if the injured person’s injuries are severe enough to enter the Scheme it does not matter if the injured person was at fault in the accident or not. This Scheme also covers vehicles registered in other States / Territories, provided the accident occurs in NSW. LTCS services are paid for as they are required, rather than paying the injured person a one-off lump sum to meet their lifetime needs at settlement of their CTP claim.


MANDATORY REQUIREMENTS

Should a person injured in a motor accident whose injuries appear to meet the eligibility requirements for the Scheme present to a public hospital / facility, the public hospital / facility should contact the LTCS Authority. The Authority will appoint a LTCS co-ordinator who will assist with the completion of an application for participation in the Scheme.

Bulk billing arrangements, under the Purchasing Agreement for NSW Health Services to Motor Accident Patients, applies to all LTCS patient services except for services provided by designated Brain or Spinal Injury Rehabilitation units. The NSW Ministry of Health administers charging under the bulk billing arrangements from hospital / facility activity data recorded and conveyed via the Health Information Exchange (HIE) and disseminates this revenue to LHDs as appropriate. Hospitals / facilities / Local Health Districts (LHD) should ensure that LTCS activity is accurately identified and coded to ensure that appropriate charging occurs.

LTCS services provided by designated Brain or Spinal Injury Rehabilitation units to patients who are admitted to a designated Brain or Spinal Injury Rehabilitation Unit or are in a Transitional Living Unit and non-admitted patient services provided by designated non-admitted patient units are chargeable in accordance with the rates advised in this Policy Directive. LHD / hospital / facilities are to raise invoices against the LTCS Authority for these services.
IMPLEMENTATION

Local Health District / Network Chief Executives are to ensure that the requirements of this Policy Directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

1. BACKGROUND

6.2

6.3 1.1 About this document

The bulk billing arrangements under the MAA / LTCS Purchasing Agreement applies for all LTCS patients except for LTCS patients who are in a designated admitted patient Brain Injury Rehabilitation Unit or in a designated Spinal Injury Rehabilitation Unit or in an admitted patient Transitional Living Unit and non-admitted patient services provided by designated non-admitted patient units.

The NSW Ministry of Health administers charging under the bulk billing arrangements from hospital / facility activity data recorded and conveyed via the Health Information Exchange (HIE) and disseminates this revenue to LHDs as appropriate. Hospitals / facilities / LHDs should ensure that LTCS activity is accurately identified and coded to ensure that appropriate charging occurs.

6.4 1.2 Legal and legislative framework

The LTCS Authority of NSW (level 7, 321 Kent Street, Sydney 2000), a statutory authority established under the Motor Accidents (Lifetime Care and Support) Act 2006, is responsible for the administration of the LTCS Scheme.

2. LTCS CHARGING POLICY - OTHER THAN DESIGNATED UNITS

Bulk billing arrangements, under the Purchasing Agreement for NSW Health Services to Motor Accident Vehicle Patients, applies for all LTCS patients except those who are in a designated Brain or Spinal Injury Rehabilitation Unit.

The NSW Ministry of Health administers charging under the bulk billing arrangements from hospital / facility activity data recorded and conveyed via the HIE.

3. LTCS CHARGING POLICY – DESIGNATED UNITS

Accounts should be raised against the LTCS Authority at applicable rates, as advised below, for admitted patient services provided in a designated Brain Injury Rehabilitation Unit or a designated Transitional Living Unit and for non-admitted patient services provided by designated non-admitted patient units as per the following:–

6.5

6.6 3.1 Admitted patient Brain Injury/Spinal Injury Rehabilitation designated units.

<table>
<thead>
<tr>
<th>Category</th>
<th>Daily Bed Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
<td>$1,241</td>
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<td>Category B</td>
<td>$794</td>
</tr>
<tr>
<td>Category X</td>
<td>$1,765</td>
</tr>
</tbody>
</table>
3.2 Admitted and Non-Admitted Patient Transitional Living Units in relation to Brain Injury/Spinal Injury Rehabilitation designated units only.

<table>
<thead>
<tr>
<th>Category</th>
<th>Daily Bed Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
<td>$886</td>
</tr>
<tr>
<td>Category B</td>
<td>$439</td>
</tr>
</tbody>
</table>

3.3 Non-admitted patient Rehabilitation Services, including Outreach
At the cumulative rate of **$85 per half-hour**. The fee shall not be greater than the equivalent of 5 hours per day of non-admitted patient care.

3.4 Non-admitted patient Medical Clinic Appointments

Medical Consultation – (New) - applies to a new patient referred for medical assessment by an attending medical officer - charged at the standard rate of **$293**.

Medical Consultation – (Review) - applies to follow-up appointments of a patient by an attending medical officer - charged at the standard rate of **$146**.

3.5 Reports
The charging for reports is in accordance with the rates set out in NSW Health Information Bulletin IB2017_035 (or as amended periodically), subject to the fees policy set out in Policy Directive PD2006_050.

Reports that are part of the rehabilitation process such as rehabilitation plans, progress reports and case closures will be charged at the same half hourly rate as non-inpatient services.

3.6 Group Activities

Group activities - qualified applies to those group activities directly supervised by a qualified allied health clinician - charged at the cumulative half hour rate of **$54**.

Group activities - unqualified applies to those group activities not directly supervised by a qualified allied health clinician - charged at the cumulative half hour rate of **$39**.

4. ADMITTED PATIENT FEE CATEGORIES - DESIGNATED UNITS

Category A applies to patients who are being assessed for or receiving active rehabilitation.

Category B applies to patients who are not on an active rehabilitation program. This category includes but is not limited to patients who are admitted for respite care or patients who have finished their rehabilitation program and are waiting for a transfer, placement or appropriate accommodation elsewhere.

Category X is for the rare patient who requires an extremely high level of support or monitoring. It is only to be used in very specific circumstances that cannot be managed without constant close supervision, generally requiring temporary additional staffing.

The unit / hospital will nominate the appropriate category classification for a patient and identify the proposed classification on the rehabilitation plan, and update the classification in the progress reports. The LTCS Authority may seek clarification of the classification if necessary in the course of reviewing the rehabilitation plans and progress reports.
5. DESIGNATED UNITS

5.1 Admitted patient Brain Injury Rehabilitation designated units:
- Westmead Hospital Brain Injury Rehabilitation Service
- Liverpool Hospital Brain Injury Rehabilitation Unit
- Royal Rehabilitation Centre Sydney Brain Injury Unit

5.2 Admitted and Non-Admitted patient Brain Injury Rehabilitation designated Transitional Living units:
- Westmead Hospital Brain Injury Rehabilitation Service
- Liverpool Hospital Brain Injury Rehabilitation Unit
- South West Brain Injury Rehabilitation Service
- Southern Area Brain Injury Service
- Hunter Brain Injury Service
- Dubbo Brain Injury Rehabilitation Program
- New England Brain Injury Rehabilitation Program
- Mid West Brain Injury Rehabilitation Program

5.3 Non-admitted Brain Injury patient Rehabilitation designated units:
- Children’s Hospital Westmead
- Sydney Children’s Hospital
- Illawarra Brain Injury Service
- Mid North Coast Brain Injury Rehabilitation Service
- Northern Brain Injury Rehabilitation Service

5.4 Admitted patient Spinal Injury Rehabilitation designated units:
- Prince of Wales
- Royal North Shore
- Children’s Hospital at Westmead
- Sydney Children’s Hospital
- Royal Rehabilitation Centre Sydney.

5.5 Admitted and Non-Admitted patient Spinal Injury Rehabilitation designated Transitional Living units:
- Prince of Wales
- Hunter Spinal Injury Service

5.6 Non-admitted Spinal Injury patient Rehabilitation designated facilities:
- Prince of Wales
- Children’s Hospital Westmead
- Sydney Children’s Hospital
- Illawarra Spinal Injury Service
- Royal North Shore
- Spinal Outreach Service
- Rural Spinal Injury Service

104(03/07/18)
CLASSIFICATION OF VICTIMS OF CRIME PATIENTS (PD2005_542)

This section is to clarify the position relating to the classification of patients who present for treatment as a victim of crime and where compensation may be payable under the *Victims Compensation Act 1996*.

The Victims Compensation Tribunal (VCT) has determined that victims of crime are unable to claim expenses under the Act for hospital treatment and this view is supported by the Department, as the Act does not confer a right to compensation.

The following is to be implemented when treating victims of crime:

- Where an inpatient or non-inpatient presents at a public hospital as a victim of crime they are not to be classified as compensable;
- Medicare eligible victims of crime inpatients may elect to be treated as either a chargeable or non-chargeable patient (with usual policies to apply);
- Medicare eligible victims of crime non-inpatients are not to be charged for emergency department/outpatient services, but outpatient pharmaceutical charges are to apply as is the case with other non-inpatients.
  The exception to these general principles would be those persons who are the victim of crime for which they are entitled to claim some form of compensation (eg worker’s compensation) other than a claim against the VCT. In these instances the person would be classified as compensable and charged the appropriate compensable rate.
- Medicare ineligible (overseas visitors) victims of crime who present at a NSW public hospital are to be charged as follows:
  - where the appropriate authority (i.e. Police) has confirmed that the person is a victim of crime and treatment is provided by a hospital nominated doctor - no hospital/medical charges are to be raised.
  - In all other instances the current charging arrangements for ineligible inpatient/non-inpatients are to be applied.
STAFF SPECIALIST RIGHTS OF PRIVATE PRACTICE ARRANGEMENTS (PD2017_002)

PD2017_002 rescinds PD2016_042

PURPOSE
This Policy Directive addresses the rights of private practice arrangements for Staff Specialists in respect of fees that can be charged where medical gap cover insurance is held, the availability of medical indemnity, and the disbursement of funds from the No 1 Account. The Policy Directive does not introduce any changes to existing practices, but extends the period in which Staff Specialists can be reimbursed medical indemnity costs from 30 June 2016 to 30 June 2017.

MANDATORY REQUIREMENTS
All Public Health Organisations (PHOs) are required to comply with the attached arrangements.

IMPLEMENTATION
Chief Executives are responsible for ensuring that this Policy Directive is brought to the attention of Staff Specialists and staff who are involved with Staff Specialist private practice billing arrangements. Staff Specialists are responsible for ensuring that their billing procedures are in conformity with the provisions of this Policy Directive.

1 BACKGROUND
1.1 About this document
This Policy Directive deals with the rights of private practice arrangements for Staff Specialists, as established by section 2 of the Staff Specialists Determination, in respect of fees that can be charged where medical gap cover insurance is held, the availability of medical indemnity, and the disbursement of funds from the No 1 Account. (This Policy Directive does not introduce any changes to existing practices.)

