FEES PROCEDURES MANUAL FOR PUBLIC HEALTH ORGANISATIONS
FEES PROCEDURES MANUAL

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FOREWORD

This is one of a series of Public Hospital Procedure Manuals produced as a joint project by the Health Department of New South Wales and the Australian College of Health Service Administrators (NSW Branch).

While the manual reflects the current Departmental policies contained in the Consolidated Circulars that it supersedes, it must be emphasised that it is a “live” document to which amendments will be issued on a regular basis. Amendments should be recorded on the amendment sheet.

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GENERAL

NON-ADMITTED PATIENT (INCLUDING CASUALTY) SERVICES

Non-admitted patient and casualty services will be free for all public non-admitted patients attending public hospitals. This exemption from charges does not apply to privately referred non-admitted patients, “ineligible” persons and persons covered by compensation arrangements, who are not affected by the Health Care Agreement. On attendance at the casualty or outpatient clinic, hospital staff should ask the patient whether they are ineligible or a compensable patient, i.e. THIRD PARTY or WORKERS COMPENSATION. In most cases this will be evident in respect to clinic attendances where a medical record will indicate the classification.

The current priority arrangements will continue for the issue of aids and appliances under the joint Commonwealth/State program of aids for disabled persons.

If a person attends a hospital casualty/outpatient department for specialist treatment that is not available at that hospital, then the person should be referred to the nearest public hospital where such services are available. However, if it is not practicable to arrange for treatment to be provided by another public hospital, the patient may be referred to a private medical practitioner outside the hospital. In this case the patient should be advised that treatment provided will not be a hospital service and that, if the doctor does not direct bill, the patient will be liable to pay the medical fee(s) raised by the doctor. Of course, 85% of the schedule fee can be recovered from Medicare agencies. However, no payment should be made by the hospital to the doctor for these services.

For Meals-on-Wheels services, existing meal charges should continue to apply.

Hospitals are reminded that non-admitted public patients are not to be charged by doctors under any circumstances.

Payments to hospital visiting medical staff on a fee-for-service basis are to be made at 85% of the Medical Benefits Schedule fee.

See page 2.76.5 for fees applicable in respect to non-inpatients under the “Brain Injury Rehabilitation Program”.

See page 1.44 in respect to the free treatment for Medicare ineligible persons with suspected or confirmed tuberculosis.

NON-ADMITTED PATIENTS - WORKERS COMPENSATION, PUBLIC LIABILITY ETC.

1. The patients should be registered as a non-inpatient and be identified as a Workers Compensation/ Third Party/Public Liability Non-inpatient.

NOTE: Non-admitted patient services associated with the admission of a patient on the same day or within a period of 24 hours should not attract a charge.

- see inpatients Third Party section for GIO provisions.
2. Hospitals should render accounts for Workers Compensation and Public Liability patients on the appropriate insurance company, in accordance with the amounts notified in the Government Gazette from time to time, **on the basis that each occasion of service is an attendance.** Notices of Claim for Third Party patients do **not** have to be forwarded to the GIO or other Insurance Companies.

3. Accounts for clinical or diagnostic services provided by visiting medical officers **should not** be rendered on any insurance company or patient. Visiting medical officers are remunerated for these services under sessional or modified fee-for-service arrangements or contract basis.

4. Accounts for clinical or diagnostic services provided by staff specialists with rights of private practice **should not** be rendered on any insurance company or patient. Staff specialists are remunerated for these services by way of salary.

5. 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 hospital should cancel the accounts issued in accordance with (2) above.

6. i) In respect of compensable accidents or incidents for employees of 2nd, 3rd and 5th Schedule Hospitals, a worker’s compensation claim should not be made where the only compensable cost incurred is the gazetted cost of non-inpatient treatments or services provided.

   Initiating such claims merely increases costs because, apart from the considerable administrative expense in preparation, submission and finalisation of the claim, the amounts paid by the insurer in settlement of claims are ultimately reflected in future premium costs, together with an additional fixed percentage of the amount paid on claims as an administrative charge.

   ii) In all cases of accident or injury to an employee, the appropriate form of report should be completed and held by the employer. Resultant non-inpatient treatment or services provided through a staff clinic, accident or emergency or casualty department of the employing hospitals or institution should be regarded as non-chargeable.

   iii) In the event of subsequent compensable costs being incurred (e.g. time lost, private medical accounts) a claim may be made on the insurer up to 6 months after the occurrence of the incident which occasioned the injury. Discretion should be used in determining whether such claim should include an account for the gazetted cost of prior non-inpatient treatments or services, having regard to the administrative expense of retrospectively raising such account and the ultimate effect on future premium costs.

**CHARGING FOR PRIVATELY REFERRED NON-ADMITTED PATIENTS IN RECOGNISED HOSPITALS (PD2005_501)**

The Commonwealth Department of Health has recently reported instances to the Health Department where registered non-admitted patients attending recognised hospitals have been issued with accounts in the name of visiting medical officers or staff specialists exercising their rights of private practice. Hospitals are reminded that such accounts are not to be raised against admitted patients or registered non-admitted patients of a recognised hospital. (PD2005_501) This prohibition also applies to central services such as group pathology services.
The arrangements will not affect those patients who are admitted patients or registered non-admitted patients of a recognised hospital, but will apply to privately referred non-admitted patients who satisfy the following conditions:

1. The referral must be to the Medical Practitioner by name not to the hospital or the outpatient department;
2. The referral must be made by a doctor in private practice (including a visiting medical officer/staff specialist exercising a right of private practice); it must not be made by an intern, a resident medical officer, registrar or medical superintendent.
3. No patient who presents as Casualty or an outpatient clinic is to be privately referred for treatment of, or examinations relating to, the episode of illness which caused him/her to present at Casualty; or the outpatient clinics (PD2005_501).
4. Referrals are to be genuine referrals, made “at arm’s length”, i.e. the referral letter shall be completed before the patient’s first appointment is made for an examination, treatment or consultation.
5. At the time that the appointment is being made, patients are to be advised that they will not be treated as registered non-admitted patients of the hospital, and that they will be charged by the attending specialist(s) as well as for diagnostic services ordered by that specialist(s).
   - Private referred non-admitted patients will not be registered as non-admitted patients.
   - The hospital will prepare and issue accounts as the agent and the fees collected will be recorded and disbursed under the terms and conditions under which the staff specialists engage in private practice.
   - It is doctor’s responsibility to ensure that the criteria for a privately referred non-admitted patient as outlined in this section have been met (PD2005_501).

Charging arrangements for privately referred non-admitted patients are to apply for all staff specialists who have been granted rights of private practice by the hospital (previous PD2005_501 still apply).

NON-ADMITTED PATIENTS (OUTPATIENT)(PD2016_055) (Excerpt of Chapter 2, Section 3, 5.1)

PD2016_055 rescinds PD2016_31

The following applies to all Medicare Ineligible non-admitted patients who are not eligible for treatment at no charge under section 3 PATIENT CLASSIFICATION of PD2016_055.

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

98(23/6/16)
Requests for medical records or cremation certification must be charged according to the schedules.

**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 venesection
  - 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.

**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

**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.
NON-INPATIENTS 1.5

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.

Remuneration to specialists

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.

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.

97(8/12/16)

OUTPATIENT PHARMACEUTICAL ARRANGEMENTS AND SAFETY NET ARRANGEMENTS (PD2012_068)


PURPOSE

This Policy Directive outlines the procedure for the purchase and provision of pharmaceuticals in NSW public hospitals (Attachment 1), and details the requirements under the National Safety Net Scheme for provision of prescription items supplied by a public hospital outpatient pharmacy (Attachment 2).

The Australian Government announces its decision annually concerning pharmaceutical fees for general category beneficiaries and concessional beneficiaries. The updated charges for 2013 for pharmaceuticals and the expenditure thresholds for safety net concessions are provided separately in IB2014_079.

MANDATORY REQUIREMENTS

The requirements for the purchasing and supply of pharmaceuticals as outlined in this policy are to be implemented within all public hospital pharmacies. The annual rates for outpatient pharmaceutical charging and the safety net threshold, as set by the Australian Government (covered in IB2014_079), are applied in accordance with the attached procedures.

IMPLEMENTATION

Local Health District Chief Executives must ensure this policy and its attachments are brought to the attention of Hospital Pharmacy staff, Medical Administrators and Finance staff for implementation.

69(10/01/13)
ATTACHMENT 1

NSW HEALTH PROCEDURES FOR PURCHASE AND SUPPLY OF PHARMACEUTICALS

1. The Pharmaceutical Benefit Schedule (PBS) prescriptions should not be used to obtain hospital pharmaceutical supplies for use within the hospital.

2. Hospital Pharmacies are required to purchase pharmaceuticals in accordance with the supply contracts arranged by the NSW State Contracts Control Board. If a required pharmaceutical substance is not available as a contract item, it may be purchased from a non-contract supplier.

3. Pharmaceuticals are to be issued without charge as medically prescribed to inpatients and same day patients of the hospital irrespective of whether they are public or private inpatients. Take home supplies of pharmaceuticals should NOT EXCEED 7 DAYS’ SUPPLY to patients when they are discharged from hospital, unless prior authority has been obtained from the Chief Executive, the Medical Administrator, or the Medical Administrator’s nominee.

   • Where a prescription for a S100 Highly Specialised Drug is provided on discharge, an amount up to the PBS authorised maximum quantity, when ordered by the prescriber and where clinically appropriate, can be supplied. No repeats may be authorised on a discharge prescription.
   • Where a full course of medication is provided to an admitted patient on discharge, then a patient co-payment is to be charged at the same level as directed for outpatients. (Note that where (as detailed under paragraph 3) the amount of S100 HSD supplied on discharge exceeds 7 days’ supply, the appropriate Commonwealth determined co-payment should be charged.)

4. The issue of pharmaceuticals classified as Section 100 Highly Specialised Drugs, can be supplied up to the PBS authorised maximum quantities and number of repeats, pending stock availability and product stability, under the following circumstances:

   • The patient has been stabilised on the current regimen and the regimen is unlikely to change in the foreseeable future.
   • The patient is adherent to the current regimen.
   • The patient is able to afford to pay outpatient co-payments for the prescribed items and quantities.
   • The prescriber considers that the patient is clinically appropriate to receive up to the prescribed quantity at a time.

However, for medications where restricted supply requirements are mandated (eg. thalidomide, lenalidomide, clozapine), extended supply beyond the mandated program requirements should not be permitted.

Eligible patients will pay the designated co-payment for the dispensed quantity for each item on each occasion, even if 2 or more items are different strengths or forms of the same medicine. Where multiple supplies of the same drug under Regulation 24 of the National Health Act are dispensed, one co-payment per maximum PBS quantity must be applied.

While existing S100 Patient Declaration Forms (PDF) should be retained, new prescriptions endorsed with the streamlined computer authorisation codes do not require a PDF.

69(10/01/13)
5. Issue of pharmaceuticals which are NOT classified as Section 100 Highly Specialised Drugs, should normally not exceed one month’s supply per medical attendance, however, up to a maximum of four months’ supply per medical attendance may be permitted, pending stock availability and product stability, but only under the following circumstances:
   - The patient has been stabilised on the current regimen and the regimen is unlikely to change in the foreseeable future.
   - The patient is adherent to the current regimen.
   - The patient is able to afford to pay outpatient co-payments for four months’ supply.
   - The prescriber considers that the patient is clinically appropriate to receive up to four months of medication at a time.

Eligible outpatients (other than chemotherapy patients) will pay the designated co-payment for one month supply for each item dispensed, even if 2 or more items are different strengths or forms of the same medicine.

Chemotherapy patients pay only one co-payment for each original prescription dispensed for chemotherapy medicines for injection/infusion, but not for repeat prescriptions. Note that arrangements do not change for oral chemotherapy medicines or for highly specialised drugs.

6. Charges should not be raised for supply of small quantities of medication issued to hospital accident and emergency patients (ie starter pack).

7. Where pharmaceuticals are supplied to an outpatient for the purpose of an official clinical trial, no charge is to be raised for either a public or private patient. Prior approval must be obtained from the Chief Executive, the Medical Administrator or the Medical Administrator’s nominee.

8. Subject to Point 10 below, non-hospital clients/patients (ie privately referred non-inpatients) are NOT to be provided with pharmaceuticals, except where special forms of drugs are not available from a source other than a hospital pharmacy. Such supplies may only be dispensed with the approval of the Chief Executive, the Medical Administrator or the Medical Administrator’s nominee, and are to be charged at the normal hospital outpatient rate.

9. Medical practitioners who prescribe and administer medications in their rooms to non-hospital patients for any of the purposes indicated in Point 10 must submit a signed order to the pharmacy of a hospital for replacement, free of charge, of this medication. It is the responsibility of the medical practitioner to establish a relationship with a hospital pharmacy for this purpose.

10. To enhance patient compliance and control of certain infectious diseases, non-hospital patients will be supplied the following free of charge:
   a. Medications specifically for tuberculosis, bacterial sexually-transmissible diseases and leprosy; and
   b. Medications prescribed subsequent to attendance at a Sexual Assault Service.