2 FEES THAT CAN BE CHARGED WHERE MEDICAL GAP COVER INSURANCE IS HELD
1. Eligible persons treated as private (chargeable) patients by Staff Specialists when exercising rights of private practice, are able to be charged above the Medical Benefits Scheme (MBS) fee in the following circumstances:
   i. The patient has medical gap cover insurance from a health fund, so that the fund will cover the “gap” between the MBS fee and the fee charged by a hospital on behalf of the Staff Specialists and
   ii. The patient will not have any out of pocket expenses in relation to the particular service involved.

2. The approval to charge eligible patients above the MBS fee is subject to the following provisions:
   i. The arrangements can apply to all episodes of treatment and attendance in respect of which hospitals issue bills on behalf of Staff Specialists and
   ii. The relevant Public Health Organisation (PHO) must have given prior approval to a Staff Specialist’s participation in the arrangements.

99(19/1/17)
3. There is no obligation on a PHO or a Staff Specialist to become involved in these arrangements. Where a PHO does elect to become involved, they will need to arrange for procedures to be put in place so that when a patient indicates an election to be treated as a private patient, information is sought on where that patient has available health fund gap cover insurance with a health fund, in order that the necessary billing arrangements can be implemented by the hospital on behalf of the Staff Specialist.

4. The need to operate a more complex billing system may involve further administrative work, possible software revision, and possible additional extra costs. Where such additional costs can be clearly demonstrated, arrangements can be made to recoup them on a cost recovery basis. The costs so recovered:
   i. Should be the first charge on the monies received where patients have been charged above the MBS fee
   ii. Are to be in addition to infrastructure fees levied and
   iii. Are to be accounted for in the same manner as infrastructure fees received in respect of private practice revenue.

In assessing whether additional charges are to be made, regard should be had to any additional revenue from infrastructure fees that would be received as a result of the high charges that would be involved.

3  APPROVED LEVEL OF ACTUAL ACCOUNTING COSTS FOR PARTNERSHIPS

Approval for the payment from the relevant sub-ledger of the No. 1 Account of actual accounting costs associated with establishing and operating partnerships for Staff Specialists who have elected a Level 2 to 5 right of private practice arrangement are up to the following amounts:

- $2,420 for established costs
- $5,500 p.a. for ongoing costs.

These amounts will be reviewed from time to time as appropriate.

4  PROVISION OF MEDICAL INDEMNITY

1. Staff Specialists are indemnified by the NSW Treasury Managed Fund (TMF) in the circumstances set-out in this section. TMF cover will not be provided to Staff Specialists:
   a. if the conduct constituting the tort to be indemnified was criminal and / or arose out of fraudulent, dishonest or malicious conduct, acts or omissions, except where the employee had no knowledge of and could not have reasonably been expected to know of the conduct, acts or omissions.
   b. for the legal costs associated with personal representation for coronial inquests, inquiries of the Health Care Complaints Commission (HCCC) or other disciplinary matters.
      (Consideration should be given to making alternative arrangements to provide indemnity cover for these types of matters.)

2. TMF indemnity is subject to certain qualifications including:
   a. The Staff Specialist has a signed contract of liability coverage with the public health organisation with which he or she is engaged. Staff Specialists with a contract of liability coverage should refer to their contract for specific details of the applicable terms and conditions of cover.
   b. The Staff Specialist agrees that the management and conduct of the claim passes entirely to the PHO and the TMF.
   c. Any decision as to whether a claim is to be settled or defended rests with the TMF.
3. **Staff Specialists Level 1**

Staff Specialists employed by PHOs who have elected a Level 1 private practice arrangement, are indemnified through the TMF against liability for claims arising during the course of treating both public and private (i.e. chargeable) patients in public hospitals or as part of other services provided by the PHO.

4. **Staff Specialists Level 2 to 5**

Staff Specialists employed by PHOs who have elected a Level 2 to 5 private practice arrangement, are indemnified through the TMF against liability for claims arising during the course of treating public patients in public hospitals or as part of other services provided by the PHO.

Where a Staff Specialist who has elected a Level 2 to 5 private practice arrangement has entered into a contract of liability coverage for indemnity under the TMF, indemnity is also provided in respect of services provided as part of the exercise of rights of private practice to private rural and / or paediatric patients in or at public hospitals or as part of other services provided by the PHO.

5 **REIMBURSEMENT OF MEDICAL INDEMNITY COSTS**

The scheme by which medical indemnity costs incurred by Staff Specialists who have elected a Level 2 to 5 private practice arrangement can be reimbursed, will remain in place until 30 June 2017.

1. Staff Specialists who have elected a Level 2 to 5 private practice arrangements are authorised to receive reimbursement from the relevant sub-ledger of the No. 1 Account of amounts paid in order to obtain medical indemnity cover relating to the exercise of their rights of practice which is not covered by TMF indemnity. This includes all amounts paid in relation to membership of medical indemnity provider organisations and insurance (excluding those costs incurred in respect of outside private practice as specified below at section 5(4)).

2. In circumstances where an agreed group of partnership pools private practice billings, it is a matter for the members of the agreed group of partnership to determine the manner in which claims for reimbursement are to be made, having regard to the possibility that there may be insufficient funds to meet all costs. Each agreed group or partnership will need to advise their PHO of the approach they wish to take in respect of reimbursement prior to reimbursement being paid.

3. Reimbursement is only payable where originals or certificated copies of renewal forms, receives or other documents provided by the medical insurer have been provided, which show the amount of the membership subscription or premium payable, and the amount paid.

4. The amount that can be reimbursed will reflect only the costs relating to obtaining indemnity cover in respect of a Staff Specialist’s private practice billings in the public hospital system (not relating to any outside private practice component). Staff Specialists can obtain reimbursement only for that part of their indemnity costs that would have been paid exclusive of any outside practice billings. Any additional premium or membership costs that arise from or are due to outside practice will not be reimbursed.

5. The costs for which reimbursement can be made also include payments made during a financial year to purchase run off cover where a Level 2 to 5 Staff Specialist proposes to acquire TMF cover in respect of all patients treated as private patients under the private practice arrangements, and as a consequence purchases run off cover from a medical defence organisation. For such reimbursement to be made, it will be necessary for a Staff Specialist to provide evidence that is acceptable to the relevant PHO that an election to Level 1 private practice arrangements has been made of that a contract of liability cover for the treatment of private rural and / or paediatric patients has been signed, and that the reimbursement is only of costs incurred in purchasing run off cover and does not involve any other costs (such as obtaining medical indemnity cover for patients treated outside the public health system as part of outside practice).
6. **PHOs are to reimburse only the GST - exclusive amount of the medical indemnity costs. It is a matter for the individual Staff Specialist or the Staff Specialist partnership, as appropriate, to claim input tax credits in relation to the GST paid on these costs.**

7. **Where a Staff Specialist ceases employment in the New South Wales public health system, having obtained reimbursement for indemnity costs which relate to a full year of practice, before the conclusion of that year, a pro rata repayment of that extent of the reimbursed costs which corresponds to that proportion of the year of practice which remain following the cessation of the employment should be recovered from the Staff Specialist. Where a Staff Specialist increases the proportion of outside practice so as to reduce the amount of indemnity insurance costs payable that relate to public hospital private practice, the amount of any reimbursed indemnity costs that no longer relates to private practice billings should also be removed with effect from that time.**

### 6 DISBURSEMENT OF FUNDS FROM THE NO. 1 ACCOUNT

1. The following charges are to be made on a monthly basis against the relevant sub-ledgers of the No. 1 Accounts, in the order given and only to the extent that funds are available:
   b. Approved costs for Levels 2 to 5 Staff Specialists, which are accounting costs for partnerships as provided for at section 3 above and reimbursement of medical indemnity insurance costs as provided for at section 5 (1) above.

2. **Where a Staff Specialist is entitled under the Determination to a guaranteed level of drawings under Level 2, 3 or 4 rights of private practice arrangements, supplementation shall take into account and be reduced by any amounts paid to the Staff Specialist for approved costs (i.e. under section 5 (1) above). (Therefore supplementation in these circumstances would be the amount of the guaranteed supplementation, minus amounts already paid or payable as approved costs under section 6 (1) (b) above and drawing rights under section 6 (1) (c) above.)**

3. **Approved costs and drawing rights are only to be paid to the limit of funds that are available in the No. 1 Account during the financial year. If there are insufficient funds to pay fully for approved costs, a partial reimbursement is payable, to the extent that funds are available. (There would be no entitlement to drawing rights in these circumstances.) At the end of the financial year, PHOs are to raise a tax invoice for the residual funds in the No. 1 Account (called the annual infrastructure charge) and transfer the appropriate residual funds to the No. 2 Account.**

8. **Reimbursement is only payable where originals or certificated copies of renewal forms, receives or other documents provided by the medical insurer have been provided, which show the amount of the membership subscription or premium payable, and the amount paid.**

9. **The amount that can be reimbursed will reflect only the costs relating to obtaining indemnity cover in respect of a Staff Specialist’s private practice billings in the public hospital system (not relating to any outside private practice component). Staff Specialists can obtain reimbursement only for that part of their indemnity costs that would have been paid exclusive of any outside practice billings. Any additional premium or membership costs that arise from or are due to outside practice will not be reimbursed.**

99(19/1/17)
ATTACHMENT A

Attachment A -1 - Estimate of cost and agreement to pay forms (examples)

a. Medicare Ineligible – Inpatient estimate of cost and agreement to pay
b. Medicare Ineligible with Visas 401, 403, 416, 420, 457, 485, 500, 570 to 576, 580 or 590 Inpatient estimate of cost and agreement to pay
c. Medicare Ineligible Asylum Seeker - Inpatient estimate of cost and agreement to pay
d. All Medicare Ineligible - Non-admitted Patient estimate of cost and agreement to pay

Also available on Revenue Toolkit Forms page

Attachment A -2 - Guarantee of Payment

a. Medicare Ineligible Financial Guarantees - Guide for Revenue or Finance officers
b. Information Statement for Guarantor – Guarantees
c. Deed of Guarantee

Attachment A -3 - RHCA ready reckoner
Attachment A – 1 Cost estimates and agreement to pay form examples

(A) Medicare Ineligible – Inpatient estimate of cost and agreement to pay
Example only – see Revenue website forms page for up-to-date document
(B) Medicare Ineligible with Visas 401, 403, 416, 420, 457, 485, 500, 570 to 576 and 580 and 590 -
Inpatient estimate of cost and agreement to pay
Example only – see Revenue website forms page for up-to-date document

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AHA Rate Serv...
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</table>

Payment Details

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</table>

This form is for site/patient records only

A copy of the completed form supplied to patient by ______________________ on __/__/___
(C) Medicare Ineligible Asylum Seeker - Inpatient estimate of cost and agreement to pay
Example only – see Revenue website forms page for up-to-date document

<table>
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<tbody>
<tr>
<td>Patient information and declaration (to be complete by or on behalf of the patient)</td>
<td></td>
</tr>
<tr>
<td>Patient name</td>
<td></td>
</tr>
<tr>
<td>AUID</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Norfolk Island address</td>
<td></td>
</tr>
<tr>
<td>Phone number</td>
<td>Mobile Other</td>
</tr>
<tr>
<td>Email address</td>
<td></td>
</tr>
<tr>
<td>Address mainland</td>
<td></td>
</tr>
<tr>
<td>Licence or ID number</td>
<td>Copied</td>
</tr>
</tbody>
</table>

I understand that the amount shown below is an estimate of fees that I owe to myself or my insurer. I understand that any amounts my insurer refuses to pay will be my responsibility.