69(10/01/13)
ATTACHMENT 2

OUTPATIENT PHARMACEUTICAL CHARGES AND SAFETY NET ARRANGEMENT PROCEDURES

1.1 Joint Australian Government/State Pharmaceutical Arrangements

The Safety Net Scheme is designed to protect those patients and their families who require a large number of prescription items supplied either by a National Health Act (NHA) approved community pharmacy or public hospital outpatient pharmacy.

The Scheme requires patients to maintain for safety net reasons, a separate record of expenditure on medications supplied through NSW public hospital outpatient pharmacies and NHA approved community pharmacies. When patient expenditure reaches a certain monetary value they qualify for any further items at either a concessional price or free.

The administrative procedures underpinning the Joint Australian Government/State safety net scheme are set out below:

1.2 Prescription Record Forms (PRF).

- Patients concurrently obtaining prescription supplies from NHA approved community pharmacies and hospital outpatient clinics will be required to operate parallel Prescription Record Forms and separately record prescription purchases received from either source.  
- A similar but not identical PRF will be used in both the hospital and community pharmacy settings.

1.3 Eligible Drugs

Drugs eligible for inclusion under joint arrangements will be:

- Where supplies are received from a NHA approved community pharmacy - PBS listed drugs only; and
- Where supplies are received from a public hospital in association with attendance at an outpatient clinic - PBS listed drugs and non-PBS drugs prescribed by a hospital physician which have been approved by a hospital therapeutics committee.

1.4 Procedures for Issue of Entitlements

When the combination of medications received from the NHA approved community pharmacy and hospital outpatient clinics and recorded on the PRF(s) reaches the designated expenditure threshold, the patient (or patient’s agent) upon presentation of the completed PRF(s) to a public hospital, Medicare office or community pharmacy will be issued either:

- a **PBS Safety Net Entitlement Card**, conveying eligibility for free benefits; or
- a **PBS Safety Net Concession Card**, conveying eligibility for concessional benefits (general patients having reached the annual safety net threshold).

Entitlement or Concession Cards so issued will convey common eligibility under the community pharmacy or NSW public hospital outpatient system.
1.5 Drug Supply

The outpatient co-payment charges will apply to the quantity of medication supplied as specified in Attachment 1.

1.6 Recording of Prescription Information

In order to meet Australian Government requirements in relation to identification of individual drugs recorded on a PRF, hospital pharmacists must ensure the entry of sufficient information on the PRF to allow proper identification of the drug supplied.

Patient prescription information which must be recorded on the PRF includes:
- date of supply
- hospital approval number
- drug identification (strength and quantity not required) and
- value

Please note that the consequence of not recording the drug identification is that the amount recorded next to this purchase will not be recognised by Medicare Australia for issue of a PBS Concession or Entitlement card, and hence such patients would be seriously disadvantaged financially.

1.7 Distribution of Safety Net Stationery

Supplies of Safety Net Entitlement and Concession Cards and other stationery such as Prescription Record Forms can be obtained by contacting Medicare by telephone on 132 290 from anywhere in Australia.
PHARMACEUTICAL CHARGES FOR HOSPITAL OUTPATIENTS AND SAFETY NET THRESHOLDS (IB2018_058)

IB2018_058 rescinds IB2017_051 IB2016_061

PURPOSE

Annually the Australian Government announces its decision concerning pharmaceutical fees for general category beneficiaries and concessional beneficiaries.

The updated charges for pharmaceuticals and the expenditure thresholds for safety net concessions are advised in this Information Bulletin and are effective on and from 1 January 2019.

This Information Bulletin should be read in conjunction with the latest Outpatient Pharmaceutical Arrangements and Safety Net Arrangements Policy Directive (PD2012_068), which can be found at: http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2012_068

KEY INFORMATION

HOSPITAL OUTPATIENT CHARGES

NON-HIGHLY SPECIALISED DRUGS

Concessional Patients (Card holders and pensioners)

Effective from 1 January 2019, the standard charge for pharmaceuticals supplied to outpatients of public hospitals will be $6.50 per item per month supply.

Patients may become eligible to a Low Income Health Care Card and a Commonwealth Seniors Health Card following changes to the asset test, effective 1 January 2018. If the patient does not yet have their new card, Centrelink has advised that patients can provide their Centrelink Customer Reference Number to ensure they receive script concession entitlements.

General Patients

Effective from 1 January 2019, the standard charge for pharmaceuticals supplied to outpatients of public hospitals will be $40.30 per item per month supply.

Eligible outpatients obtaining medication supply from NSW Public Hospitals for acute conditions (excluding Highly Specialised Drugs) with a course longer than seven days or for chronic conditions will pay the designated co-payment for each item dispensed even if two or more items are different strengths or forms of the same medicine.

HIGHLY SPECIALISED DRUGS (s100 HSD) AND s100 INJECTABLE AND INFUSIBLE CHEMOTHERAPY MEDICINES

ARRANGEMENTS FOR ELIGIBLE NSW RESIDENTS ONLY

From 1 October 2015, NSW residents who are patients of NSW public hospitals or authorised community prescribers in NSW are NOT required to pay the patient co-payments for Section 100 Highly Specialised Drugs (s100 HSD) or s100 injectable and infusible chemotherapy medicines in NSW.

This co-payment will be paid by the NSW Government on behalf of eligible patients. Co-payments paid by the NSW Government will count towards the patient safety net threshold. This arrangement applies to both general and concessional patients. Patients not eligible to have their co-payment paid by the NSW Government are required to pay the co-payment for s100 HSD and s100 injectable and infusible chemotherapy medicines at rates stated in the “CO-PAYMENTS FOR NON-ELIGIBLE PATIENTS” SECTION.

Patients must provide consent to having the NSW Government pay the co-payment on their behalf by filling out a patient consent form. From 1 April 2016, eligible patients are able to consent for a period of 12 months.
The changes apply regardless of whether prescriptions are filled through NSW public hospitals, NSW community pharmacies or pharmacies used by NSW public hospital oncology services. Co-payments paid by the NSW Government will count towards the patient safety net.

Factsheets, the consent form, eligibility and other information in relation to changes to s100 co-payments in NSW can be found on the NSW Health webpage at:


For further information, email: NSWH-s100CoPayment@health.nsw.gov.au

Non-NSW residents are required to pay the co-payment of highly specialised drugs and chemotherapy medicines at rates stated in the “CO-PAYMENTS PAYABLE BY NON-NSW RESIDENTS” section.

CO-PAYMENTS PAYABLE BY NON-ELIGIBLE RESIDENTS

Co-payment rates payable by patients that are not eligible to have their co-payment paid by the NSW Government for s100 HSD or s100 injectable and infusible chemotherapy medicines are stated below.

Concessional Patients (Card holders and pensioners)

Effective from 1 January 2019, the standard co-payment charge for S100 HSD pharmaceuticals supplied to outpatients of public hospitals will be $6.50 per item for any quantity supplied up to the PBS maximum.

General Patients

Under the Commonwealth’s revised efficient funding of chemotherapy drugs, only one co-payment is required for each original prescription and all repeats dispensed for chemotherapy medicines for injection/infusion. For oral chemotherapy medicines, one co-payment is required for each original prescription dispensed and one co-payment for each repeat dispensed. For further information please visit:

http://www.pbs.gov.au/info/browse/section-100/chemotherapy

Effective from 1 January 2019, the co-payment charge for S100 HSD pharmaceuticals supplied to outpatients of public hospitals will be $40.30 per item for any quantity supplied up to the PBS maximum.

Where increased quantities of a S100 HSD have been authorised by the Commonwealth on an Authority Required prescription, the appropriate co-payment applies to whatever quantity has been authorised (for example, where the Commonwealth has authorised a prescription for an increase of the PBS maximum quantity of 100 tablets to 200 tablets, only one co-payment applies for each 200 tablet supply).

Multiple repeats dispensed at the same time under Regulation 24 attract one co-payment per item per repeat (for example, for a S100 HSD with 5 repeats, the supply under Regulation 24 of 6 packs of the medicine would attract 6 amounts of the co-payment).

SAFETY NET THRESHOLDS

Expenditure outlays required to trigger the safety net concession as from 1 January 2019 are:

Concessional Patients (Card holders and pensioners)

- Free benefits after $390.00.
- General Patients
NON-INPATIENTS 1.12

- Concessional benefits ($6.50) after $1,550.70.

Expenditure thresholds relate to expenditure outlays within a calendar year.

Note: the NSW Government will pay co-payments on behalf of HSD patients (NSW residents) up to the concessional and general patient thresholds.

The same Safety Net thresholds apply for individuals and families. The factsheets and other information in relation to NSW Government waiving co-payments for S100 HSD can be found here: http://www.health.nsw.gov.au/pharmaceutical/Pages/s100-copayments.aspx

ATTACHMENT 1: PHARMACEUTICAL CHARGES FOR OUTPATIENTS OF PUBLIC HOSPITALS

<table>
<thead>
<tr>
<th>Classification</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pensioner Concession Card holders</td>
<td>$6.50 per item¹</td>
</tr>
<tr>
<td>Australian Government Seniors Health Card holders</td>
<td></td>
</tr>
<tr>
<td>Health Care Card holders</td>
<td></td>
</tr>
<tr>
<td>2. General (except those listed below)</td>
<td>$40.30 per item¹</td>
</tr>
<tr>
<td>3. All holders of PBS Safety Net Concession Card</td>
<td>$6.50 per item¹</td>
</tr>
<tr>
<td>4. DVA Health Card for all conditions (gold card)</td>
<td>$6.50 per item¹</td>
</tr>
<tr>
<td>DVA Health Card for specific/accepted conditions only (white card)</td>
<td></td>
</tr>
<tr>
<td>DVA Health Card for pharmaceuticals only (orange card)</td>
<td></td>
</tr>
<tr>
<td>(White card holders can still receive concessional rate if they also hold a card listed under category 1 above)</td>
<td></td>
</tr>
<tr>
<td>5. All holders of PBS Safety Net Entitlement Card</td>
<td>Free of charge</td>
</tr>
<tr>
<td>6. Medications specifically for Tuberculosis (TB), sexually transmitted diseases (STD), leprosy patients and patients attending a Sexual Assault Service</td>
<td>Free of charge</td>
</tr>
<tr>
<td>7. Methadone and buprenorphine dispensed under the NSW Opioid Treatment Program and depot preparations of haloperidol and fluphenazine</td>
<td>Free of charge</td>
</tr>
<tr>
<td>8. Prisoners</td>
<td>Free of charge</td>
</tr>
<tr>
<td>9. Medicare Ineligibles (incl. Overseas visitors), except those people covered by a reciprocal health care agreement (RHCA)</td>
<td>Actual cost of item or $40.30 whichever is greater</td>
</tr>
<tr>
<td>10. Overseas visitor covered by an RHCA</td>
<td>$40.30 per item</td>
</tr>
<tr>
<td>11. Joint Safety Net Threshold Levels</td>
<td>Free benefits after $390.00</td>
</tr>
<tr>
<td>1. Concessional Patients</td>
<td></td>
</tr>
<tr>
<td>2. General Patients</td>
<td>Concessional benefits (i.e. $6.50) after $1,550.70</td>
</tr>
</tbody>
</table>

Revenue should be receipted as General Fund - Other User Charges.

1 HSD (s100 HSD and s100 injectable and infusible chemotherapy medicines) co-payments will be paid for by NSW Government for NSW residents (see section ARRANGEMENTS FOR NSW RESIDENTS ONLY of this Information Bulletin for details and effect on safety net threshold arrangements).
FUNDING ARRANGEMENTS FOR OUTPATIENT USE OF HIGH COST DRUGS NOT FUNDED BY THE COMMONWEALTH (PD2005_395)

(See Patient Matters Manual for detailed requirements.)

Supersedes Circular 97/15.

A number of high cost drugs prescribed in NSW for outpatient usage are not funded through the Pharmaceutical Benefits Scheme, Repatriation Pharmaceutical Benefits Scheme, or Section 100 of the National Health Act and may be subject to the provisions of this Circular. The responsibility for defining the high cost drugs that are subject to these funding arrangements is delegated by NSW Health to the NSW Therapeutic Advisory Group (NSW TAG), in consultation with Directors of Pharmacy and Drug Committees of tertiary units.

The NSW TAG defines High Cost Drugs for the purposes of these arrangements as medicines which:

1. are not listed for subsidy on the Schedule of Pharmaceutical Benefits under either Section 85 or Section 100 of the National Health Act, and
2. incur acquisition costs equivalent to or more than $500 per week per drug per patient (subject to annual review by NSW TAG), and
3. require particular expertise for management of patient care.

And which:
4. are being used in accordance with the Approved Product Information, or
5. are being used in a manner that is supported by high quality clinical evidence

(see NSW Health Department Information Bulletin 2004/15: Off-Label Use of Medicines and Use of Medicines Obtained under the Commonwealth Personal Importation Scheme in NSW Public Hospitals. Where the quality of the evidence is unclear, the matter may be referred to NSW TAG for guidance.)

Therapy with high cost drugs not funded by the Commonwealth should only be initiated in tertiary units (principal or major referral hospitals) with the approval of the hospital Drug Committee. Where the patient being treated at the tertiary unit resides in another Area, the initiating Area Health Service should inform the Area Health Service (or the appropriate hospital Drug Committee with delegated authority) in which the patient resides. This enables queries or clarifications regarding the clinical indications for the drug to be discussed and resolved between the Areas prior to the transfer of costs.

The Area Health Service of the unit initiating therapy is responsible for financing the cost of the drugs for twelve months from the date of discharge from the episode during which the therapy was commenced, or for twelve months from the date of commencement if therapy was initiated on a non-inpatient basis. After twelve months the responsibility for financing passes to the Area of residence of the patient. Notification and billing should occur at an Area level between CEOs.

To avoid duplication of supplies, the Area initiating treatment should give the Area of residence details of the therapy including the patient’s initials, address, date of birth, date of commencement, quantity and cost of the drug at least three months prior to the transfer of funding responsibility. Notification of intention to bill should be made by way of a standard notification form developed by NSW TAG (available on the NSW TAG web site: http://www.nswtag.org.au).
NON-INPATIENTS

These arrangements should not be used to cover:
1. Drugs that are being used in the context of a formal research protocol;
2. Drugs that are being used in “exceptional” circumstances (as described in NSW Health Department Information Bulletin 2004/15: Off-Label Use of Medicines and Use of Medicines Obtained under the Commonwealth Personal Importation Scheme in NSW Public Hospitals);
3. Drugs that are being used under the Special Access Scheme.

In such circumstances, the patient should continue to attend the hospital where the research or exceptional use was approved, unless new approvals are obtained via the local hospital and/or service provider. Financing of such therapy remains the responsibility of the hospital that has facilitated approval for such use.

For the purpose of this circular, outreach clinics are considered part of their original tertiary unit. However, the responsibility for supply and funding of drug therapy prescribed as a result of outreach clinic consultations is the responsibility of the Area Health Service in which the outreach clinic is located, unless such drug therapy has been specifically identified under the outreach service agreement.

These arrangements do not apply to financing outpatient chemotherapy cycles.

NSW TAG may be contacted at nswtag@stvincents.com.au

ELIGIBILITY OF PERSONS FOR PUBLIC ORAL HEALTH CARE IN NSW (PD2017_027)

PD2017_027 rescinds PD2016_050

PURPOSE

This Policy Directive establishes the eligibility criteria for NSW residents who wish to access NSW Health public oral health services. This document replaces PD2016_050.

MANDATORY REQUIREMENTS

Public Oral Health Services managed by NSW Local Health Districts (LHD) must provide oral health care to persons who meet the eligibility criteria set out in this document.

At each appointment, staff of NSW Public Oral Health Services must ensure a person meets the eligibility criteria set out by this document prior to providing care.

IMPLEMENTATION

The NSW Ministry of Health is responsible for ensuring the requirements of this policy and attached procedures are monitored and acted on accordingly, and that the eligibility criteria are openly communicated to the public.

LHD Chief Executives are responsible for ensuring the public oral health services in their LHD provide oral health care to eligible persons in accordance with this document.

Oral Health Managers, Clinical Directors and staff of public oral health services are responsible for ensuring compliance with the eligibility criteria set out in this policy and attached procedures, and that the eligibility criteria are openly communicated to the public.
This Policy Directive should be read in conjunction with the following NSW Health policies:

- Priority Oral Health Program and List Management
- Oral Health Fee for Service Scheme (OHFFSS)
- Oral Health Specialist Referral Protocols
- Oral Health Referral Form for Medical Emergency Departments

1 BACKGROUND

1.1 About this document

NSW public oral health services provide a range of dental care services through funding provided or managed by the NSW Government. To ensure available resources are used efficiently, NSW Health limits access to these services to those populations at higher risk of dental disease or who are less able to afford dental care through private providers. This is achieved through the setting of eligibility criteria through this Policy Directive.

Section 2 sets out the criteria for a person to be eligible to receive dental care through NSW public oral health services. Public oral health services managed by NSW Local Health Districts (LHDs) must provide oral health care to persons who meet these criteria.

Staff of NSW public oral health services must ensure a person meets the eligibility criteria set out by this document prior to providing care (Section 2.3).

Section 3 provides additional detailed information on how staff from public oral health services should manage the delivery of patient care. It provides information on variations and exceptions to eligibility criteria, including patients admitted to hospital for other health care, ineligible patients, and patients who are accessing care outside their LHD.

The NSW Ministry of Health is responsible for ensuring the requirements of this policy are monitored and acted on accordingly, and that the eligibility criteria are openly communicated to the public (Sect 4).

LHD Chief Executives are responsible for ensuring the public oral health services in their LHD provide oral health care to eligible persons in accordance with this document.

Oral Health Managers, Clinical Directors and staff of public oral health services are responsible for ensuring compliance with the eligibility criteria set out in this policy and that the eligibility criteria are openly communicated to the public (Section 4).

1.2 Key definitions

An episodic course of care is defined as a limited course of care provided with the intent of only addressing a specific, clinically urgent patient presentation.

An oral health emergency is defined as a child or adult patient categorised as Priority 1 through the PD2017_023 Priority Oral Health Program and Waiting List Management policy directive1 triage.

Dental pain by itself is not considered an oral health emergency.

2 ELIGIBILITY

2.1 Eligibility of Adults for Non-admitted Oral Health Care Services

For an adult to be eligible for free public oral health services they must:

- Be normally resident within the boundary of the providing LHD, and
- Be eligible for Medicare, and
- Be 18 years of age or older, and
- Hold, or be listed as a dependent on, one of the following valid Australian Government2 concession cards:

2 Includes Centrelink and the Department of Veterans Affairs.
2.2 Eligibility of Children and Young Persons for Non-admitted Oral Health Care Services

For a child or young person to be eligible for free public oral health services they must:

⇒ Be normally resident within the boundary of the providing LHD, and
⇒ Be eligible for Medicare, and
⇒ Be less than 18 years of age.

Additional eligibility criteria may apply for some specialist oral health care. These are detailed in the Oral Health Specialist Referral Guidelines.3

NSW Health requires that a Child Dental Benefits Schedule (CDBS) bulk billing patient consent form is completed for children aged 2-17 years.


2.3 Confirmation of Eligibility

At each visit the patient is responsible for proving their eligibility prior to receiving treatment, by showing a valid Medicare card and, for adults, a valid concession card. Electronic versions of cards may be used through the Centrelink mobile app on a smart phone.

If a valid concession card cannot be produced, the patient must seek a temporary concession card to establish that they are eligible for treatment, except where the person requires emergency treatment (as defined in Section 1.2).

The patient may also be asked to produce secondary identification such as a drivers licence to confirm their identity. A formal letter of identification from a homelessness agency is also acceptable as a secondary identification.

Where programs exist that involve partnerships and referral pathways between Oral Health Services and Aboriginal Community Controlled Health Services or LHD Aboriginal Service, LHDs may apply discretion to waive eligibility requirements for the clients of these programs. This may also be extended to client’s partners and children.

3 PATIENT CARE

3.1 Inter-district agreements

Due to funding and reporting arrangements, dental care will normally be provided by the LHD in which a patient lives. However, LHD’s may have inter-district arrangements that allow for patients to receive care in a bordering LHD to facilitate accessibility to an appropriate service.

103(15/8/17)
3.2 Admitted or Day Only Oral Health Care Patients.

Where a patient’s oral health treatment requires them to be treated as an inpatient, they may be treated as:

- Non Chargeable Patients
- Compensable Patients
- Private Patients.

Standard LHD procedures for processing and charging patients should be followed, in accordance with Section Two of the NSW Health Fees Procedures Manual.

3.3 Patients Admitted for Other than Oral Health Treatment

Free oral health care will only be provided to adult patients admitted for care other than oral health treatment where:

- The oral health treatment is an emergency (as defined in point 1.2), or
- The oral health treatment is an essential part of the surgical or medical management of the patient, and
- They hold, or are a listed dependent of the holder of, a current concession card (see section 2).

Treatment of hospital inpatients referred for oral health care will be negotiated with the LHD Oral Health Clinical Director if the oral health treatment is not an intrinsic part of their medical treatment. Patients who do not hold, or are not listed dependents on, a current concession card may be charged for services. The treatment sought will need to be prioritised in adherence with current LHD and NSW Health prioritisation policies for access to public oral health care.

Note that private admitted patients must pay for oral health care provided.

3.4 Services Provided to Ineligible Patients at Oral Health Clinics or at an Emergency Department

Persons not meeting the eligibility criteria set out above, including interstate visitors, may receive emergency treatment only and should see their own private general dental practitioner for all other treatment. Emergency treatment (as defined in Section 1.2) may be provided to such patients who present at either a public oral health clinic or at a hospital emergency department.

Unless covered by an inter-district agreement, residents of NSW who are outside of their LHD of residence, but are otherwise eligible for free public oral health care, should only be provided with an episodic course of care (as defined in Section 1.2) and/or an Oral Health Fee For Service voucher if required. Additional dental care may be provided at the discretion of the clinical director, taking into account any additional personal circumstances of the patient.

In consultation with the patient, the LHD that provides this episodic care should make arrangements for the patient to receive any follow-up treatment required from the patient’s LHD of residence.

Emergency oral health treatment and an episodic course of care (as defined in Section 1.2) may be provided to a person who is unable to prove eligibility because they are experiencing homelessness or are seeking asylum on humanitarian grounds. The person must be referred to the oral health service by an established agency and the requirement for proof of eligibility may be waived in these circumstances. Identification and treatment of these patients should be provided in accordance with PD016_055 Medicare Ineligible and Reciprocal Health Agreement – Classification and charging.

Compensable patients are to be charged at the compensable rate for an occasion of service (see Fees
Procedures Manual6. These patients should be advised that oral health treatment does not attract Medicare rebates and may not attract private health insurance rebates.

4 COMMUNICATION STRATEGY

Eligibility criteria and information on how eligible persons can access NSW Public Oral Health Services is made available through the NSW Health website at http://www.health.nsw.gov.au/oralhealth/Pages/eligibility.aspx.

The Centre for Oral Health Strategy, NSW Health has developed brochures that identify the eligibility criteria and process for accessing public dental care. The brochures that are available include; ‘Public Dental Services’, ‘Oral Health Fee for Service Scheme’, ‘Child Dental Benefits Schedule Fact Sheet’, Child Dental Benefits frequently asked questions’.

These brochures can either be downloaded from Centre for Oral Health Strategy website (http://www.health.nsw.gov.au/oralhealth/Pages/resources.aspx) or, alternatively, be ordered free of charge from Better Health Centre – Publications Warehouse 02 9887 5450.

ORAL HEALTH FEE FOR SERVICE SCHEME (OHFFSS) (PD2016_018)

Rescinds PD2008_065.

Purpose

This Policy Directive establishes a clear, patient focused, referral pathway that ensures a care management focus between public oral health services and private practitioners who participate in the scheme.

Mandatory Requirements

Local Health Districts and participating private dental businesses and practitioners must establish business rules that address the requirements in this policy’s procedures and change from a paper based administration system to the NSW Health web-based administration system.

Implementation

The responsibilities of the key parties to ensure the mandatory requirements and standards of this policy are monitored and acted on accordingly.

Chief Executives:
Assign responsibility and personnel to implement the policy.

Oral Health Clinical Directors and Oral Health Managers:
Ensure timely and open communication to establish a patient focused outsourcing dental program with participating private practitioners.

All Local Health District Staff and contracted Private Dental Practitioners and Businesses:
Comply with the policy directive and actively participate in establishing efficient patient referral processes and effective dental care.

Comply with the policy directive and actively participate in establishing efficient patient referral processes and effective dental care.
1 BACKGROUND
The Oral Health Fee for Service Scheme (Scheme) provides a framework by which Local Health Districts (LHDs) may engage private dental practitioners (practitioners) and associated dental businesses (businesses) to provide care to public oral health service patients.

This document provides an overview of the Scheme and outlines the processes for:
- Web based administration
- Approving businesses and practitioners to participate in the Scheme
- Utilisation and payment for services under the Scheme
- Terms and conditions, and
- Governance of the Scheme.

1.1 Key definitions
In this document the term:
- **Must** – indicates a mandatory action required that must be complied with.
- **Should** – indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

The following is clarification of key terms used throughout the document:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodic dental care voucher</td>
<td>Is the voucher type for emergency or acute course of care that is associated with a limited examination (013).</td>
</tr>
<tr>
<td>General dental care voucher</td>
<td>Is the voucher type for a general course of care (excludes dentures) that is associated with a full examination (011).</td>
</tr>
<tr>
<td>Denture provision voucher</td>
<td>Is the voucher for full or partial dentures and is associated to a limited examination (013) for dentists and consultation (014) for dental prosthodontists.</td>
</tr>
<tr>
<td>Business</td>
<td>Is a facility where dental services are rendered either by a single dental practitioner or a group of dental practitioners, and/or, a business purely associated with an ABN that has been identified as a place for payment of services.</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>Is an LHD/Speciality Network clinician who is employed as an Area Clinical Director Level 1 – 3, or is a LHD delegated senior clinician.</td>
</tr>
</tbody>
</table>
1.2 Regulatory and legislative framework

The regulatory and legislative framework within which this procedure operates is set out in the *Health Practitioner Regulation National Law (NSW)* (http://www.legislation.nsw.gov.au/maintop/view/inforce/act+86a+2009+cd+0+N), and further information in relation to the registration of practitioners can be sourced from the Dental Board of Australia and the Australian Health Practitioner Regulation Agency.