Patient or representative signature

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate (updated)</th>
<th>No.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care</td>
<td>$1,755</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single room – overnight (where available)</td>
<td>$80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared room – overnight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient treatment fee (hospital Dr)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist services (private Dr)</td>
<td>Item number/s @ 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td>Item number/s @ 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging (if required)</td>
<td>AMA rates of imaging and reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>Cost recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy (if required)</td>
<td>Direct cost of items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Aids, prostheses etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AMA rates or procedures: if more than space allows, attach detail or record over page

<table>
<thead>
<tr>
<th>Date</th>
<th>Age / Procedures</th>
<th>MBS Item #</th>
<th>MBS Rate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Payment details</th>
<th>Amount</th>
<th>Receipt Number</th>
<th>Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash/Cheque/Money Order</td>
<td>S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit card/Debit</td>
<td>S</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This form is for site / patient records only.*
(D) Medicare Ineligible - Non-admitted patient estimate of cost and agreement to pay
Example only – see Revenue website forms page for up-to-date document

![Non-admitted Patient - estimate of cost and agreement to pay](image)

### Details of Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate</th>
<th>No.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Consult</td>
<td>$133</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology collection</td>
<td>$266</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology (other)</td>
<td>$133</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging – AMA</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Admitted to Psychiatric Hospital</td>
<td>$99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Admitted – Public clinic</td>
<td>$133</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor procedure – AMA rate</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic equipment or aids (crutches, immobilisers, etc)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### AMA Services – Imaging and Minor Procedures

<table>
<thead>
<tr>
<th>Date</th>
<th>Image / Procedures</th>
<th>AMA Item #</th>
<th>AMA Rate</th>
</tr>
</thead>
</table>

### Payment Details

<table>
<thead>
<tr>
<th>Method of Payment</th>
<th>Amount</th>
<th>Receipt Number</th>
<th>Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash/Bank Cheque/Money Order</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit Card / EFTPOS</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form is for site/patient records only

A copy of the completed form supplied to patient by ________________ on __/__/____
Attachment A - 2 – Guarantee
Guide for Revenue or Finance officers
Medicare Ineligible Financial Guarantee
Overseas visitors or temporary Australian residents who are not Australian citizens or permanent residents are required to pay for medical services.

If a Medicare ineligible patient indicates they may have difficulty or be unable to pay for some or all of the costs of the services that are expected to be provided you may request a Guarantee from a supporting person.

This guide provides information about:
- how you should engage and consult with a supporting person who may be willing to provide a Guarantee; and
- what you should and should not do or say in arranging for a supporting person to grant and sign a Guarantee in favour of the Hospital.

What is a guarantee?
A guarantee is a promise made by a person that the patient will pay, on time, the amounts owed by the patient, for services provided.

Under this promise, the guarantor will be liable for all amounts that:
- are or become payable by the patient, for services provided
- that remain unpaid by the patient
- are owing but not yet payable.

Under the promise made by the guarantor, if the patient does not pay, as agreed, the amounts raised for services, the guarantor promises to pay the amount owing as soon as the money is asked for.

The option to take a Guarantee
You may request a Guarantee from a supporting person if there is doubt about whether the patient can or will make payment of the expected costs for the services to be provided.

If you form the view that a Guarantee would provide additional protection for the health services, you may ask the patient or the person providing apparent support to the patient, such as the spouse or accompanying adult whether they or someone else would consider providing a supporting Guarantee to assist in securing amounts that will become payable.

You should not suggest:
- that the patient will not receive required services if a Guarantee is not provided;
- that the services provided to the patient will be conditional on a Guarantee being provided.

You may say that if a Guarantee can be provided, this is likely to avoid or reduce the need for the hospital to consider or monitor the extent of services that it is able to provide to the patient over and above those that are immediately necessary to stabilise or maintain the current state of health of the patient.
Consulting with a prospective guarantor

It is important that a prospective guarantor has the opportunity to decide whether to provide the Guarantee, without any inappropriate pressure – whether spoken or implied.

Any final discussions with a prospective guarantor should not take place in the presence of the patient. If discussions about the provision of a Guarantee initially commence in the presence of the patient, and the prospective guarantor indicates a potential willingness to provide a Guarantee, you should not conclude those discussions in the presence of the patient.

Ideally, any detailed discussions with a prospective guarantor who may be willing to provide a Guarantee should not take place in the presence of the Patient. Once you establish a potential willingness on the part of a supporting person to provide a Guarantee you should speak with the prospective guarantor alone in a room away from the patient and from any other relevant relative of the patient who may be able to influence the prospective guarantor in deciding whether or not to enter into the Guarantee.

The guarantor should be given the opportunity to reach a final decision to provide the Guarantee without the emotional presence of another person being allowed to interfere with that decision.

When speaking with a prospective guarantor, you should follow the scripts and procedures set out below.

Explain why a Guarantee is being asked for

In the initial discussion with a prospective guarantor, you should explain the reasons why the hospital is seeking the Guarantee. For example:

"In situations like these:

where a patient is not eligible for Medicare; and where there is a concern that the Hospital will be at financial risk in providing the required Services to the patient,

it is the Hospital's preference to obtain a guarantee from a person who is willing to provide financial support to the patient.

The provision of a Guarantee can assist the Hospital with its decisions and planning about the extent of the Services it can provide to the Patient- over and above those that are immediately necessary.

I should emphasise that the desire for a Guarantee will not prevent the Hospital from providing treatment that is immediately necessary for the patient's welfare."

You should also explain that the supporting person is under absolutely no obligation to provide a Guarantee. For example:

"I want to make it clear that it is entirely up to you, as to whether you decide to provide us with a Guarantee. This is strictly your decision and we will respect your decision regardless of what you choose to do.

As I have explained, if we hold a Guarantee, this can assist the Hospital in its planning as to the extent of the Services it can provide to the Patient – over and above those that are immediately necessary."
Ask the supporting person to read the Guarantee document and the guarantor Information Statement

If a prospective guarantor expresses an interest in entering into a Guarantee, you should:

- ensure the supporting person reads a copy of the Guarantee document; and
- the guarantor Information Statement 'Information Statement – Guarantees'

If a further explanation of the document is required

Ask the supporting person if they have understood the terms of the Guarantee.

If you need to explain the general nature of a guarantee, the following is an explanation of the Guarantee that you can give.

"If you give a guarantee in the terms of this document you will be making a legally binding and enforceable promise to the Hospital that you will be liable to make payment to the Hospital, on demand, for all outstanding amounts that are to become payable by the patient in connection with the Services that the provided to the patient by the Hospital.

This means that if the patient does not pay the outstanding amounts for the Services he or she has received, we may seek payment from you instead. If you do not pay, we can then take enforcement action against you to recover the money originally owing by the patient. We can also recover any reasonable enforcement expenses.

Before you agree to sign the Guarantee, you should carefully read it."

As far as practical, you should not seek to explain the individual clauses of the Guarantee document or their effect. You should explain that you are not able to give advice on the particular terms of the Guarantee. You should explain that this is why the guarantor Information Statement has been provided to assist the guarantor.

If the prospective guarantor persists in seeking an explanation, you should suggest that they may wish to take separate advice if they feel the need to do so.

Explaining the 'cooling off period'

As an alternative to seeking independent advice before signing the Guarantee, the guarantor can elect to rely on the right to cancel the Guarantee during the 'cooling off' period.

You can explain this as follows.

"We recognise that a decision to provide support for the patient by providing a Guarantee can be a complex or difficult one.

For that reason, if you choose to sign the Guarantee, you will have the right to cancel the Guarantee by giving the Hospital a written notice of cancellation within the two Business Days that follow after you sign the Guarantee.

This will allow you to reconsider your choice to provide the Guarantee, or to seek additional advice about the Guarantee after you have signed it.

Your cancellation rights and the applicable time limits of two Business Days are set out in the Guarantee document."

90(4/8/16)
Execution of the Guarantee

Once a person has agreed to sign the Guarantee, you should state:

*You understand that you are not obliged in any way to provide the Guarantee and may decline to do so.*

*You confirm that you have read and understood this document.*

The Guarantee should then be signed by the guarantor and dated. You should sign as the witness of the guarantor's signature and complete the details of your full name and address.

Translators

If the prospective guarantor requires a translator, the staff member should seek an appropriate person to communicate with the supporting person using a translation of the suggested dialogue above.

The prospective guarantor should be provided with:

a) a copy of the Guarantee; and

b) a copy of the *Information Statement – Guarantees*, including a copy of the *Deed of Guarantee*.

You should then:

- ask the prospective guarantor to return as soon as possible with a qualified translator; or
- arrange for the prospective guarantor to attend the Hospital at a time that you are able to provide a suitably qualified translator, in each case, at an agreed time in the near future.

The same processes should then be followed with the assistance of the translator, and with the translator providing required translations to the prospective guarantor of what is being said and what is written in the documents.

The translator should then be asked to certify in writing that they have faithfully translated what you have said, as well as the contents of the Guarantee and the Information Statement. You should ask the prospective guarantor to confirm, with the assistance of the translator as required, that they have understood the terms of the Guarantee document and its effect. You should confirm that they are providing the Guarantee of their own free will.
### Place and mode of execution

The following is a checklist to be completed before and after the guarantor signs the Guarantee:

<table>
<thead>
<tr>
<th>Question</th>
<th>✓/X</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Guarantee being signed in a room separate to where the Patient and any relations of the Patient are located?</td>
<td>✓</td>
<td>[If the answer to this question is &quot;X&quot;, signing must be postponed until you and the Guarantor are in a room separate to the Patient and his or her relatives.]</td>
</tr>
<tr>
<td>Who are the attendees in the room at the time of the signing of the Guarantee and what relation do they have to the Guarantor?</td>
<td>✓</td>
<td>[Provide a list]</td>
</tr>
<tr>
<td>Has the Guarantor obtained any legal and/or financial advice before signing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In your opinion, does the Guarantor understand the capacity in which he or she is signing the Guarantee?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In your opinion, has the Guarantor been subject to any duress, undue influence or commercial pressure to sign the Guarantee?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the Guarantor received a copy of the signed Guarantee?</td>
<td>✓</td>
<td>[Following the execution of the Guarantee, you should provide a copy of the executed document to the Guarantor.]</td>
</tr>
</tbody>
</table>

### Additional notes

<table>
<thead>
<tr>
<th>Has a translator been used?</th>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

| Does the translator certify that they have faithfully translated what has been said and the contents of any documents? | I certify I have faithfully translated any conversations and documents. | Translator Signature |

| Does the translator confirm that the guarantor has indicated that they understand the terms of the Guarantee Document and is making the guarantee of their own free will? | I confirm that the prospective guarantor indicates that they understand the terms of the guarantee document and are making the guarantee of their own free will. | Translator Signature |
Information Statement for Guarantor - Guarantees

1. **THINGS YOU SHOULD KNOW ABOUT GUARANTEES**

   You are being asked to provide (or have offered to provide) a guarantee in respect of the liabilities of the patient (Patient) described in the guarantee document that is being provided to you with this information statement.