1.3 Related NSW Ministry of Health policies, guidelines and information bulletins

The implementation of this procedure should be read in conjunction with the following NSW Ministry of Health policy directives, guidelines and information bulletins as updated from time to time:

- Clinical Procedure Safety
- Complaint Management Policy
- Complaint or Concern about a Clinician - Management Guidelines
- Complaint or Concern about a Clinician - Principles for Action
- Complaints Management Guidelines
- Consent to Medical Treatment – Patient Information
- Employment Checks – National Criminal Record Checks and Working with Children Checks
- NSW Health Privacy Manual for Health Information
- OHFFSS Schedule of Fees
- Oral Health - Eligibility of Persons for Public Oral Health Services in NSW
- Oral Health Record Protocols
- Oral Health: Cleaning, Disinfecting and Sterilizing
- Priority Oral Health Program and Wait List Management

NSW Ministry of Health policy directive, guidelines and information bulletins are public documents and are available on their website. (http://www.health.nsw.gov.au/policies/pages/default.aspx)

2 SCHEME OVERVIEW

The Scheme allows LHDs to engage private businesses and practitioners to provide dental care for eligible child and adult patients that have requested care from the LHD directly. LHD representatives will issue a voucher to eligible patients. Vouchers can be redeemed by patients at a business approved to participate in the Scheme. Once the patient’s treatment is completed, the business or practitioner, forwards the voucher to the LHD for payment. The principal of the business and practitioner agrees to a set price schedule and the terms and conditions as listed in the current OHFFSS Schedule of Fees. The Schedule of Fees is updated annually and is indexed against the Department of Veterans Affairs fee schedule for dental care - http://www.dva.gov.au/Pages/home.aspx.

2.1 Participating Practitioners

All dental practitioners registered with the Dental Board of Australia are encouraged to apply to be approved practitioners under the Scheme.

All dentists and oral health practitioners must only provide dental services within their scope of practice under the OHFFSS.

The LHD may indicate to the patient the practitioner type most suitable for the treatment required.
2.2 Service Types

The OHFFSS provides the opportunity for referred public dental patients to receive dental care through the following service types:

- Episodic care for children and adults
- General care for children and adults
- Dentures
- Domiciliary, and
- Specialist services such as oral surgery and periodontics.

2.3 OHFFSS Voucher

An OHFFSS voucher can only be provided through the Priority Oral Health Program triage questionnaire, which assesses the patient’s oral health need, or an authorised mechanism approved by NSW Health.

There are three types of vouchers that may be issued, these are:

1. Episodic care – The intent of this voucher is to address the most urgent treatment needs of a patient
2. General care – A voucher that covers comprehensive care identified by a full examination of a patient
3. Denture provision – A voucher that specifically includes denture care.

2.3.1 Voucher expiry timeframes

An OHFFSS voucher has an expiry date from the date of issue. The expiry timeframes for the three voucher types are:

- One (1) month for episodic care, and
- Three (3) months for general care and dentures.

2.4 Specific conditions related to the provision of dental treatment under the Scheme.

- The items claimable are restricted by the voucher type (refer to Point 2.3) and the Schedule of Fees.
- Generally dentures will be acrylic, unless specified by the LHD. If a patient wishes to have a chrome denture that is not specified or approved on the voucher, or any other additional feature, the business and/or practitioner may enter a private agreement with that patient to cover the additional expense.
- Dentures are to comply with the Therapeutic Goods Administration (TGA) Standards (http://www.tga.gov.au/).
- Surgical removal of tooth needs to be supported by a pre-surgical radiograph
- The provision of pulp extirpation and Root Canal Therapy (RCT) is limited to those vouchers where the need for this item is specifically recorded/authorised.
- The provision of orthopantomogram radiographs (OPGs) is limited to those vouchers where the need for this item is specifically recorded/authorised.
2.5 Recording of dental treatment provided under the Scheme.

The recording of dental care items for the Scheme is to be in accordance with the Australian Schedule of Dental Services and Glossary (http://www.ada.org.au/publications/schedule.aspx).

3 OHFFSS ADMINISTRATION PROCESSES

3.1 Web Based System

To participate in the Scheme a business and practitioner must agree to the OHFFSS conditions of access (Attachment A) and establish an electronic profile within the OHFFSS web based administration system (System) that is located at http://ohffss.health.nsw.gov.au/

This web based participation process is divided into two profile pathways - business and practitioner - each containing mandatory requirements (Point 5).

These two pathways support the process of the business profile allocating practitioner(s) to their services, nominating the service type and LHD(s) of their choice. The practitioner’s profile independently maintains their contact details and relevant mandatory requirements (refer to Point 5).

Upon receipt of the mandatory information (refer to Point 5) and subsequent processing by the relevant LHD(s) and/or OHFFSS State-Wide Coordinator, all businesses and practitioners will be notified of their participation status as accepted or not accepted via a system email.

3.1.1 Conditions of Access

To start a business and practitioner profile, or to login as an existing participant, the conditions of access (refer to Attachment A) must be agreed to.

3.1.2 Conditions of Use

To access the System authorised LHD staff must agree to conditions of use (refer to Attachment B).

3.1.3 System Security

All business and practitioner information uploaded to the OHFFSS online profile will be stored securely and only authorised Local Health District staff, OHFFSS and Scheme administrators will have access to this information. Business and practitioner information will only be used and disclosed for the purposes of the OHFFSS.

The LHD must only allocate authorised staff to the System. The LHD must also ensure that any staff who have left the employment of the LHD have their profile to access the System made obsolete.

3.1.4 Confidentiality

To ensure confidentiality businesses and practitioners will only be able to view and edit their profile. Businesses and practitioners maintain responsibility for the username and password of their profile, including changing the password regularly and ensuring proper use and access.

Authorised LHD staff and OHFFSS State-Wide Coordinator must comply with NSW Health Privacy Manual for Health Information.
3.1.5 Finding a Participating Practitioner

The web-based System provides easy access for NSW residents and LHD staff to find a current participating OHFFSS practitioner, dental clinic contact details, type of service/s provided, scope of practice and other services such as languages spoken and disability access.

3.1.6 Mandatory Expiry Date Alerts

The System will send businesses and practitioners a reminder email twenty one (21) days, fourteen (14) days and seven (7) days prior to the expiry date, and on the expiry date of the mandatory requirements identified in Point 5.

If the associated information has not been updated, the business and/or practitioner name will be suspended from the OHFFSS and patient referrals will be postponed until this has been rectified. After 30 days from the expiry date the business and/or practitioner profile will be made obsolete. If this occurs the business and/or practitioner will be required to contact either the LHD or OHFFSS State-Wide Coordinator to reactivate their profile.

3.2 NSW Ministry of Health Caveat

NSW Health and/or the relevant LHD/s retain discretion with regards to accepting a business or practitioner for approval to the Scheme. A business or practitioner may be denied approval for a number of reasons, including and not limited to:

- Not providing the required documentation
- Concerns about service standards, or the practitioner’s registration with the Dental Board of Australia
- Infection control standards are inadequate and/or
- No demand for the Scheme in the geographical region where the practitioner or business are located.

3.3 Complaints and Disputes

Complaint/dispute handling processes are to follow NSW Ministry of Health policies and guidelines.

Complaints can be managed:

- At the point of service
- Through a staged process, or
- Through referral to an external body/agency or NSW Health OHFFSS Governance Committee (refer to Point 3.3.2).

If a dispute cannot be satisfactorily resolved or the business and/or practitioner does not comply with the terms and conditions of this policy NSW Health and/or the relevant LHD retain discretion to remove a business or practitioner from the Scheme.

3.3.1 Complaint/Dispute Issues

Complaint/dispute issues may include but are not limited to:

- Receipt of a complaint from a patient, family member or person external to the NSW Health System
- Complaints or concerns raised by other clinicians
- Coronial Inquiries or Health Care Complaints Commission (HCCC) investigations
• Investigation of an incident
• Concerns about questionable claims or the quality of care, or
• Compliance with Code of Conduct and Scope of Practice.

3.3.2 OHFFSS Governance Committee
The OHFFSS Governance Committee is to be established and will meet on an as needs basis to provide the following functions:

• Review clinical treatment procedures or manage waiting lists/times
• Provide a forum where issues can be discussed in a confidential manner
• Mediate unresolved disputes concerning the nature/quality or application of the OHFFSS
• Provide recommendations/actions for unresolved disputes to the Chief Health Officer and Chief Executives of LHDs, and
• To allow opportunities for a complainant to contact the Chair regarding their grievance.

The membership of this Committee consists of:

• A NSW Health Manager (Chair),
• NSW Chief Dentist
• An LHD Clinical Director
• One representative of the Australian Dental Association NSW Branch and/or the Australian Dental Prosthetists Association and/or the Australian Dental and Oral Health Therapists Association, as relevant to the issues being discussed, and
• A minimum of two community representatives.

3.4 Leave Notification
Businesses and practitioners may either withdraw or have periodic leave from the Scheme at any time by using the ‘leave request’ functionality in the System.

It is preferable to give two weeks written notice to the relevant LHD. Any outstanding claims must be forwarded to the relevant LHD(s) prior to their withdrawal date.

4 NSW HEALTH AND LOCAL HEALTH DISTRICT CONTACT DETAILS

4.1 OHFFSS State-Wide Coordinator
NSW Health provides a state-wide administration service for the implementation of the Scheme, complaints/dispute handling and support to businesses, practitioners and LHDs in relation to the System.

Contact details are:

Centre for Oral Health Strategy NSW
1 Mons Road, Westmead NSW 2145
Phone: 1800 938 133 (toll free)
Email: WSLHD-ohffss@health.nsw.gov.au
Fax: (02) 8821 4302.
4.2 Local Health Districts OHFFSS Coordinators

Each LHD employs an OHFFSS Coordinator whose role is to implement the Scheme and to respond to businesses or practitioners inquiries regarding clarification of patient dental history, patient’s treatment, approval status or non-payment.

Contact details for LHD OHFFSS Coordinators can be located in the OHFFSS System or oral health call centre numbers at www.health.nsw.gov.au/oralhealth.

5 BUSINESSES AND PRACTITIONERS

5.1 Mandatory Participation Requirements

5.1.1 Businesses

- Company/Trading name
- Australian Business Number (ABN)
- Relevant bank details
- Certification of Public liability insurance to the value of $20 million*
- Relevant Workers Compensation Insurance policy*
- Radiation Management Licence* (excluding Dental Prosthetists), and
- Completed Health Share vendor form*. (http://www.healthshare.nsw.gov.au or ring the Master File Maintenance Team on 1300 477 679 option)

5.1.2 Practitioners

- Australian Health Practitioner Regulation Agency (AHPRA) registration number and conditions of registration
- Certification of Professional indemnity insurance of $20 million*, and
- Working with Children Check number. (www.kidsguardian.nsw.gov.au)

Key: * indicates documents requiring uploading into the System.

5.2 Terms and conditions

5.2.1 Proof of Documentation

All mandatory documentation (*) must be certified by an appropriately authorised person before being uploaded on the OHFFSS System.

5.2.2 Environmental Protection Agency

For those practitioners who offer OPGs under the Scheme, evidence of a current Environmental Protection Agency (EPA) licence (http://epa.nsw.gov.au) will be required and uploaded into the OHFFSS System.
5.2.3 Maintaining Participation

To maintain approval to participate in the Scheme:

- Businesses must update their profiles on changes to: their contact and banking details; practitioner(s), service delivery type(s) and LHD(s); and the annual renewals of:
  - Public Liability Insurance certificate*
  - Workers Compensation Insurance policies*, and
  - Radiation Management Licence*.
- Practitioners must immediately update their profiles with any changes of their AHPRA registration status including AHPRA registration number and any conditions on registration; contact details; banking details (if applicable); and also the renewal of:
  - Professional indemnity insurance annually*, and
  - Working with Children Check (WWCC) every five (5) years.

5.2.4 Patient Care

All practitioners are required to:

- Review and be satisfied with the patient’s medical history
- Review the treatment proposed (if provided) and if necessary to adjust the treatment plan according to the current condition, first consult with the LHD for approval
- Document the informed consent from the patient before carrying out any treatment that is covered by the voucher
- Complete all the required details of treatment provided on the voucher form (i.e. tooth number, surfaces, denture teeth replaced, and date of service)
- Ensure that the patient signs the voucher at completion of treatment verifying that they have received the treatment claimed, and
- Provide post-treatment instructions and any reasonable after care management.
- All practitioners understand they:
  - must fully discuss any treatment that is not covered by the voucher with the patient for which they will be charged (as part of a private agreement);
  - they may be asked to provide radiological evidence for all surgical extractions, and any pre-approved endodontic treatment;
  - they must provide at least three or more denture adjustments, as necessary, following the issue of a denture(s).

5.3 Businesses and Practitioners Joint Roles and Responsibilities

- All businesses and practitioners are required to:
  - Cooperate with the LHDs in resolving complaints from patients and disputes about claims
  - Check that vouchers have not exceeded the expiry date and, if expired, contact the relevant LHDs prior to commencement of the treatment
  - Check the patient’s identity, current Medicare Card, and Centrelink concession status if the patient is an adult before treatment is started
5.3.1 Processing of Vouchers

- To ensure payment the following must occur:
  - The patient must provide an original OHFFSS voucher that has been approved by a LHD (refer to Point 6)
  - The dental care outlined on the voucher must have been completed by the expiry date on the voucher, unless otherwise agreed with the LHD
  - All details of the voucher must be completed
  - The voucher must be forwarded to the LHD within 30 days after completion of treatment, and
  - The treatment must have been authorised by a LHD staff member.

- If payment is greater than the maximum entitlement, as identified in the Schedule of Fees, it must be approved by the LHD Manager or Clinical Director before the treatment is carried out.

- If goods and services tax (GST) is to be claimed a tax invoice is to be submitted for processing as per LHD policy and procedures.

- Non-payment of a voucher may result if:
  - Dentures provided are non-compliant with TGA standards
  - There has been a surgical removal of a tooth that is not supported by a pre-surgical radiograph
  - A pulp extirpation has been provided where the voucher has specifically stated ‘No Root Canal Therapy (RCT)’
  - The voucher is received after 30 days from the date treatment is completed
  - Treatment items have been provided after the voucher expiry date (unless prior authorisation has been obtained from the LHD)
  - Services have been provided by a business or practitioner not currently approved to participate in the OHFFSS
  - Treatment has been provided that is over and above that recommended
  - The treatment provided is not of a required standard, or
  - If treatment items used are not identified in the Schedule of Fees

6 LOCAL HEALTH DISTRICTS

6.1 Administration Requirements

Once a business or practitioner is approved in one LHD, other LHDs can engage that business or practitioner. Businesses and practitioners should therefore be advised that authorised officers from all LHDs and System administrators can access their profiles.

LHDs are required to:

- Use the OHFFSS System to process and communicate with private businesses and practitioners to approve participation in the Scheme
- Ensure that there is a designated employee who is responsible for the implementation of the Scheme

103(7/6/16)
CONFIRM VIA EMAIL THAT THE BUSINESS OR PRACTITIONER HAS BEEN APPROVED TO PARTICIPATE IN THE SCHEME

ENSURE THAT ALL FIELDS IN THE SYSTEM HAVE BEEN COMPLETED

PROVIDE AN EXPLANATION TO THE BUSINESS OR PRACTITIONER IF THEY ARE NOT APPROVED

REQUEST AN ENVIRONMENTAL PROTECTION AGENCY (EPA) LICENCE FOR THOSE PRACTITIONERS WHO HAVE OFFERED TO PROVIDE OPGs

PROVIDE ACCURATE AND COMPLETE INFORMATION TO PATIENTS ABOUT THE SCHEME AND THE PATIENT’S RIGHT TO CHOOSE AN APPROVED PRACTITIONER

ISSUE VOUCHER(S) WITH OR WITHOUT UNDERTAKING A CLINICAL ASSESSMENT

EITHER POST THE VOUCHER TO THE PATIENT OR HAND TO THE PATIENT AT THE TIME OF THE APPOINTMENT

IF AN INITIAL APPOINTMENT IS NOT MADE FOR THE PATIENT BY THE LHD, THE PATIENT SHOULD BE ADVISED TO MAKE AN APPOINTMENT WITHIN TEN WORKING DAYS

MAINTAIN A PROCESS OF AUDITING AND GOVERNING THE EFFICIENT USE OF THE SCHEME, INCLUDING PERIODIC AUDITS OF RELEVANT BUSINESSES AND PRACTITIONERS’ RECORDS. THIS AUDITING SHOULD ENCOMPASS THE FOLLOWING AREAS:

- FINANCIAL ACCOUNTABILITY (ERRORS OF ACCOUNTING AND CLAIMING) AND
- CLINICAL AUDITING (ENSURING THE QUALITY OF CLINICAL CARE IS WITHIN A REASONABLE STANDARD AND THAT ACCURATE AND COMPLETE MEDICAL RECORDS ARE KEPT FOR EACH PATIENT AND EACH VISIT).

**Note that:** NSW Health agencies may not apply for or pay for WWCCs on behalf of individuals (Section 5.3 Employment Checks – National Criminal Record Checks and Working with Children Checks PD 2013_028)

### 6.2 OHFFSS Voucher

The OHFFSS voucher is a combined authority, claim form, and treatment plan.

- The LHD must use the OHFFSS voucher that is required to have:
  - An oral health IT system unique ID authority number and bar code
  - Patient details
  - Date of issue
  - Maximum amount of the voucher as per Schedule of Fees, and
  - Treatment required (if applicable).

- The public dental practitioner should include on the voucher information relevant to the patient’s clinical need:
  - Assessed treatment need and related tooth numbers,
  - Whether an OPG is authorised for the patient,
  - Number of teeth required for a denture, or
  - Indicate pre-prosthetic mouth preparation for clasps and rests if required.
6.2.1 Payment

- To ensure payment the following must occur:
  o Payment for one (1) diagnostic service per authorised voucher (episodic, general and
denture) as per the Schedule of Fees
  o Issue of the appropriate voucher type for the service type required
  o The voucher was submitted for payment by an approved business or practitioner, and
  o The business or practitioner has complied with the policy’s roles and responsibilities
    (refer to Point 5).

- The following may result in non-payment of the voucher:
  o The business and practitioner has not complied with the policy’s roles and responsibilities
    (refer to Point 5)
  o Vouchers received more than 30 days after the treatment has been completed
  o Vouchers with treatment items that were provided after the voucher expiry date (unless
    prior authorisation has been obtained from the LHD)
  o Services provided by a business or practitioner that is not currently approved to participate
    in the OHFFSS
  o Treatment over and above recommendation
  o Treatment not to a required standard, or
  o Treatment items not included in Schedule of Fees.

- Once the above procedures have been followed, the LHD are required to:
  o Return any radiograph(s) supplied by the business or practitioner unless double
    radiographic films have been used, and
  o Forward the claim to the relevant LHD Manager, or nominee, for authorisation and
    HealthShare payment processing.

6.3 Quality Assurance

LHDs are accredited institutions and therefore undertake quality assurance activities on a regular basis.
The operation of the OHFFSS and the care provided under the Scheme is included in these
accreditation processes.

The NSW Ministry of Health, the Australian Dental Association NSW Branch and the Australian
Dental Prosthetist Association NSW support the use of quality assurance measures.

The evaluation of the Scheme may include relevant Australian Council of Healthcare Standards clinical
indicators and other quality activities.
Attachment A: Conditions of Access to Web-based Oral Health Fee for Service Scheme

The conditions of access set out below need to be read in conjunction with the Oral Health Fee for Service Scheme Implementation Procedures. Non-compliance with the conditions of access set out here and in that Policy Directive could lead to suspension or removal from the OHFFSS.

1. Access to the facility is via a user name and password. The user is responsible at all times for the proper use of an allocated password and for all access under the password, which should be changed regularly to prevent misuse.

2. To protect both business and practitioner personal information that is uploaded onto the OHFFSS web based system, users will only be able to view and edit their own profile.

3. It is the policy of NSW Health (the administrator of the Oral Health Fee for Service Scheme) that:
   - Access to the web-based scheme be monitored on an ongoing, continuous basis to guard against intentional inappropriate use and
   - Records of access are maintained and routinely audited to ensure appropriate use of the web based system.

**Personal information** – In agreeing to be registered with the OHFFSS, you acknowledge that your personal information will be stored and backed up securely and that only authorised Local Health District or OHFFSS administrators will have access to the information. Your personal information will only be used and disclosed for the purposes of the Oral Health Fee for Service Scheme or as lawfully required.

If at any time you have concerns about how your personal information is being used, accessed or disclosed, please contact the Local Health District’s Privacy Liaison Officer or State-Wide OHFFSS Coordinator on 1800 938 133 or WSLHD-ohffss@health.nsw.gov.au.

**Acceptance**

In accepting entry I confirm that I have read, understood and will comply with the NSW Health Policy Directive on the Oral Health Fee for Service Scheme and Schedule of Fees, and agree to the conditions and requirements set out in that Policy Directive and Schedule of Fees. I agree that my use of the web-based administration tools will be in accordance with the conditions and requirements set out in the conditions of use and the Policy Directive. I understand and accept that my access and usage is liable to be monitored on an ongoing and continuous basis. I understand and accept that my registration on the OHFFSS may be suspended or removed if I breach the Policy Directive or the conditions of access.

If I provide dentures I will comply with the Therapeutic Goods Administration Standards (http://www.tga.gov.au/). I understand and accept that my participation in the Oral Health Fee for Service Scheme will be monitored on an ongoing and continuous basis.

To read the Oral Health Fee for Service Scheme Policy and Schedule of Fees, click on Read for the Policy and click on Read for the Schedule of Fees.

Click Accept to comply and to access the Oral Health Fee for Service Scheme and Schedule of Fees.

If you click on Reject it means that you do not wish to comply and you will not be able to proceed any further.
Attachment B: Conditions of Use to Web-based Oral Health Fee for Service Scheme

These conditions of use apply to staff of the relevant Local Health District and the NSW Ministry of Health who as part of their role, have access to the Web-based Oral Health Fee for Service Scheme system.

All staff are required to comply with the Health Records and Information Privacy Act (HRIP) 2002 to protect the privacy of health information in NSW. All staff are also required to comply with the Privacy and Personal Information Protection (PPIP) Act 1998 which covers other personal information such as employee records.

NSW Health is committed to safeguarding the privacy of patient, employee and personal information and has implemented measure, to comply with these legal obligations.

Guidance for staff in relation to their legal obligations is provided in the NSW Health Privacy Manual for Health Information. All staff are also bound by a strict code of conduct to maintain confidentiality of all personal and health information which they access in the course of their duties.

In addition to the legislative and policy related obligations, staff must comply with the following conditions of access:

1. Staff may only access patient/employee, personal or health information where this is required in the course of their employment.

2. Access to the OHFFSS web-based system is by staff employee number and password. The user is responsible at all times for the proper use of an allocated password and for all access under the password, which should be changed regularly to prevent misuse.

3. Personal and health information contained in the OHFFSS web based system must not be used or disclosed for improper purposes.

4. To protect both business and practitioner personal information that is uploaded onto the OHFFSS web based system LHD staff, unless approved to have super users rights, will only view and edit records of businesses and practitioners who are participating in the OHFFSS within their LHD.

5. It is the policy of NSW Health, the administrator of the Oral Health Fee for Service Scheme, that:
   - Access to the web-based scheme be monitored on an ongoing, continuous basis to guard against intentional inappropriate use and
   - Records of access are maintained and routinely audited to ensure appropriate use of the web based system.

If at any time you have concerns about how system information is being used, accessed or disclosed, please contact the State-Wide OHFFSS Coordinator on 1800 938 133 or WSLHD-ohffss@health.nsw.gov.au.

Acceptance

In accepting entry I confirm that I have read, understood and will comply with the NSW Health Privacy Manual for Health Information, the Code of Conduct (PD2015_049), the OHFFSS Policy Directive and these Conditions of Use. I understand and accept that my access and usage will be monitored on an ongoing and continuous basis. To read the NSW Health Privacy Manual for Health Information (http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf), click on Read and click on Read for the Code of Conduct PD2015_049. (http://www0.health.nsw.gov.au/policies/pdf/PD2015_049.pdf)

Click Accept to comply with NSW Health Privacy Manual for Health Information and Code of Conduct PD2015_049. If you click on Reject it means that you do not wish to comply and you will not be able to proceed any further.
IMPROVING ACCESS TO PRIMARY CARE IN RURAL AND REMOTE AREAS (S19(2) EXEMPTIONS) INITIATIVE (GL2017_005)

GL2017_005 rescinds PD2012_034

PURPOSE

In April 2011, New South Wales entered into a Memorandum of Understanding (MoU) with the Commonwealth in relation to the Improving Access to Primary Care Services in Rural Areas (s19(2) Exemptions) Initiative (the Initiative).

A new MoU was entered into in May 2016. Under the Initiative, rural and remote hospitals and health services in small communities (within categories 5-7 of the Modified Monash Model [MMM] Classification System), are eligible for an exemption from section 19(2) of the Commonwealth Health Insurance Act 1973 (the Act).