   This information statement tells you about some of the rights and obligations you will have as a guarantor if you sign the guarantee document (Guarantee). This information does not provide a full or complete description of the terms and conditions of the Guarantee. Instead, this document is designed to tell you more about what it will mean to be a guarantor of the liabilities of the Patient.

2. **WHAT IS A GUARANTEE?**

   If you sign the Guarantee you will provide a promise to the person described in the Guarantee as the "Provider". You will promise that the Patient will pay, on time, the moneys owed by the Patient to the Provider for the 'Services' that are provided to the Patient while he or she is an admitted patient of the Provider.

   - The 'Services' that may be provided by the Provider, and that the Patient will be directly liable to pay for, are **all services, goods and materials that are provided to the Patient while the Patient [is/continues to be] an admitted patient of the Provider (including for accommodation, medical tests, diagnostic services, surgery, other medical or hospital services, medicines, food and other goods and materials, specialist services such as physiotherapy and all other services and materials provided to the Patient in relation to the health and wellbeing of the Patient)**.

   - The liabilities of the Patient that you will guarantee (being the 'Guaranteed Money') are **all amounts that are or become payable, are owing but not yet payable, or that otherwise remain unpaid by the Patient to the Provider on any account at any time in connection with Services provided to the Patient on and following the admission date of the Patient (e.g. while the Patient is an admitted patient of the Provider)**.

   Accordingly, if the Patient does not pay the Guaranteed Money, you promise under the Guarantee to pay the Provider all of the money owing (and any reasonable enforcement expenses) as soon as the money is asked for, and where it is payable by the Patient. If you do not pay on request, then the Provider can take enforcement action against you.

3. **CAN I WITHDRAW FROM MY GUARANTEE IN A COOLING OFF PERIOD?**

   There is a "cooling off" period.

   You can withdraw from your Guarantee by giving written notice to the Provider of your decision to cancel and withdrawal from your Guarantee PROVIDED THAT you provide that written notice to the Provider within 2 'Business Days' of your execution of the Guarantee (and do so in the manner provided for in clause 5 of the Guarantee).

   *The purpose of the cooling off period is to allow you a short period of time to review or reassess your decision to provide the Guarantee.*

   If you do decide to withdraw from your Guarantee, this may affect the extent of the Services that the Provider will be willing to continue to provide to the Patient. If you do withdraw your Guarantee, the Patient will remain liable to pay, on time, the moneys owed by the Patient to the Provider for the Services provided.
4. **IF THE PATIENT DEFAULTS, DO I GET ANY WARNING THAT THE PROVIDER WANTS TO TAKE ACTION AGAINST THE PATIENT?**
In most cases both you and the Patient will get a reasonable amount of notice of a default and of the date something must be done about the matter.

You should immediately discuss any such notice of demand with the Patient and consider getting independent legal advice and/or financial advice.

5. **IF THE PATIENT CANNOT BE FOUND AND/OR THE PROVIDER INTENDS TO TAKE LEGAL ACTION AGAINST ME DO I GET ANY WARNING?**
You will receive a written demand before any enforcement proceedings are taken against you.

6. **CAN THE PROVIDER TAKE ACTION AGAINST ME WITHOUT FIRST TAKING ACTION AGAINST THE PATIENT?**
Yes. The Provider can take enforcement proceedings against you without first having taken enforcement proceedings against the Patient – for example, where the Patient is no longer in Australia.

7. **HOW MUCH DO I HAVE TO PAY THE PROVIDER IF THE PATIENT DEFAULTS?**
You have to pay, the moneys owed by the Patient to the Provider for the Services provided plus the Provider's reasonable expenses in making you honour your contract of guarantee.

8. **WHAT CAN I DO IF I AM ASKED TO PAY OUT THE GUARANTEED MONEY AND I CANNOT PAY IT ALL AT ONCE?**
Talk to the Provider and see if some arrangement can be made about paying. There are other people, such as financial counsellors, who may be able to help.

9. **IF I PAY OUT MONEY FOR THE PATIENT, IS THERE ANY WAY I CAN GET IT BACK?**
You can sue the Patient, but remember, if the Patient cannot pay the Provider, he or she probably cannot pay you back for a while, if at all.

10. **DO I HAVE ANY OTHER RIGHTS AND OBLIGATIONS?**
Yes. The law does give you other rights and obligations. You should also **READ YOUR GUARANTEE** carefully.
**DEED OF GUARANTEE**

Before you sign this document, you should ensure that you have read and understand its contents. By signing this guarantee, you will be entering into a binding commitment to pay the Guaranteed Money to the Provider (each as described in this document).

After you sign this guarantee, you will have the option of cancelling your obligations as a guarantor, but only where you do so in writing and within 2 Business Days of the time that you signed this document. (Clause 5 of this document sets out the details of this 'cooling off' period and the way in which you must act if you wish to cancel your guarantee within the period of 2 business days that is allowed as the cooling off period.)

The cooling off period that is provided for in this document will allow you to take independent advice (where you wish to do so) following your execution of this document.

<table>
<thead>
<tr>
<th>Details of Provider</th>
<th>[Name of Provider] ABN/ACN/ARBN [number] Opt [whose registered office is at [address]] (the Provider) (which expression includes the Provider's successor in title, substitute or assign)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of Guarantor</td>
<td>[Name of Guarantor] whose address is at [address] (the Guarantor)</td>
</tr>
<tr>
<td>Details of Guarantor</td>
<td>[Name of Guarantor] whose address is at [address] (Alt a/the Guarantor)</td>
</tr>
<tr>
<td>Details of Guarantor</td>
<td>[Name of Guarantor] whose address is at [address] (Alt a/the Guarantor)</td>
</tr>
<tr>
<td>Details of Patient</td>
<td>[Name of Patient] whose address is at [address] (the Patient)</td>
</tr>
<tr>
<td>Date of Admission</td>
<td>[year]</td>
</tr>
</tbody>
</table>

**BACKGROUND**

The Patient has been, or will be, admitted as a patient who will receive Services from the Provider. To better secure the payment by the Patient of the costs of the Services being provided (and to be provided) to the Patient, the Guarantor has agreed to provide the guarantee and indemnity set out in this document.

**THE PARTIES AGREE AS FOLLOWS:**

**GUARANTEE**

**Obligations guaranteed**

The Guarantor guarantees to the Provider the due and punctual payment by the Patient of the Guaranteed Money.

**Consequences of Patient's defaults**

If the Patient defaults in the due and punctual payment of any Guaranteed Money, the Guarantor must pay that money on demand to, or as directed by, the Provider.
Consideration and solvency

The Guarantor represents and warrants to the Provider that:

(a) the Guarantor has received valuable consideration for entering into this document;
(b) the Guarantor considers that the Guarantor will benefit by entering into this document;
(c) this document constitutes the Guarantor's legal, valid and binding obligations, enforceable against the Guarantor in accordance with its terms; and
(d) there are no reasonable grounds to suspect that, after entering into this document, the Guarantor will be unable to pay the Guarantor's debts as and when they fall due.

Nature of obligations and enforcement

The Guarantor's obligations in this document are principal obligations (and not ancillary or collateral to any other right or obligation) and may be enforced against that Guarantor without the Provider first being required to:

(e) exhaust any remedy against the Patient or any other person; or
(f) enforce any other guarantee or Security Interest the Provider may hold relating to the Guaranteed Money.

Continuity and preservation of Guarantor's obligations

This document is a continuing guarantee. The Guarantor's obligations in this document are absolute, unconditional and irrevocable. The liability of the Guarantor under this document extends to and is not affected by the grant of any time or indulgence to the Patient or by any other circumstance, act or omission which, but for this subclause, might otherwise affect the Guarantor at law or in equity, and the Guarantor irrevocably waives any right the Guarantor may have to claim that the Guarantor's liability has been so affected.

LIMITATIONS ON GUARANTOR'S RIGHTS

Until the Guaranteed Money has been irrevocably paid in full, the Guarantor may not have or exercise any rights as surety in competition with the Provider or claim to be entitled (by way of contribution, indemnity, subrogation, marshalling or otherwise) to the benefit of any agreement or document to which the Provider is a party.

INDEMNITY IN RESPECT OF GUARANTEED MONEY

Indemnity

For the consideration mentioned in clause 1.3 the Guarantor must unconditionally indemnify the Provider against, and must pay the Provider on demand the amount of, any loss that the Provider may suffer because:

(g) any obligations in respect of the Guaranteed Money are unenforceable; or
(h) the Guaranteed Money is not recoverable from the Patient or is repaid or restored after it has been recovered, including the amount of any Guaranteed Money (or any money which, if recoverable, would have formed part of the Guaranteed Money) that is not or may not be recoverable.
Application of the indemnity

The indemnity in clause 0 extends to any money that is not recoverable:

(i) because of any legal limitation, disability or incapacity of or affecting the Patient or any other person;

(j) because any transaction relating to that money was void, illegal, voidable or unenforceable;

(k) whether or not the Provider knew or should have known any of the relevant matters or facts; or

(l) because of any other fact or circumstance.

GENERAL INDEMNITY

The Guarantor must indemnify the Provider against, and must pay the Provider on demand the amount of, all losses (including loss of profit), liabilities, costs, expenses and Taxes that the Provider incurs in connection with the preparation, negotiation, execution, stamping or administration of, and any actual or attempted preservation or enforcement of any rights under, this document.

GENERAL

Demand by the Provider

A demand by the Provider under this document may be signed by any of its managers or other officers, or any of its solicitors, and served on the Guarantor at the address shown on the first page of this document, or served personally on the Guarantor. If posted, with the postage prepaid, the demand will be conclusively taken to have been served in the ordinary course of post but in any event not later than two business days after posting.

Statements by the Provider

A statement by an authorised representative of the Provider on any matter relating to this document (including any amount owing by the Guarantor) is, in the absence of evidence to the contrary, to be treated as correct.

COOLING OFF PERIOD AND TERMINATION OF GUARANTOR'S OBLIGATIONS BY NOTICE

The Guarantor may terminate the Guarantor's obligations under this document by giving written notice to the Provider within the 2 Business Days following the date of the execution of this document, notifying the Provider of the Guarantor's election to withdraw from and cancel this document.

Such a notice of withdrawal and cancellation must be given to the Provider, within the required time, by one of the following means:

(m) by hand delivery to the Provider at [set out address and other requirements] marked for the attention of [set out the details];

(n) by fax to the following fax number [set out the applicable fax number];

(o) by email to [set out the applicable email address]
The Provider will acknowledge receipt of a written notice from the Guarantor that has been given in accordance with this clause 5.1.

Execution by less than all parties

This document binds each of the persons executing it even if:

(p) one or more of the persons named in this document as a Guarantor does not execute this document or is not bound or ceases to be bound by this document; or

(q) the Provider does not execute or only subsequently executes this document.

INTERPRETATION

Definitions

The following definitions apply in this document.

Admission Date is the date described as the Admission Date on page 1 of this document.

Business Day means a day (other than a Saturday, Sunday or public holiday) on which banks are open for general banking business in Sydney, Australia.

Government Agency means: a government or government department or other body; a governmental, semi-governmental or judicial person including a statutory corporation; or a person (whether autonomous or not) who is charged with the administration of a law.

Guaranteed Money means all amounts (including damages) that are payable, owing but not yet payable, or that otherwise remain unpaid by the Patient to the Provider on any account at any time in connection with Services provided to the Patient on and following the Admission Date, whether present or future, actual or contingent or incurred alone, jointly, severally or jointly and severally and without regard to the capacity in which the Patient is liable.

Patient means the person named on page 1 as the Patient and includes the Patient's successor in title, permitted substitute or a permitted assign.

Security Interest means: a security interest that is subject to the Personal Property Securities Act 2009 (Cth); any other mortgage, pledge, lien or charge; or any other interest or arrangement of any kind that secures the payment of money or the performance of an obligation or which gives a creditor priority over unsecured creditors in relation to any property.

Services means all services, goods and materials (including any prosthesis) provided to the Patient while the Patient is an admitted patient of the Provider, including for accommodation, medical tests, diagnostic services, surgery, other medical or hospital services, medicines, food and other goods and materials, allied health services such as physiotherapy and all other services and materials provided to the Patient in relation to the health and wellbeing of the Patient.

Tax means a tax, levy, duty, charge, deduction or withholding, however it is described, that is imposed by law or by a government agency, together with any related interest, penalty, fine or other charge.
Multiple Guarantors

If a term is used in this document to refer to more than one Guarantor then, unless otherwise specified in this document:

(r) an obligation of those Guarantors is joint and several;
(s) a right of those persons is held by each of them severally; and
(t) any other reference to that party or that term is a reference to each of those persons separately.

A singular word includes the plural and vice versa.

EXECUTED as a deed
SIGNED, SEALED and DELIVERED by [NAME OF PARTY] in the presence of:

Signature of party

Signature of witness

Name

Address of witness

SIGNED, SEALED and DELIVERED by [NAME OF PARTY] in the presence of:

Signature of party

Signature of witness

Name

Address of witness
### Reciprocal Healthcare Agreement Ready Reckoner

<table>
<thead>
<tr>
<th>Country and Conditions</th>
<th>Tourist, short term visitor or visa other than those to the right &gt;</th>
<th>Student Visa 500, 570-576, 580 &amp; 590</th>
<th>Work Visa 401, 403, 416, 420, 457 or 485</th>
<th>Retirement Visa 405 or 410</th>
<th>Diplomat</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>United Kingdom:</strong></td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Must show a current UK passport (including those issued in the Isle of Man, Jersey or Guernsey) and have lived in the United Kingdom within the past five years. Or hold an Australian Medicare Card</td>
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</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY, as long as the conditions to the left are met.</td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.</td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.</td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.</td>
<td>NOT ELIGIBLE</td>
</tr>
<tr>
<td>Must show a current NZ passport or be a permanent residents who holds a Returning Residents Visa New Zealand citizens living permanently in Australia are eligible for full access to Medicare (Green card)</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Republic of Ireland:</strong></td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY, as long as the conditions to the left are met.</td>
<td>NOT ELIGIBLE</td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.</td>
<td>NOT ELIGIBLE</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Must show a current Republic of Ireland passport. Not eligible for a RHCA Medicare card</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Italy:</strong></td>
<td>ELIGIBLE but only for six months from date of entry to Australia</td>
<td>NOT ELIGIBLE</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Must show a current Italian passport showing visitor is a Citizen of Italy (resident is not sufficient) EXCLUDES maintenance dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country and Conditions</td>
<td>Tourist, short term visitor or visa other than those to the right</td>
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<td>Retirement Visa 405 or 410</td>
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</tr>
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<td>-----------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Malta:</td>
<td>ELIGIBLE but only for six months from date of entry to Australia</td>
<td>NOT ELIGIBLE</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Sweden:</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Belgium:</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>NOT ELIGIBLE</td>
</tr>
<tr>
<td>Finland:</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>NOT ELIGIBLE</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Norway:</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>Not Eligible.</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>NOT ELIGIBLE</td>
</tr>
<tr>
<td>Slovenia:</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>NOT ELIGIBLE</td>
</tr>
<tr>
<td>Netherlands:</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ELIGIBLE as long as the conditions to the left are met.</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ONLY ELIGIBLE if holding a current Medicare Card</td>
<td>ELIGIBLE for full Medicare (not subject to medically necessary rules)</td>
</tr>
</tbody>
</table>
ADMITTED PATIENT ELECTION FORM INFORMATION FOR PATIENTS

Patient Election

Australian residents and certain overseas visitors have the choice to be treated as either a public or private patient in NSW public hospitals. The basic principle involved in a patient making an election is that he or she should freely make an informed decision based on accurate information.

All eligible persons have the choice to be treated as a public (hospital non-chargeable) or private (chargeable) patient regardless of whether or not you have private health insurance ie: you do not have to be treated as a private patient because you have private health insurance. However there are some differences between choosing to be treated as a public or private patient.

If you wish to be treated by a doctor nominated by you, for example a doctor who you have attended outside the hospital, you may do so by choosing to be admitted as a private (chargeable) patient under the care of that doctor (and any other doctors whom he/she may call into consultation to assist in your care).

You may select as your private doctor the medical practitioner on call and be admitted under the care of that doctor as a private patient.

Alternatively, you may choose to be admitted as a public (hospital non-chargeable) patient and the hospital will nominate a doctor or doctors to care for you.

A patient election form is to be completed by all admitted patients except those who have completed separate forms such as Declaration of Overseas Residence, or of Coverage by Workers Compensation, Third Party Insurance or Department of Veterans Affairs or other compensable Acts. It may be completed at the hospital or prior to that in your Doctor’s surgery.

By completing an election form you are making an election (choice) to be admitted as a public or private patient. Your election may only be changed as a result of unforeseen circumstances. Your choice will affect which doctor treats you while you are in hospital and the fees, if any, you will be responsible for paying.

It should be noted that even though you complete an election form as an eligible patient, if you are later found to be eligible for compensation under Workers Compensation, Third Party insurance or under any other type of arrangement (and therefore not eligible under Medicare arrangements), you will be reclassified as compensable and be charged accordingly.

You should also make sure you are familiar with your rights and responsibilities as a patient of a NSW public hospital. This information is contained in the pamphlet “You and Your Health Service” which is available from your local public hospital or Area Health Service.

The election is to be completed by you (the patient) or on your behalf by a responsible person that is legally entitled to make decisions about your health care (usually spouse, parent or other relative). When you have completed the form it must be witnessed by a hospital employee (eg: admission clerk) who will certify this on the form.

A. Private (Chargeable)

- You will have a private contract for care by the doctor selected and with other doctors, whom you and he/she select to assist in your care. These doctors will charge you for services rendered. You will also be charged for all diagnostic and pathology services.
- Your post-discharge care will ordinarily be carried out by the doctor you have selected in his or her consulting rooms.

37(10/01)
INPATIENTS

• You will be able to claim on Medicare for all medical expenses incurred including diagnostics and pathology. Medicare will refund 75% of Schedule Fee for any single service. If the doctor charges over the schedule fee you will be liable to pay the difference from your own pocket. The private health funds offer a cover for the 25% Medicare gap for those patients so insured.
• You will be charged for prostheses. The private health funds will meet these charges in most instances if basic hospital cover is held.
• You will be charged by the hospital at the Standard Ward rate for shared accommodation or the Single Room rate for single accommodation (if available and if requested) or one of four day only rates depending on type of treatment. Your private health insurance fund will cover you for all, or a substantial part, of the hospital’s charges depending on your level of insurance cover.
• If you have private health insurance you should seek advice, prior to admission, from your fund, your doctor and the hospital to confirm the extent to which your health fund will cover all your costs. You will be responsible for meeting those costs not covered by your health insurance.
• It should be noted that hospitals will provide copies of your election form to your private health insurance fund should they request it. If you have any objection to this occurring please notify the hospital. However you should be aware that failure to provide this may result in your health fund not paying benefits for your treatment.

B. Public (Hospital Non-Chargeable)

• You will be treated by a doctor or doctors nominated by the hospital and you will not be charged personally for medical or hospital services.
• Post-discharge care may be carried out in an outpatient clinic or a doctor’s rooms depending on circumstances.

C. Deferred Election

Generally speaking, a patient should fill out an election at or before admission. There are two exceptions to this policy:

1) emergency admissions after hours in hospitals where staff are not available to organise the completion of the election form until the following working day.

2) should a patient be unable to make a valid election at the time of admission because of:
   • unconsciousness
   • impaired consciousness
   • severe pain
   • dementia
   • shock
   • inability to speak English
   • not being accompanied by a responsible relative
   • the unavailability of staff to classify the patient
   • or other reasons that may inhibit informed decisions.

The process of classification may be deferred until the patient or a responsible relative can complete the process of election.
Patients unable to make an election at the time of admission will be classified as public and treated by a doctor chosen by the hospital until a valid election can be made.

When a valid election is made such an election shall be retrospective to the time of admission to the hospital.

D. Alteration of Election

A valid election can only be changed in the event of unforeseen circumstances. These include but are not limited to:

- Patients who are admitted for a particular procedure but who are found to have complications requiring additional procedures
- Patients whose length of stay has been extended beyond those reasonably planned by an appropriate health care professional
- Patients whose social circumstances change while in hospital for instance a change in income status resulting in an inability to meet hospital and medical bills

Where a valid election is changed as a result of unforeseen circumstances, the change in status will only be from the date of change onwards. It is not to be retrospectively backdated.

Please note that inadequate private health insurance cover will not normally be considered sufficient reason to alter your election status from private to public. You should check you level of cover with your fund prior to admission and completion of your election.
III. COMPENSABLE ENTITLED PATIENT DECLARATION
(To be completed by or on behalf of the patient)

Patient’s Name.................................. Medical Record No.........................