Exemptions allow eligible services provided by primary health care providers under state and territory funded remuneration arrangements to be claimed against the Medicare Benefits Scheme (MBS).

For a site granted an exemption from section 19(2) of the Act, the Initiative allows Medicare benefits to be claimed for eligible non-admitted, non-referred professional services that have traditionally been provided by state governments in small rural health facilities.

KEY PRINCIPLES

The Principles of the MoU are that:

• All Australians should have equitable access to appropriate and quality health care throughout their lifetime, regardless of their place of residence within Australia.
• Australians in rural and remote communities face particular challenges when it comes to accessing appropriate health care, and it is the responsibility of all Australian governments to seek to address these challenges.
• The health and medical workforce is a finite and valuable resource and its members’ involvement and support is crucial to the continued success of the initiative.
• Funding accessed through the initiative should not be used for any purpose that undermines the viability or profitability of existing, privately operated health services, including existing general practices.
• Implementation of the initiative should take place as transparently as possible, while ensuring that agreed data collection and reporting requirements remain straightforward and uses existing processes where possible.

USE OF THE GUIDELINE

The purpose of this Guideline is to articulate the obligations of rural Local Health Districts and any eligible health professionals and/or Visiting Medical Officers participating in this initiative. This will ensure that Local Health Districts, eligible health professionals and Visiting Medical Officers are aware of and are able to comply with the requirements for Medicare billing, the assignment of Medicare Benefits Scheme (MBS) funds and the subsequent investment in primary health care services under this Guideline.
1 BACKGROUND

The Council of Australian Governments (COAG) Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative (the Initiative) is targeted at rural and remote hospitals and health services in small communities (within categories 5-7 of the Modified Monash Model [MMM] Classification System). Under the Initiative, these facilities are eligible for an exemption from section 19(2) of the Commonwealth Health Insurance Act 1973. The MMM is updated annually. If an exempted site becomes ineligible due to changes in the MMM, the Commonwealth will provide 18 months’ notice that the site will be phased out of the initiative.

This guideline applies to those locations that have applied for and been granted an exemption, under this initiative, from section 19(2) of the Health Insurance Act 1973 by the Commonwealth Minister for Health. It does not apply to any other circumstance. In those locations granted an exemption, it applies only to eligible services provided by Visiting Medical Officers and/or eligible health professionals with a Medicare provider number issued for the purposes of the Initiative.

Application templates are available at Attachment 4 for eligible sites that would like to apply for an exemption under the initiative. For the avoidance of doubt, this guideline is a “rule” for participating Local Health Districts for the purposes of clauses 2.5.3 of the standard RDA Fee-for-Service Contracts – Rural Doctor Package Hospitals for individual VMOs and 3.6.3 for Practice Company Contracts - Rural Doctor Package Hospitals.

Participating rural Local Health Districts are required to issue a Visiting Medical Officer -Letter of Agreement (Attachment 1) to participating Visiting Medical Officers and the Eligible Health Professional – Letter of Agreement (Attachment 2) to eligible health professionals prior to commencement of Medicare billing. A copy must be retained with the Visiting Medical Officer’s contract or with the eligible health professional’s employment records.

Local Health Districts are required to supply to participating eligible health professionals and Visiting Medical Officers an End of Financial Year - Medicare Information Letter (Attachment 3) at the end of each financial year. A copy must be retained for reporting and audit purposes.

2 DEFINITIONS

<table>
<thead>
<tr>
<th>Agreement of local primary health care practitioners</th>
<th>Agreement should be defined or measured as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• agreement obtained by the states and then demonstrated to the Commonwealth</td>
<td></td>
</tr>
<tr>
<td>• the Commonwealth will require evidence of support or otherwise from local privately practicing or community-based primary health care practitioners in the area or nearby (if there are any such providers) and other stakeholder groups (such as the local Primary Health Network, Aboriginal Medical Services, and Royal Flying Doctor’s Service) as appropriate</td>
<td></td>
</tr>
<tr>
<td>• primary health care practitioners may choose to be represented by a representative in negotiations.</td>
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</table>

Where agreement cannot be reached by all health practitioners, the process outlined in Clause 8.3 of the MoU will apply that Parties agree to jointly:

• Review, with input from the relevant Primary Health Network, whether there is sufficient support to grant an exemption where agreement cannot be established by all stakeholders, or where support is later withdrawn, noting that the Commonwealth reserves the right to make a final decision on granting an exemption;

• Monitor and evaluate the initiative’s ongoing effectiveness and discuss proposals for changes to its operation.

<table>
<thead>
<tr>
<th>Eligible health</th>
<th>Means an employee of a participating Local Health District who is a:</th>
</tr>
</thead>
</table>
## NON-INPATIENTS

| Professional | Nurse practitioner, or  
| | Medical officer or staff specialist, or  
| | Midwife, or  
| | Allied health professional, or  
| | Dental professional and who is eligible for a Medicare provider number.  |

### Eligible Services
Professional non-admitted, non-referred services (including eligible nursing and midwifery services) and eligible allied health and dental services. For diagnostic imaging services, the same provisions that currently apply to GPs would also apply under the Initiative.

### Eligible Site
An eligible site is a health facility from which services are traditionally provided by the state health authority - including hospitals and their outreach services, Multipurpose Services (MPS), and community clinics - and that is situated in a locality that is subject to a s19(2) exemption.

### Medicare Benefits Provider Eligibility
A medical practitioner or health professional (including eligible nurse practitioners, eligible midwives, allied health and dental practitioners) wishing to access Medicare benefits will need to meet the requirements of the Health Insurance Act 1973. Information about such eligibility is available on the Department of Human Services website at: [www.humanservices.gov.au](http://www.humanservices.gov.au). Medical practitioners or health professionals will not be able to access Medicare benefits if they do not meet the appropriate requirements. In some cases this will mean seeking exemptions from the usual requirement because of special circumstances, such as working in a district of medical workforce shortage.

### Modified Monash Model (MMM)
The Modified Monash Model (MMM) is a new classification system that better categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and town size. The system was developed to recognise the challenges in attracting health workers to more remote and smaller communities. The MMM has seven categories (1 through to 7). For the purposes of the Initiative, eligible locations must be within categories 5, 6 or 7.

### MoU
Memorandum of Understanding (MoU) signed between the Commonwealth of Australia and NSW in relation to the cooperative implementation of the Council of Australian Governments “Improving Access to Primary Care in Rural and Remote Areas Initiative (Section 19(2) Exemptions Initiative 2016-2020.

### Non-Admitted Patients
A non-admitted patient is a patient who does not undergo a hospital’s formal admission process. There are three categories of non-admitted patient:
- Emergency department patient
- Outpatient
- A patient treated by hospital employees off the hospital site – includes community/outreach services.

### Operational Plan
An Operational Plan outlines how particular sites intend to implement and operate the Initiative. An Operational Plan will be provided by the Local Health District in applying for a site’s exemption under the Initiative. It is the Local Health District’s responsibility to ensure that revised plans are provided if significant changes in implementation or operations occur, and that any other changes are noted in annual reporting.
3 RESPONSIBILITY

Local Health District Chief Executives are responsible for:

- Implementing local policies to assist with the implementation of this initiative
- Implementing processes to ensure the Visiting Medical Officer - Letter of Agreement, Eligible Health Professional – Letter of Agreement, and the End of Financial Year – Medicare Information Letter, are provided to participating VMOs and eligible health professionals as outlined in this guideline
- Establishing local billing, accounting and reporting procedures to assist with the implementation of this initiative where sites become eligible
- Monitor and evaluate the implementation of this initiative
- Monitor, evaluate and report on the investment of revenue as identified in the site Operational Plan.

Participating Visiting Medical Officers and eligible health professionals are responsible for:

- Compliance with Medicare Australia rules, especially with respect to the assignment of Medicare income from the patient
- Allocation of appropriate MBS item numbers
- Paying over Medicare earnings to the Local Health District.

4 PROCESS FOR IMPLEMENTATION

1. Identify the locality and determine if the site meets eligibility requirements. Consultation with Primary Health Networks can be undertaken to ensure suitability of sites are identified. This can assist with integrating the initiative with other health services being coordinated by Primary Health Networks.
2. Undertake initial development phase of operational plan in consultation with Primary Health Networks so the diverse needs of health service providers and the local community are considered. The Primary Health Networks may be able to assist with negotiations with local health service providers to gain their support for the Initiative.
3. Provide information on S19(2) to all stakeholders, including primary care providers such as general practitioners, allied health practitioners, Aboriginal Health Services and the Royal Flying Doctor Service.
4. Undertake negotiations with all stakeholders and seek written support. Sufficient time should be given to allow stakeholders to respond appropriately.
5. Finalise the operational plan that will be used for the site.
6. Identify how the MBS rebate will be spent.
7. Identify the arrangements in place to oversee distribution of funds.
8. Send application for exemption to the Commonwealth through the Auskey portal.

5 REQUIREMENTS OF PARTICIPATING SITES

A participating site is a rural health facility granted an exemption by the Commonwealth Minister for Health. Attachment 4 includes application templates which are used to seek an exemption under the NSW COAG S19(2) exemption initiative. Local Health Districts, eligible health professionals and Visiting Medical Officers (VMOs) participating in the Initiative should be aware of the following:

5.1 Impact on Current Industrial Arrangements

The Initiative relates exclusively to public patient services provided by participating hospitals. In respect of those services, existing terms and conditions of employment (in the case of eligible health professionals) and of engagement (in the case of VMOs) will continue to apply. This includes relevant NSW industrial instruments, as well as applicable NSW Health policies, rules and guidelines. Further, this initiative does not affect or impact on the rights of private practice of employed eligible health professionals (where
Non-Inpatients

Local Health Districts should obtain support for the initiative from local primary health care providers, including (but not limited to), Primary Health Networks, general practitioners, the Royal Flying Doctor Service and Aboriginal Health Services. Where support is not received from all stakeholders, a review process may be conducted.

5.2 VMO Contractual Arrangements and TMF Coverage

VMOs participating in the Initiative will continue to be eligible for Treasury Managed Fund (TMF) cover on the basis the VMO has a signed VMO Service Contract and a signed Contract of Liability Coverage. Participating VMOs shall continue to be indemnified by the TMF in accordance with the terms of their Contract of Liability Coverage.

VMOs are required to comply with NSW Health Policy Directives, Guidelines and Information Bulletins as per standard contractual arrangements. The Visiting Medical Officer - Letter of Agreement (Attachment 1) sets out the additional requirements for VMOs participating in the Initiative and will be provided to a participating VMO once an exemption from s19(2) of the Health Insurance Act 1973 has been granted by the Commonwealth Minister for Health to the participating site.

5.3 Employment status of eligible health professional

Eligible health professionals will remain subject to standard NSW Health employment terms and conditions, but will be eligible to claim Medicare benefits for eligible services.

Eligible health professionals are required to comply with NSW Health policies. Eligible health professionals must be consulted by the Local Health District to seek their agreement to participate in the Initiative. Following this, an Eligible Health Professional – Letter of Agreement (Attachment 2) must be provided to the eligible health professional.

Eligible health professionals participating in the Initiative will remain indemnified by the NSW Government (through Treasury Managed Fund) in respect of services provided under the Initiative as the services will be provided in the course of their employment with NSW Health.

5.4 Remuneration

Since 1988 NSW has operated under the Rural Doctors Settlement Package for remuneration of VMOs in designated rural facilities. A section 19(2) exemption will not change these remuneration arrangements. What the exemption allows is for Medicare benefits to be claimed for services provided by VMOs to public patients in respect of which the VMO is remunerated by the Local Health District in accordance with their VMO Service Contract and the Rural Doctors Settlement Package. Any eligible health professional who is employed by a Local Health District will continue to be remunerated under the relevant industrial award.

5.5 Medicare Benefit Revenue

Local Health Districts and participating VMOs/eligible health professionals will be responsible for ensuring that:

1) Patients who receive eligible services must assign their Medicare benefits to the VMO/eligible health professional in accordance with Medicare Australia requirements.

   It is important to note that the requirements for the assignment of Medicare benefits remain unchanged under this initiative. Compliance with these requirements is the responsibility of the VMO/eligible health professional, and generally requires that:

   • An agreement must be made between the patient (assignor) and the provider for the assignment of benefit.
   • The agreement is ‘evidenced’ through the use of the assignment of benefit form.
   • The patient is required to sign the form.

95(16/3/17)
- A copy of the agreement must be offered to the patient. 

Note: there are approved forms under the Health Insurance Act 1973 for this purpose. For example, the DB2-GP is the approved form for General Practitioners. Further information regarding assignment of benefits can be obtained from Medicare Australia at https://www.humanservices.gov.au/customer/dhs/medicare.

Patients must not be charged a co-payment for MBS billed services under this initiative.

2) The Medicare benefits must be claimed in accordance with the Health Insurance Act 1973 and Medicare Australia billing rules. It will be the responsibility of the VMO/eligible health professional to allocate the item numbers and otherwise ensure compliance with Medicare Australia requirements.

3) VMOs/eligible health professionals must pay over all Medicare benefit income they receive under the Initiative to the Local Health District.