6.6.1 Compensable Patient

I believe that I am eligible to claim compensation/damages for hospital charges under Workers’ Compensation, or Public Liability Insurance and that charges raised against me as a compensable patient will be covered by such Workers’ Compensation, or Public Liability insurance.

Workers’ Compensation Only

) Name of Insurer:......................................
) Name of Employer:.....................................
) Address of Employer:.................................

In the event that my compensation/damages claim is unsuccessful (for whatever reason), I elect to be a (tick one box):

□ Private (chargeable) patient, in which case I will be:

(1) The private patient of the doctor under whose care I have been admitted.

(2) Responsible for fees for medical services and prosthesis. I understand that Medicare will refund 75% of the fee for each service as listed in the Medical Benefits Schedule. The private health funds offer a cover for the 25% gap for those patients so insured and also for prosthesis charges if basic hospital cover is held.

(3) Responsible for the hospital’s accommodation charge for Standard Ward ($__) which will be covered by private health insurance, if you hold such insurance.

Hospital (Non-chargeable) patient, in which case I will not be charged for medical services or hospital accommodation.

................................................. ..........................................
(Signature) (Date)

(Name of person signing if not patient)..................................................

19(9/94)
VETERANS' AFFAIRS ENTITLED PATIENT
ELECTION FORM

I declare that I am entitled to claim all expenses for my hospital treatment from the Department of Veterans' Affairs for the condition requiring my hospitalisation.

In the event that the Department of Veterans' Affairs does not accept responsibility for my hospitalisation and treatment I elect to be:

☐ PRIVATE (CHARGEABLE) and be treated by
Dr. ______________ and doctors to whom this
doctor refers me.

☐ HOSPITAL (NON-CHARGEABLE)
and be treated by doctors nominated by the hospital.

If I elect to be a PRIVATE patient and be treated by a private doctor (doctor nominated by me) and the Department of Veterans' Affairs refuses to cover the costs of my hospital treatment, I acknowledge my liability to meet the hospital accommodation charge of $___________ per day (shared ward) and associated medical and diagnostic charges.

_________________________   __/___/
(Signature)       (Date)

(Name of person signing if not patient) ________________________________

Signature of Admissions Clerk ____________________ (Date) __/___/___
ATTACHMENT D

IV. OVERSEAS RESIDENTS
PATIENT DECLARATION

Delete (i) I am an overseas visitor to Australia and I do not intend to stay in Australia for longer than six months.
where inapplicable.
(ii) I am a member (or a dependant of a member) of a diplomatic mission to Australia.

PATIENT’S NAME: ...........................................................

I accept that I will be responsible for paying the Ineligible rate of $__ during the period that I am accommodated in this hospital as well as:

- all diagnostic and medical charges raised by visiting medical officers and staff specialists exercising rights of private practice.
- all prosthesis
- all aids and appliances

...........................    ................
(Signature)              (Date)

Please provide name of insurance fund (if any):

Signature of
Admissions Clerk......................... Date .../.../....

18(5/94)
YOUR HEALTH RIGHTS AND RESPONSIBILITIES (PD2011_022)

PD2011_022 rescinds PD2009_053.

PURPOSE

Your Health Rights and Responsibilities policy directive outlines the rights and responsibilities of NSW Health services and staff, and patients and carers. Basic rights are detailed in the policy, including: Access, Safety, Respect, Communication, Participation, Privacy, and the right to Comment. The Policy Directive has been produced to set out NSW Health’s Public Patients’ Hospital Charter and Commitment to Service. The publication incorporates the principles of the Australian Charter of Healthcare Rights and is consistent with the National Healthcare Agreement (NHCA) 2009.

MANDATORY REQUIREMENTS

All health professionals delivering healthcare services within NSW Health must be made aware of the detailed rights and responsibilities outlined in this publication.

IMPLEMENTATION

Chief Executives must ensure:

- that information about patients’ rights and responsibilities is provided to health professionals and stakeholder agencies concerned with treatment and healthcare provision;
- associated documents are displayed and available to healthcare professionals, consumers, carers, and visitors.

Your Health Rights and Responsibilities publication has been produced to set out NSW Health’s Public Patients’ Hospital Charter and Commitment to Service. The publication incorporates the principles of the Australian Charter of Healthcare Rights and is consistent with the National Healthcare Agreement (NHCA) 2009.

INTRODUCTION

On 1 February 1984 the Federal Government’s new health insurance scheme, “Medicare” began. Medicare covers the full cost of accommodation and all medical services in public hospitals when treatment is provided by doctors nominated or selected by the hospital. It also covers the cost of a single room if this is needed for medical reasons.

All New South Wales public hospitals follow these principles:

• priority of treatment is based on medical need.
• no-one is discriminated against.
• no emergency is turned away.
• every patient has the right to choose to be treated by a doctor nominated by the hospital or by a doctor of their own choice (provided the doctor has an appointment at the hospital).
• if the patient is unable to make this choice, for example, because he or she is unconscious and there is no-one who can choose on the patient’s behalf:
  • where the patient holds private health insurance he or she will be classified as a private (chargeable) patient until such time as an election can be made.
  • if the patient does not hold private health insurance the hospital will initially nominate the doctor and the patient or relative, on his or her behalf, may later exercise the option of being treated by a doctor of their own choice.

How do I get admitted to a public hospital in New South Wales?

There are several ways in which you can be admitted to a public hospital in New South Wales.

1. If you are involved in an accident or require urgent treatment, you can go to a casualty department of a public hospital. If you need immediate inpatient treatment, you will be admitted to hospital.
2. You may visit your own private doctor and if inpatient treatment is required, he or she will make arrangements to admit you to hospital. In this case, depending on your wishes and your condition, the doctor will make arrangements with a public hospital.

When you visit your own doctor, he or she may suggest that you be referred to a specialist for assessment, and in this case it would be the specialist who assesses if inpatient treatment is required.

3. If you believe you have a particular health problem, which may require hospital treatment, you can go to one of the large public hospitals which has an outpatient clinic and seek treatment there.

**How do I pay for public hospital services?**

Under Medicare, we all pay a 1¼% levy on our taxable income if we earn over a certain amount. This pays for many of our health services.

Medicare provides benefits of 75% of the medical benefits schedule fee for services provided by the doctor of your choice or other doctor he/she may call in to assist with the treatment of the patient.
<table>
<thead>
<tr>
<th>FEES RAISING ARRANGEMENTS</th>
<th>HOSPITAL DOCTOR</th>
<th>PRIVATE DOCTOR (+)</th>
<th>VET AFFAIRS (Hosp Doctor Also)</th>
<th>ONE DAY ADMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SHARED ROOM</td>
<td>SINGLE ROOM</td>
<td>NURSING HOME TYPE</td>
<td>SHARED ROOM</td>
</tr>
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<td></td>
<td>CHARGE</td>
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<td>CHARGE</td>
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<tr>
<td>HOSPITAL ACCOMMODATION</td>
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<td></td>
<td>NO CHARGE</td>
<td>NO CHARGE</td>
<td>NO CHARGE</td>
<td>HOSPITAL CHARGES ON BEHALF OF DOCTOR</td>
</tr>
<tr>
<td>SALARIED CLINICIANS</td>
<td></td>
<td>To</td>
<td>To</td>
<td>To</td>
</tr>
<tr>
<td>SALARIED DIAGNOSTICIANS</td>
<td></td>
<td>T</td>
<td>T</td>
<td>X</td>
</tr>
<tr>
<td>VISITING CLINICIANS</td>
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<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>VISITING DIAGNOSTICIANS</td>
<td></td>
<td>F</td>
<td>F</td>
<td>X</td>
</tr>
</tbody>
</table>

- **O**: SALARIED CLINICIANS (WITH THE RIGHT OF PRIVATE PRACTICE) AND VISITING CLINICIANS MAY ONLY CHARGE FOR SERVICES TO PATIENTS WHO ARE CLASSIFIED AS PRIVATE DOCTOR.
- **T**: MONEYS RECEIVED BY THE HOSPITAL ON BEHALF OF THE DOCTORS ARE PAID INTO THE PRIVATE PRACTICE TRUST FUNDS INCORPORATED IN THE SPECIAL PURPOSES AND TRUST FUND WITH THE HOSPITAL DEDUCTING A CHARGE FOR THE USE OF HOSPITAL FACILITIES (ARRANGEMENTS A, B, C AND D).
- **X**: COMPENSABLE PATIENTS ARE NOT CHARGED FOR DIAGNOSTIC SERVICES. IN RESPECT OF COMPENSABLE PATIENTS THE GENERAL FUND IS DEBITED AND THE PRIVATE PRACTICE TRUST FUND IS CREDITED (78/141, 80/251, 84/28).
- **F**: IN RESPECT OF VISITING DIAGNOSTICIANS CHARGES RECOVERED ARE PAID INTO TRUST ACCOUNT FOR DOCTORS WITH THE HOSPITAL DEDUCTING A FACILITY CHARGE FOR THE USE OF HOSPITAL EQUIPMENT AND FACILITIES.
- ***:** THIRD PARTY ACCOMMODATION ACCOUNTS ARE RAISED BY MEMORANDUM. ACCOUNTS ARE SETTLED BY THE G.I.O. ON A LUMP SUM BASIS STATEWIDE.
- **(+)**: CHARGES ARE TO BE RAISED FOR PROSTHESIS (as listed in the FEES MANUAL page 4.4.1) FOR ALL PRIVATE DOCTOR PATIENTS OTHER THAN COMPENSABLE.
- **R**: SEE VETERANS AFFAIRS SECTION OF MANUAL FOR CHARGES RE NURSING HOME TYPE ETC. 40(5/03)
## COMPENSABLE PATIENT DECLARATION

**MOTOR VEHICLE THIRD PARTY INSURANCE**

**Area Health Service / Hospital:**

To be completed by or on behalf of the patient. If completed on behalf of the patient it should be by a responsible person, usually a spouse, parent or other relative.

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>( Surname )</th>
<th>( Other Names )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Records No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Date / Month / Year</td>
<td></td>
</tr>
<tr>
<td>Place of Motor Accident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Motor Accident</td>
<td>Date / Month / Year</td>
<td></td>
</tr>
<tr>
<td>Registration No. Of Motor Vehicle/s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Were you a: PEDESTRIAN  PASSENGER  DRIVER  RIDER

If a Driver or Rider, were other Motor Vehicle/s involved? YES  NO

Did the Police attend the Motor Accident? YES  NO

If so from which Station?

* If No, Compulsory Third Party Compensation is NOT applicable.

I declare that to the best of my knowledge the above particulars are true and correct and I believe that I am entitled to claim compensation under the Motor Accidents Act.

In the event that my compensation claim is unsuccessful (for whatever reason), I elect to be a: -- (tick one box)

- [ ] PRIVATE (Chargeable) Patient
- [ ] HOSPITAL (Non-Chargeable) Patient

( Signature ) / / ( Date )

( Name of person signing if not Patient ) 7/9/90
INPATIENTS 2.131

Statutory Declaration - MOTOR ACCIDENTS ACT 1988

Note: Section 65 of the Motor Accidents Act 1988 provides for a penalty of up to $5,000 for knowingly providing false or misleading particulars in this form. This statutory declaration must be made by the injured person unless he/she is under the age of eighteen years or is otherwise unable to make the declaration. In such case the declaration must be made by the injured person's parent, guardian, relative or friend, as is appropriate.

I solemnly and sincerely declare that to the best of my knowledge the information given in this Motor Accident Personal Injury Claim Form is true and correct in every respect.

I authorise the insurer of a person, or the Nominal Defendant, against whom a claim is made pursuant to the Motor Accidents Act 1988 to contact and obtain any information or documents from:

(a) any treating doctor or other service provider
(b) any ambulance service
(c) any hospital
(d) any employer or accountant of the injured person
(e) the Police Department of any State or Territory
(f) any Workers' Compensation Insurer
(g) the Department of Social Security

in respect to the claim herein.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Oaths Act, 1900 (as amended).

Declared before me at this day of 19

Justice of the Peace

If the statutory declaration is not made by the injured person, specify:-

Name of Injured Person

Name of Person making the Statutory Declaration

Telephone Number of Person Making the Statutory Declaration

Relationship to Injured Person

Reason why Injured Person is unable to make the Statutory Declaration
6.6.2 THIRD PARTY INSURANCE - MOTOR VEHICLES

INTRODUCTORY:

The Motor Vehicles (Third Party Insurance) Act 1942 as amended, (which only relates to vehicles registered in NSW, or non-registered vehicles whether from NSW or not) requires that there must be, in relation to every motor vehicle used upon a public street, a policy of insurance in a prescribed form which is issued by an authorised insurer and which insures the owner and any person driving the vehicle (with or without the authority of the owner) against liability which may be incurred in respect of death or bodily injury caused by, or arising out of the negligent use of the vehicle.

The Act contains provisions conferring on hospitals the right to recover the estimated average cost to the hospital, for treatment of any person, including a passenger, who suffers injury caused by or arising out of the use of a motor vehicle. Every hospital should obtain from the Government Printer a copy of the Act and the Regulations thereunder.

Attention is particularly drawn to certain points of special importance to hospitals.

Sections 24, 25 and 26 are the ones which confer upon hospitals the right to recover the estimated average cost of treatment, at such hospital, of persons injured in motor accidents. It is important to note that Section 25 gives hospitals the right to recover from an authorised insurer or, in the case of an uninsured or unidentified motor vehicle, from the nominal defendant (up to 1/7/83), the estimated average cost to the hospital, for treatment of such patients without the necessity of proof of liability on the part of the owner of the motor vehicle for damages to a third party where a payment is made by the authorised insurer, under or in consequence of, the third party policy in existence in relation to the particular vehicle, or, in the case of an uninsured or unidentified vehicle, by the nominal defendant (up to 1/7/83).

Section 26 covers the case where no such payment has been made but the right of the hospital to recover against the authorised insurer depends on the existence of negligence on the part of the person owing or driving the motor vehicle.

Section 15 preserves, inter alia, the right of the hospital to recover the estimated average cost to the hospital, for treatment of a motor accident case where the insured person dies before a claim is settled or cannot be served with process.

Particular attention is invited to Sections 15(2)(b), 25(2) and 26(2) which require that notice of intention to make a claim under any of the Sections referred to shall be given:

a) to the authorised insurer as soon as practicable after the hospital becomes aware of the identity of the authorised insurer of the motor vehicle causing the injury; but not in any case later than thirty days after it could with reasonable diligence have ascertained his identity; and excluding by agreement outpatient admissions.

It is to be noted that the motor vehicles covered by the Act include those owned by any State, including the State of New South Wales, but excluding any motor vehicle used on a railway or tramway, and any motor omnibus or trolley bus owned by the Commissioner for Road Transport (Regulation 16).
The Act (as amended to take effect on 1/7/83) now does not cover motor vehicles owned by the Commonwealth or any person or body of persons representing the Commonwealth (Section 5(1)). Persons injured by such vehicles and treated in public hospitals should be classified as either “hospital” or “private patients”.

Section 37 sets out the procedure for the service of notice. If the notice is not delivered personally, it is suggested that notice should always be given by registered post.

Other sections which call for special examination are 10(4) (Motor Vehicles to which a Trader’s Plate is Affixed) and 27.

ASCERTAINING IDENTITY OF THE INSURER:

It is the duty of hospitals to take all possible steps to obtain adequate information regarding the identity of vehicles and of the insurers. It is pointed out that the nominal defendant is under no obligation to pay a claim unless the hospital, after making due inquiry, cannot identify the vehicle or ascertains that it is not insured. Furthermore, neither the nominal defendant nor, in the case of an insured vehicle, the GIO, is under any liability to make a payment if the owner or driver of the vehicle was not negligent.

Where only one motor vehicle was concerned in the accident and such vehicle was owned, and being driven by the patient, the patient would not be a third party, and the hospital would not be entitled to any payment from the insurer or the nominal defendant (up to 1/7/83).

In any other case the procedure set out below should be observed:

The hospital should, as early as practicable after the admission of the patient, as the case may be, submit a “Notice of Claim” form to the Government Insurance Office, as set out in item 1 page 5. The patient, the person who brought him/her to the hospital, and any other person, who may know anything about the accident, should be asked for any information which he/she can give concerning the registered number of the vehicles and the names and addresses of the owners. If information cannot be obtained from these sources, the officer-in-charge of the Police Station nearest to the scene of the accident should be asked whether the accident has been reported to him/her and, if so, whether he/she can furnish the registered number of the vehicle and the name and address of the owner.

Whilst making inquiries regarding the registered numbers of the vehicles and names and addresses of the owners, the hospital should also seek information as to whether the accident appears to have been due to the negligence of the particular owner or driver.

NOTICE OF INTENTION TO MAKE A CLAIM:

As soon as practicable after the completion of inquiries concerning the identity of the vehicles and notwithstanding that it may not then be known whether or not the motorist was negligent, a notice of intention to make a claim should be given as explained below.

Insured Vehicle: Where, in the case of a NSW vehicle, it has been ascertained, or is assumed, that the motor vehicle was insured at the time of the accident, a notice in the following form should be given:

(Name of Hospital)

(Date)

To the Government Insurance Office.
A claim under Section 25 or 26 of the *Motor Vehicles (Third Party Insurance) Act 1942*, as amended, will be made by the abovenamed hospital in respect of hospital treatment rendered to Mr/Ms........... as a consequence of injuries received by him/her in an accident on the ....... in the which motor vehicle No.   , registered in the name of Mr/Ms...... was concerned.

(Signature)......................
INPATIENTS

CONTENTS

About this Manual

Background to Day Arrangements

Type B Procedures

Same Day Band Descriptors

Type C Procedures

Health Benefit Fund (HBF) Private Hospital (PH) Circulars

Private Patient Hospital Claim Form

Form 1830 Day Only Procedures

33(5/00)
ABOUT THIS MANUAL

This manual summarises details of the day only arrangements and is intended for use as a reference source for personnel who are involved in administering the day only procedure arrangements. Please note that item descriptors are detailed in Department of Health and Aged Care HBF/PH circulars as distributed by the Department from time to time. The current Medicare Benefits Schedule Book should be consulted for further detail on the item descriptions.

The first Day Only Procedures Manual was printed in November 1992. The second edition was printed in November 1993. The manual was not reprinted in November 1994 or November 1995. The third edition was printed in August 1996. This, the fourth edition of the manual, is in a new format. It is hoped that this short manual will serve as a useful reference, supplemented by up-to-date HBF/PH circulars.

Information contained in this manual is correct at the time of going to print. All components are subject to change at any time. Circulars will be issued to notify changes.

BACKGROUND TO DAY ARRANGEMENTS

On 29 December 1989, the Commonwealth introduced new arrangements concerning day only procedures.
Health Insurance Basic Table differential facility benefits were introduced for procedures carried out on a day only basis for admitted patients in a public or private hospital or a licensed free standing day hospital facility. The procedures where the patient was privately insured qualified for at least a day only facility basic table benefit. These basic insurance benefits have been replaced by further Commonwealth arrangements. The declared minimum benefits are known as Default Table Benefits. (The authority to declare these benefits is found in paragraph (bj) of Schedule I of the National Health Act 1953.)

The Default Table Benefits identify three types of categories of professional attention. Basically these types are:

- Type A: professional attention normally requiring admitted overnight hospital stays;
- Type B: professional attention normally requiring admitted hospital treatment, but does not include part of an overnight stay;
- Type C: professional attention that does not normally require admitted hospital treatment.

Professional attention is defined in the Health Insurance Act 1973 as meaning:

(a) medical or surgical treatment by or under the supervision of a medical practitioner;
(b) obstetric treatment by or under the supervision of a medical practitioner or a registered nurse with obstetric qualifications; or
(c) dental treatment by or under the supervision of a dental practitioner.

The day arrangements focus on Type B and Type C procedures.

There is no legislative requirement that a patient must occupy a bed in order to qualify for day facility benefits.

**TYPE B PROCEDURES**

As stated previously, Type B procedures are recognised as requiring admitted hospital treatment but patients would not “normally” be admitted to hospital for an overnight stay.

It is recognised that there will be instances where it is necessary to admit a patient overnight who is undergoing a Type B procedure. However, if a patient undergoing a Type B procedure is admitted to hospital overnight it will be necessary for the treating doctor to complete “overnight certification” outlining why the patient required an overnight admission.
If certification is not completed, health insurance benefits will be paid at the day benefit rate only. It should be noted that patients who are operated on late in the day, necessitating “overnight” recovery will not automatically be entitled to receive an overnight benefit. This is because benefits are based on the procedure performed and whether there were complications or other matters rather than the time of admission and discharge.

Overnight stays may be certified by using Form 1830 Day Only Procedures (page 11), where stocks are still available. Please note that Form 1830 is no longer being printed, instead hospitals and day hospital facilities should Use the Private Patient Hospital Claim Form (page 9) as it incorporates all information required by Form 1830.

Note: If a Type B procedure is performed in conjunction with a Type A procedure (recognised as requiring overnight hospitalisation) then overnight certification will not be necessary.

Four bands classify procedures undertaken on a Type B day only basis for benefit purposes:
- Band 1(a) is a definitive list of procedures with no flexibility for re-classification to another band;
- Band 1(b) is for professional attention that embraces all other day only admissions to hospital not related to Bands 2, 3 or 4 (this category applies primarily to psychiatric and rehabilitation day patients).

See page 4 for full descriptions for Bands 1, 2, 3 and 4.