The Australian Tax Office has issued an income tax Class Ruling CR 2012/20 that confirms that:

- The Medicare benefits assigned to VMOs and eligible health professionals by the patient is assessable income of the VMOs and eligible health professionals under section 6-5 of the Income Tax Assessment Act 1997 (the ITAA); and

- The Medicare benefit income derived by VMOs and eligible health professionals paid over to the Local Health Districts is an allowable deduction under section 8-1 of the ITAA for income tax purposes.

An End of Financial Year - Medicare Information Letter (Attachment 3) will be provided by the Local Health Districts to participating VMOs and eligible health professionals to assist them in the preparation of their end of year income tax returns.

5.6 Allocation of Funds

Funds generated by the billing of Medicare under this Initiative must be used to enhance primary care services in the approved locality as identified in the site Operational Plan. In addition, as identified in the site Operational Plan, a small proportion (no greater than 30%) of the funds generated from this initiative may be directed towards meeting the administrative costs of the initiative e.g. billing procedures.

Revenue raised from exempt sites can be pooled by these sites for reinvestment initiatives which benefit all of these exempt sites and include it in any Operational Plan. For example, such funds could be put towards the cost of shared locum or shared equipment.

5.7 Financial Accountability and Reporting

Local Health Districts are expected to receipt the Medicare revenue paid over by the participating VMOs/eligible health professional in an identifiable cost centre for the purposes of this Initiative. Local Health Districts are required to report on Medicare revenue and expenditure from these cost centres to the Ministry of Health and the Commonwealth via annual reports. Local Health Districts are also required to ensure the receipt of funds and subsequent expenditure complies with NSW Health accounts and audit policies. Funds from the Section 19(2) Exemption Initiative should be placed into a designated cost centre for the exempt site within the Local Health District general funds which can be rolled over consecutive financial years.

Local Health Districts may also share annual revenue and expenditure reporting from the initiative with relevant local stakeholders annually.

6 ATTACHMENTS

1. Visiting Medical Officers - Letter of Agreement
2. Eligible Health Professional - Letter of Agreement
3. End of Financial Year - Medicare Information Letter
4. NSW COAG S19(2) exemption application templates 95(16/3/17)
6.1 Attachment 1 - Visiting Medical Officer/VMO Practice Companies - Letter of Agreement

[Local Health District Letterhead]

[Date and Reference]

[Participating VMO details]
[Address]

Dear Dr [Name]

Re: Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative (the Initiative)

Under the Initiative an exemption from section 19(2) of the Health Insurance Act 1973 allows Medicare benefits to be claimed for eligible non-admitted, non-referred professional services. An exemption has been granted by the Commonwealth Minister for Health for [insert site name].

You have consented to participate in this Commonwealth initiative. As part of the terms and conditions of the Initiative, you are required to pay over to the Local Health District the Medicare billings assigned to you for relevant services provided under the Initiative. These funds will then be reinvested in local primary health care services as articulated in the site Operational Plan. I draw your attention to GL2017_xxx Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative that sets out the requirements of Visiting Medical Officers participating in the Initiative.

You continue to be appointed as a Visiting Medical Officer by the Local Health District under existing contractual arrangements and remuneration will continue to be paid to you in respect of the services you provide under those arrangements, even where those services are also being billed under the Initiative.

The Australian Taxation Office has issued an income tax Class Ruling (CR 2012/20) in respect of VMOs and the Initiative arrangements. It confirms that the Medicare billings assigned to you by the patient with respect to eligible services are assessable income for income tax purposes. It also confirms that the billings then paid over by you to the Local Health District are a corresponding allowable deduction.

At the conclusion of each financial year a letter will be sent to you providing details of the Medicare billings received on your behalf and paid over to the Local Health District under the Initiative for the previous financial year to assist with the preparation of your income tax return.

You are requested to indicate your agreement to complying with the above requirements by signing this letter. Please retain a copy and return the original to [Details].

Thank you for your participation in this important initiative. Should you have any queries please contact [name] on [details].

Regards

Chief Executive
[Name] Local Health District

I Dr [Name] understand the requirements of my participation as outlined above.

Signed ........................................  Dated.................................
6.2 Attachment 2 - Eligible Health Professional - Letter of Agreement

[Local Health District Letterhead]
[Date and Reference]

[Participating eligible health professional details]
[Address]

Dear [Name]
Re: Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative (the Initiative)

Under the Initiative an exemption from section 19(2) of the Health Insurance Act 1973 allows Medicare benefits to be claimed for eligible non-admitted, non-referred professional services. An exemption has been granted by the Commonwealth Minister for Health for [insert site name].

Participation requires that you must pay over to the Local Health District the Medicare billings assigned to you for relevant services provided under the Initiative. These funds will then be reinvested in local primary health care services as articulated in the site Operational Plan.

These arrangements will not affect your employment status or entitlements. You are reminded that you continue to be employed by NSW Health as a [nurse practitioner/midwife/allied health professional] in accordance with your usual terms and conditions of employment and as such are required to comply with NSW Health Policy Directives. I draw your attention to GL2017_XXX Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative that sets out the requirements of health professionals participating in the initiative.

The Australian Taxation Office has issued an income tax Class Ruling (CR 2012/20) in respect of eligible health professionals and the Initiative. It confirms that the Medicare billings assigned to you by the patient in respect of eligible services are assessable income for income tax purposes. It also confirms that the billings then paid over by you to the Local Health District are a corresponding allowable deduction.

At the conclusion of each financial year a letter will be sent to you providing details of the Medicare billings received on your behalf and paid over to the Local Health District under the Initiative for the previous financial year to assist with the preparation of your income tax return.

You are requested to indicate your agreement to complying with the above requirements by signing this letter. Please retain a copy and return the original to [Details].

Thank you for your participation in this important Initiative. Should you have any queries please contact [name] on [details].

Regards
Chief Executive
[Name] Local Health District

I [Name] understand the requirements of my participation as outlined above.

Signed ……………………………………….   Dated………………………….
Re: Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative (the Initiative).

As you are aware, under your participation in the COAG Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative you have agreed to pay over the Medicare benefit income assigned to you for eligible services provided under the Initiative to the [insert name of LHD] Local Health District.

An exemption has been granted for [insert exempted site name].

You have signed a Letter of Agreement with [insert name of LHD] Local Health District under which you have agreed to pay over to the Local Health District all Medicare benefits assigned to you in respect of services provided by you under the Initiative.

Medicare benefit income of $.......... [Insert amount of Medicare revenue assigned by the patient to the VMO or eligible health professional] has been received on your behalf by the [insert name of LHD] Local Health District under this Initiative for the financial year of 20XX/20XX.

An amount of $...... [Insert billings that have been paid over to the LHD for the relevant financial year] has then been paid over to [insert name of LHD] Local Health District under the Initiative arrangements for the financial year of 20XX/20XX.

We note that in accordance with Australian Taxation Office income tax Class Ruling (CR 2012/20), the Medicare benefit income you have been assigned by the patient is assessable income under section 6-5 of the *Income Tax Assessment Act 1997 (ITAA)*. You are also entitled to claim a deduction under section 8-1 of the ITAA for the billings you have paid over to [insert name of LHD] Local Health District as part of the Initiative arrangements.

You should seek advice on your own circumstances from your taxation adviser.

Thank you for your continued support of this valuable Commonwealth initiative. Should you have any queries regarding this letter please contact [insert Local Health District Finance Officer name] on [Details].

Regards

Finance Officer
[Name] Local Health District
6.4 Attachment 4 - NSW COAG S19(2) exemption application templates

Section A - Site details

For the purposes of the exemption, an 'eligible site' is a health facility from which services are traditionally provided by the state health authority – including hospitals and their outreach services, Multi-Purpose Services (MPS) and community clinics) located within categories 5-7 of the Modified Monash Model Classification System.

Contact details for site and other key contacts

<table>
<thead>
<tr>
<th>Name of Facility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address:</td>
</tr>
<tr>
<td>Mailing Address:</td>
</tr>
<tr>
<td>Phone number:</td>
</tr>
<tr>
<td>Fax Number:</td>
</tr>
<tr>
<td>Site Contact Person:</td>
</tr>
<tr>
<td>Medical Director:</td>
</tr>
<tr>
<td>Finance Contact</td>
</tr>
<tr>
<td>Operational or Health Service Manager:</td>
</tr>
</tbody>
</table>

Other Key Contacts

*If there are any additional contacts, please attach relevant information where necessary*

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
</tr>
<tr>
<td>Organisation:</td>
</tr>
<tr>
<td>Tel:</td>
</tr>
</tbody>
</table>

Site Description

Please provide a description of the setting/hospital profile. Please include information regarding the size of the site, current staffing arrangements and the types of services currently provided.

*For example: (please note that this is not exhaustive)*

‘(Insert name of site here) is a (insert whether the site is: an MPS, Community clinic or hospital) located in MMM (insert classification number 5, 6 or 7). The facility comprises of 14 beds and has a total of 18 staff members. It provides a mix of aged care, general medical, paediatrics, obstetrics, surgical and community health services. Allied health professionals and visiting specialists visit on a regular basis. This site provides a 24 hour emergency department with medical services provided by visiting medical practitioners.’
Site Operational Model

What service types will be billed to Medicare?

‘Eligible services’ are defined in the MoU as non-admitted, non-referred professional services (including eligible nursing services) and eligible allied health and dental services.

For example:
Sessional services, on call services, after hours services, out-patients, Emergency Department (ED) presentations with primary health care needs, Diagnostic radiology and pathology related to eligible ED presentations, Approved allied health ambulatory and community based services, Approved nursing ambulatory and community based services, Outreach clinics (off hospital site) by eligible services emergency services.

Primary Health Care Practitioner details

Provide the details of each Primary Health Care Practitioner who intends to claim the Medicare rebate under this initiative.

It is a Medicare requirement that Medical Practitioners must have a separate provider number for each location at which they provide services. Only one provider number can be issued per site. If a practitioner has an existing provider number for that site then this number will be used also for claims under the exemption initiative.

To apply for initial or additional provider number for Medical practitioners, eligible allied health professionals and dental services, refer to the forms available on the Medicare website: http://www.humanservices.gov.au/health-professionals/forms/?utm_id=9

Name of Primary Care Practitioners (list below)

What are the arrangements that will be used for billing and receipts of MBS rebate?

MBS rebates

Identify the breakdown of how the MBS rebate will be spent

Please provide a percentage breakdown on how the Medicare rebate will be spent? (Please note that a minimum of 70% of the total Medicare rebate must be retained by the facility for reinvestment in new and additional services at the facility). Please refer to the expenditure guide below. E.g. 90% Reinvested in the facility for additional services and Capital improvements, 10% Administration

How will the MBS rebate generated from the Initiative be used? Please tick all that apply:

☐ Support for locum cover
☐ Employing additional salaried doctors and nurses
☐ Employing allied health professionals
☐ Professional development
☐ Recruitment and retention incentives
☐ Administration costs
☐ Equipment to support primary care services
☐ Additional services to enhance primary care
Targeting services for areas such as:

If the MBS rebate is being used to establish new initiatives for the area please provide further details below?

☐ Other (please provide details)

Which of these new/enhanced primary health care services will be billed against the MBS?

Expenditure Guide:

Reinvestment into the site:
- Support for locum cover
- Employing additional salaried doctors and nurses
- Employing allied health professionals
- Professional development
- Capital improvements to the site
- Equipment to support primary health care services
- Additional or enhanced services from the site (please identify the services).

Incentives
- Recruitment and retention incentives

Administration costs
- Cost associated with the administration of the Initiative.

What governance arrangements will be in place for the distribution of how the Medicare rebate will be spent?

Please provide information about the governance committee to determine how the Medicare rebate will be expended for this site. Please include the proposed terms of reference and membership for the committee if available.

Outline the procedures in place for the collection of data for reporting purposes to ensure effective and accurate reporting as per the MoU between the New South Wales and the Commonwealth.
Section B - Stakeholder Consultation & Endorsement

For the purpose of this application, it is necessary to consult all medical practitioners who provide services to the community and/or are materially affected by the initiative. Please also consult with all other relevant stakeholders who may be affected by the operation of the COAG s19(2) Exemptions Initiative at this site.

All stakeholders must be given the opportunity to express their support or otherwise in this application, noting that establishing stakeholder support is a requirement before a s19(2) exemption can be granted to a site by the Commonwealth.

Local medical practitioners who may be materially affected by the Initiative

All persons consulted must complete a consent form - refer to Appendix A. Where a category of practitioner does not exist in the locality, please indicate N/A.

<table>
<thead>
<tr>
<th>Categories of Practitioner Consulted:</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>All Local General Practitioners</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Salaried Hospital Doctors</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Contracted/Visiting Medical Practitioners</td>
<td></td>
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<tr>
<td>Any Aboriginal Medical Service in the Area</td>
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<tr>
<td>Royal Flying Doctor Service</td>
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<tr>
<td>Other: (please list all)</td>
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Other stakeholder groups

All persons consulted must complete a consent form - refer to Appendix B. Where a category of practitioner does not exist in the locality, please indicate N/A.