<table>
<thead>
<tr>
<th>Same Day Band Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Band 1 which includes gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic.</td>
</tr>
<tr>
<td>(a) is a definitive list of procedures with no flexibility for re-classifications to another band</td>
</tr>
<tr>
<td>(b) professional attention that embraces all other day only admission to hospital not related to Bands 2, 3, or 4.</td>
</tr>
<tr>
<td>(ii) Band 2 means procedures (other than Band 1) carried out under local anaesthetic, no sedation.</td>
</tr>
<tr>
<td>(iii) Band 3 means procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time less than one hour.</td>
</tr>
<tr>
<td>(iv) Band 4 means procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time one hour or more.</td>
</tr>
</tbody>
</table>

Note: Time in theatre means the time entering theatre to time leaving theatre.
NON-BAND SPECIFIC TYPE B LIST

A number of items have been determined to be suitable to be undertaken on a day only basis. Items on this list can be banded according to anaesthetic and theatre time within Bands 2, 3 or 4. In the absence of anaesthetic and theatre, a Band 1 classification applies.

The “overnight certification” arrangements described on page 3 also apply to the list.

A copy of the non-band specific items can be downloaded from:


TYPE C PROCEDURES

Without a requirement for a patient to “occupy a bed” it is recognised that this could open up the potential for facilities to claim same day benefits for procedures traditionally undertaken on an outpatient, accident/emergency or non admitted patient basis e.g. consultations, minor surgery, diagnostic/investigatory procedures. In an effort to clarify what usually constitutes such services the Commonwealth developed an “exclusion list” of procedures.

Known as the Type C exclusion list, it is a list of services for which fund facility benefits will not normally be paid. However, there will be occasions when admission on a day only basis is warranted. These occasions require the completion of the “Same Day Certification” section on the Private Patients Claim Form. (Form 1830 hereunder may also be used where stocks are still available.)

On completion of the box marked “Day Only Procedure - Certification” this will enable the payment of a Band 1 accommodation benefit. A band 1 benefit ONLY is payable, regardless of anaesthetic type or theatre time. A second certification, “Overnight Stay Admission Certification” is required when a designated Band 1 patient is admitted for an overnight stay in hospital. It should be noted that as the Band 1 list is comprised essentially of minor procedures then overnight admission should not be a common occurrence.

Note: If a Type C procedure is performed in conjunction with a Type A or Type B procedure then certification for hospital admission will not be necessary.

HEALTH BENEFIT FUND (HBF) PRIVATE HOSPITAL (PH) CIRCULARS

The Private Health Industry Branch of the Department of Health and Aged Care regularly sends out circulars to advise on changes to day arrangements and other default table amendments.

These circulars are issued directly to health insurance funds, private hospitals, day hospital facilities and a variety of other professional organisations and individuals.
These circulars can be downloaded from our internet site:


Circulars are also sent to State/Territory health authorities for distribution to the public sector. If you cannot locate a particular circular within your hospital please contact your local regional office or the State contact officers listed below:

<table>
<thead>
<tr>
<th>New South Wales</th>
<th>Queensland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Katz</td>
<td>Fernando Da Silva</td>
</tr>
<tr>
<td>Manager</td>
<td>Health Funding and System</td>
</tr>
<tr>
<td>Policy Development Division</td>
<td>Development Unit</td>
</tr>
<tr>
<td>NSW Department of Health</td>
<td>Health Systems Strategy Branch</td>
</tr>
<tr>
<td>Locked Bag 96l</td>
<td>Queensland Health Department</td>
</tr>
<tr>
<td>NORTH SYDNEY NSW 2059</td>
<td>7th Floor, State Health Building</td>
</tr>
<tr>
<td>Ph 02 9391 9469</td>
<td>147-163 Charlotte Street</td>
</tr>
<tr>
<td>Fax 02 9391 9615</td>
<td>BRISBANE QLD 4000</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Tasmania</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Geeves</td>
<td>Vivienne Fink</td>
</tr>
<tr>
<td>Manager</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Government Relations</td>
<td>Acute Health Services</td>
</tr>
<tr>
<td>Acute Care Services</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>Department of Health and Human Services</td>
<td>17th Floor</td>
</tr>
<tr>
<td>GPO Box 125B</td>
<td>555 Collins Street</td>
</tr>
<tr>
<td>HOBART TAS 7001</td>
<td>MELBOURNE VIC 3000</td>
</tr>
<tr>
<td>Ph 03 6233 6698</td>
<td>Ph (03) 9616 7661</td>
</tr>
<tr>
<td>Fax 03 6233 2909</td>
<td>Fax (03) 9616 7764</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>ACT</th>
<th>Western Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penny Gregory</td>
<td>Dr Brian Stokes</td>
</tr>
<tr>
<td>Executive Director</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>ACT Dept of Health and Community Care</td>
<td>Health Department of WA</td>
</tr>
<tr>
<td>PO Box 825</td>
<td>B Block, 3rd Floor</td>
</tr>
<tr>
<td>CANBERRA CITY ACT 2601</td>
<td>189 Royal Street</td>
</tr>
<tr>
<td>Ph (02) 6205 0877</td>
<td>EAST PERTH WA 6004</td>
</tr>
<tr>
<td>Fax (02) 6205 0842</td>
<td>Ph (08) 9222 4080</td>
</tr>
<tr>
<td></td>
<td>Fax (08) 9222 4044</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northern Territory</th>
<th>South Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Taylor</td>
<td>Marlene Hoppo</td>
</tr>
<tr>
<td>Director</td>
<td>Administration Officer</td>
</tr>
<tr>
<td>Acute Specialist Care</td>
<td>Strategic Planning and Policy Division</td>
</tr>
<tr>
<td>Territory Health</td>
<td>South Australian Dept of Human Services</td>
</tr>
<tr>
<td>PO Box 40596 Services</td>
<td>PO Box 65, Rundle Mall</td>
</tr>
<tr>
<td>CASUARINA NT 08II</td>
<td>ADELAIDE SA 5000</td>
</tr>
<tr>
<td>Ph (08) 8999 2659</td>
<td>Ph (08) 8226 6042</td>
</tr>
<tr>
<td>Fax (08) 8999 2955</td>
<td>Fax (08) 8226 6600</td>
</tr>
</tbody>
</table>
PRIVATE PATIENT HOSPITAL CLAIM FORM

The Australian Health Insurance Association (AHIA) guided the development of a single Private Patient Hospital Claim Form for use by hospitals and day hospital facilities with effect from 1 October 1995. The Form encompasses both overnight stay and day only stay details and includes provision for Hospital Casemix Protocol data. Hospitals should contact health funds to obtain copies of this form.

Please note that completion of the AHIA form for private day only patients negates the need to complete Form 1830. It may also be used by public hospitals for their private patients.

The Private Patient Claim Form is under review by the AHIA. Questions or comments on the design or content may be directed to:

Mr Peter McDonald
AHIA
4 Campion Street
DEAKIN ACT 2600
Ph (02) 6285 2977
Fax (02) 6285 2959
COMPLETION GUIDELINES FOR FORM 1830

HOSPITAL ADMISSION (ADMISSION AND DISCHARGE SAME DATE)

Example One
All Same day hospital admissions (other than Type C)
Form Requires: Section 1, 2 and 3 only to be completed.

Example Two
Type C same day admissions
(Will only ever be Band 1)
Form Requires: Section 1, 2 and 3 to be completed
- Sections 4 and 5 need a tick in the “day only procedures” box
- Section 5 the patients’ medical condition or special circumstances must be certified by the Doctor

HOSPITAL ADMISSIONS (STAYS OVERNIGHT)

Example Three
Defined Band 1 or non-band specific Type B stays overnight
Form Requires: Section 1, 2 and 3 to be completed
- Sections 4 and 5 need a tick in the “overnight stay” box
- Section 5 the patients’ medical condition or special circumstances must be certified by Doctor

Example Four
Type C overnight hospitalisation
Form Requires: Section 1, 2 and 3 to be completed
- Sections 4 and 5 need a tick in the “day only procedure” box
- Sections 4 and 5 need a tick in the “overnight stay” box
- Section 5 the patients’ medical condition or special circumstances to warrant the admission and the overnight stay must be certified by Doctor

Patients who have procedures falling into Bandings 2, 3 and 4 staying overnight do not require any certification.

Form 1830 is in duplicate the original top copy is to be forwarded to the patient's health fund and the duplicate copy is to be retained by the facility providing the treatment.
INPATIENTS

DAY ONLY ARRANGEMENTS LISTS

Please note that in the future the lists and amendments to the lists will not be reproduced in the Fees Procedures Manual.

Full copies of the current Type B and Type C lists incorporating amendments will be issued from time to time by the NSW Department of Health as they are received from the Commonwealth.

Hereunder is a copy of the form that can be used to order a copy of the 1 November 1997 version of the Same Day Procedures Manual.
## Form 1830 Day Only Procedures

### Day Only Procedures

<table>
<thead>
<tr>
<th>Section 1: Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth: 5/00</td>
</tr>
<tr>
<td>Date of admission: 3/31</td>
</tr>
<tr>
<td>Date of discharge: 5/00</td>
</tr>
</tbody>
</table>

### Section 2: Procedure Information

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure date</td>
<td>5/00</td>
</tr>
<tr>
<td>Procedure site</td>
<td>Hospital</td>
</tr>
<tr>
<td>Procedure code</td>
<td>1830</td>
</tr>
</tbody>
</table>

### Section 3: Additional Information

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Inpatient 2.146</td>
</tr>
<tr>
<td>Procedure type</td>
<td>Day Only Procedure</td>
</tr>
</tbody>
</table>

### Section 4: Supporting Documentation

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical record</td>
<td>Available</td>
</tr>
<tr>
<td>Laboratory results</td>
<td>Available</td>
</tr>
</tbody>
</table>

### Section 5: Additional Notes

- Patient has been informed of the risks and benefits associated with the procedure.
- Procedure performed without complications.

### Section 6: Signature

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Medical Provider</td>
</tr>
</tbody>
</table>

Original health fund code: 33(5/00)
ACCREDITATION OF NSW HEALTH PATHOLOGY LABORATORIES (PD2017_011)

PD2017_011 rescinds PD2107_005 which rescinded PD2006_064

PURPOSE
NSW Health Pathology is required 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.

MANDATORY REQUIREMENTS
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 the NPAAC Standards also require the laboratory to be certified to AS ISO 15189: Medical laboratories – Requirements for quality and competence and other Australian and International Standards.

The Commonwealth has chosen the National Association of Testing Authorities (NATA) to act on its behalf to undertake the accreditation and certification of laboratories.

Full information on the Commonwealth’s requirements for obtaining accreditation are in the Medical Benefits Schedule Category 6 – Pathology Services which can be obtained from http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201605

IMPLEMENTATION

- The NSW Health Pathology Chief Executive is responsible for ensuring pathology laboratories in NSW Health are accredited.
- The Sydney Children’s Hospitals Network Chief Executive is responsible for ensuring pathology laboratories at The Children’s Hospital at Westmead are accredited.