<table>
<thead>
<tr>
<th>Stakeholder Groups Consulted:</th>
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<tbody>
<tr>
<td>Primary Health Network</td>
<td></td>
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<tr>
<td>Local Community Representative eg: Consumer Health Council, Health Community Councils</td>
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<tr>
<td>Local Council representative</td>
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<tr>
<td>Other private primary health care providers, including allied health</td>
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<tr>
<td>Other: (please list all)</td>
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AGREEMENT OF THE PARTIES

All parties agree to:

- Cooperate with the data collection and reporting processes as agreed between the New South Wales and the Commonwealth. Each operational plan should be reviewed annually, or at any other time if a party to the agreement believes that there is a need.

- Notify the Commonwealth of any relevant issues relating to General Practice that arise as a result of the implementation of the s19(2) Exemption. The following issues should be monitored locally as these may be incorporated into the next program evaluation.
  - Impact on retention of small rural hospitals and health services
  - Impact on primary health care services in all eligible locations
  - Impact on non-medical services in eligible locations
  - Impact on GPs and salaried medical officers in eligible locations, including remuneration and retention
  - Impact on private GPs using hospital facilities
  - Assessment of the additional services that assisted in recruitment and retention, e.g. locum provision.

- Implement the Initiative in accordance with the purpose, policy objectives and principles of the MoU between New South Wales and the Commonwealth.

Signatures of parties to this site agreement

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<th>Name:</th>
<th>Name:</th>
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<tr>
<td>Role:</td>
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<td>Signature:</td>
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<td>Date:</td>
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</table>
Appendix A - Consent form for primary care providers

Declarations:

Please indicate your agreement by ticking the ‘Yes’ box corresponding to each point before signing and dating below.

<table>
<thead>
<tr>
<th>I understand the context and policy objectives of the COAG s19(2) Exemptions Initiative</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the legislative basis of a section 19(2) exemption and the effects intended by the granting of an exemption under this initiative.</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>I understand that New South Wales, within which I practice, is required to seek my support before applying to the Commonwealth for a section 19(2) exemption.</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>I understand the implications for myself, my practice, and my patients, of a section 19(2) exemption being granted in respect of the locality within which I practice and I have sought relevant advice.</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Noting the above, I give my free and informed consent for the New South Wales Government, to seek a section 19(2) exemption for the locality of (locality name)</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Name: 

Occupation/Specialty: 

Practice Location: 

Employer: 

Telephone: 

Email: 

Signature: 

/ /
Appendix B - Consent form for relevant stakeholders (other than primary care)

Declarations:

Please indicate your agreement by ticking the ‘Yes’ box corresponding to each point before signing and dating below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
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<td>I understand the context and policy objectives of the COAG s19(2) Exemptions Initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand the legislative basis of a section 19(2) exemption and the effects intended by the granting of an exemption under this initiative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that New South Wales, within which I practice, is required to seek my support before applying to the Commonwealth for a section 19(2) exemption.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noting the above, I give my free and informed consent for the New South Wales Government to seek a section 19(2) exemption for the locality of (locality name)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation/Specialty:</td>
</tr>
<tr>
<td>Practice Location:</td>
</tr>
<tr>
<td>Employer:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

Signature: _______________________________________
/  /
CHANGES TO SECTION 100 CO-PAYMENTS IN NSW (IB2016_011)

IB2016_011 rescinds IB2016_001

PURPOSE

From 1 October 2015, co-payments for Section 100 (s100) Highly Specialised Drugs and s100 injectable and infusible chemotherapy medicines will be paid by the NSW Government for NSW residents who are patients of NSW public hospitals or authorised community prescribers in NSW. This means NSW residents who are patients of NSW public hospitals or authorised community prescribers in NSW, who have been prescribed s100 Highly Specialised Drugs or s100 injectable and infusible chemotherapy medicines under the National Health Act 1953 will no longer be required to pay a co-payment.

This includes public non-admitted patients, outpatients or day patients, inpatients on discharge from public hospitals and privately referred, non-admitted patients of NSW public hospitals or by authorised community prescribers in NSW.

Section 100 Highly Specialised Drugs

The changes apply regardless of whether prescriptions for s100 Highly Specialised Drugs are dispensed through NSW public hospital pharmacies or community pharmacies in NSW.

Section 100 injectable and infusible chemotherapy medicines

The changes apply regardless of whether prescriptions are filled at NSW public hospital pharmacies or through pharmacies used by NSW public hospital oncology services.

DEFINITIONS

Authorised community prescriber in NSW

Refers to a medical practitioner or nurse practitioner accredited and authorised to prescribe Highly Specialised Drugs in NSW.

Section 100 Highly Specialised Drugs

Medicines listed on the Pharmaceutical Benefits Scheme website under the Highly Specialised Drugs Program and Section 100 of the National Health Act 1953.

A full list of s100 Highly Specialised Drugs is available on the PBS website at www.pbs.gov.au.

Section 100 injectable and infusible chemotherapy medicines

Medicines listed on the Pharmaceutical Benefits Scheme under Section 100 injectable and infusible chemotherapy medicines and Section 100 of the National Health Act 1953.

A full list of s100 injectable and infusible chemotherapy medicines is available on the PBS website at www.pbs.gov.au.

KEY INFORMATION

- From 1 October 2015, patients of NSW public hospitals or by authorised community prescribers in NSW will no longer need to pay the patient co-payment for Section 100 Highly Specialised Drugs or Section 100 injectable and infusible chemotherapy medicines in NSW. 96(7/4/16)
The changes apply to NSW residents that are patients of NSW public hospitals or authorised community prescribers in NSW, who are prescribed Highly Specialised Drugs or injectable and infusible chemotherapy medicines under Section 100 of the National Health Act 1953.

This includes public non-admitted patients, outpatients or day patients, inpatients on discharge from public hospitals and privately referred, non-admitted patients treated by NSW public hospitals.

Patients need to consent to having the NSW Government pay the co-payment on their behalf and for the necessary information to be provided to the NSW Ministry of Health. The NSW Ministry of Health will use this information to pay the co-payment and evaluate the program. The patient consent form is required for s100 Highly Specialised Drugs dispensed in NSW public hospital pharmacies and NSW community pharmacies.

One patient consent form is valid for 12 months and covers all prescriptions filled during that time period.

There will be no changes to co-payments for Section 100 Highly Specialised Drugs or Section 100 injectable and infusible chemotherapy medicines for patients accessing care in the private sector in NSW. Changes to Section 100 co-payments in NSW do not apply to medicines listed under the general schedule of the Pharmaceutical Benefits Scheme.

### Section 100 injectable and infusible chemotherapy medicines:

- Prescriptions for s100 injectable and infusible chemotherapy medicines can be filled through NSW public hospital pharmacies or pharmacies used by NSW public hospital oncology services.

- When a prescription is filled at pharmacies used by NSW public hospital oncology services, a patient consent form is signed using the existing pharmacy consent form. Eligible patients for s100 injectable and infusible chemotherapy medicines in NSW are not required to sign a Section 100 Highly Specialised Drugs patient consent form.

### Section 100 Highly Specialised Drugs:

- The commitment applies to patients filling their s100 Highly Specialised Drugs prescriptions filled through a NSW public hospital pharmacy or NSW community pharmacy.

- An arrangement is in place for community pharmacies where patients choose to get their prescriptions for Section 100 Highly Specialised Drugs that are listed under the community access arrangements on the PBS dispensed from a community pharmacy.

- The NSW Government will pay the co-payment for s100 Highly Specialised Drugs for eligible patients that choose to get their s100 Highly Specialised Drugs dispensed in community pharmacies under the community access arrangements. From 1 July 2015, HIV antiretroviral therapy, Hepatitis B medicines and clozapine (maintenance therapy only) are listed under the community access arrangements which can be dispensed from community pharmacies. A full list of s100 community access medicines is listed on the PBS website [http://www.pbs.gov.au/browse/section100-ca](http://www.pbs.gov.au/browse/section100-ca).

### Safety Net Scheme

Co-payments paid by the NSW Government will count towards the patient safety net.

**Entitled patients (concessional patients that have reached the Safety Net threshold)**

Arrangements regarding entitled patients will continue to operate in accordance with the Commonwealth Government’s Pharmaceutical Benefits Scheme.
IMPLEMENTATION

NSW public hospitals

From 1 October 2015, eligible patients that have their s100 Highly Specialised Drugs or s100 injectable and infusible chemotherapy medicines supplied through a NSW public hospital pharmacy or pharmacies used by NSW public hospital oncology services will no longer be required to pay a co-payment.

The NSW Ministry of Health will reimburse Local Health Districts (LHDs), Specialty Health Networks (SHNs) and pharmacies used by NSW public hospital oncology services for eligible patients. Claims from NSW public hospitals are to be based on reports run in i. Pharmacy. Refer to Attachment 1 for an example. An illustration of the claim process in NSW public hospital pharmacy departments is at Attachment 2. A new crystal report has been developed to support reporting and claims from public hospital pharmacies to the NSW Ministry of Health. An information sheet has been developed to support reporting in line with privacy obligations.

The reimbursements will take into account where historically, hospital pharmacies have allowed for non-collection of a co-payment due to financial or social grounds.

LHDs/SHNs can continue to use their discretion to charge a co-payment based on existing practice.

NSW community pharmacies

Where s100 Highly Specialised Drugs can be dispensed from a NSW community pharmacy, the NSW Government has an arrangement in place for eligible patients to have their co-payments paid by the NSW Government by presenting the patient consent form with the patient’s prescription (and with any repeat prescriptions) to a community pharmacist.

The NSW Government will pay the co-payment for s100 Highly Specialised Drugs for eligible patients that choose to get their s100 Highly Specialised Drugs dispensed in community pharmacies under the community access arrangements. From 1 July 2015, HIV antiretroviral therapy, Hepatitis B medicines and clozapine (maintenance therapy only) are listed under the community access arrangements which can be dispensed from community pharmacies. A full list of s100 community access medicines is listed on the PBS website http://www.pbs.gov.au/browse/section100-ca.

PATIENT CONSENT FORM

Section 100 Highly Specialised Drugs

NSW public hospital prescribers and authorised community prescribers in NSW are required to complete a patient consent form for eligible patients to have their co-payment paid by the NSW Government. A sample is at Attachment 3.

The consent form is required by patients who wish to have their Section 100 Highly Specialised Drugs paid by the NSW Government in both NSW public hospital pharmacies and community pharmacies.

Prescribers of all s100 HSD medicines are required to complete the patient consent form for eligible patients. NSW public hospital pharmacies can still choose to dispense and not charge the co-payment, however, for this initiative eligible patients require a patient consent form for the NSW Government to pay the co-payment on behalf of the patient.

Patients should present the consent form with their s100 Highly Specialised Drug prescription/s and any repeats at a NSW public hospital pharmacy or NSW community pharmacy each time.

Pharmacists will need to check that the patient consent form is valid and the details match. One patient consent form is valid for 12 months and covers all prescriptions filled during that time period.
NON-INPATIENTS

Section 100 injectable and infusible chemotherapy medicines

When a patient prescription for s100 injectable and infusible chemotherapy medicines are filled through pharmacies used by NSW public hospital oncology services, a consent form from the pharmacy is already signed by the patient.

This consent form will now include an agreement for the NSW Government to pay the co-payment on behalf of eligible patients. No additional forms are required by the LHD/SHN. LHDs/SHNs have been requested to review current arrangements and associated documentation to reflect the new processes. The process for supplying s100 injectable and infusible chemotherapy medicines to public patients in NSW public hospitals will otherwise continue as usual.

Implementation date

Implementation commenced on 1 October 2015 in both NSW public hospital pharmacies, NSW community pharmacies and pharmacies used by NSW public hospital oncology services. The changes to co-payments apply to medicines dispensed from 1 October 2015.

PRIVACY

Privacy of health information will be managed in accordance with the NSW Health Privacy Manual for Health Information and the relevant policy and legislative obligations. The NSW Ministry of Health will be maintaining this health information on its secure internal system. Access to the information will be restricted and secure.

An information sheet has been developed and disseminated to LHDs/SHNs to support reporting in line with privacy obligations.

LHDs/SHNs will also need to refer to their own local privacy policy guidelines and the NSW Health Privacy Manual for Health Information, which can be found at: www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx.

SCOPE

The changes apply to:

- Residents of NSW who are patients of a NSW public hospital prescriber or authorised community prescriber in NSW
- Patients prescribed s100 Highly Specialised Drugs or s100 injectable and infusible chemotherapy medicines under Section 100 of the National Health Act 1953
- Medicines dispensed from 1 October 2015
- s100 Highly Specialised Drugs prescriptions dispensed at NSW public hospital pharmacies, NSW community pharmacies and pharmacies used by NSW public hospital oncology services
- Border areas in NSW for eligible NSW public hospital patients that visit an interstate specialist/prescriber, and the patient returns to the NSW public hospital pharmacy to have their s100 HSD medicine/s dispensed and present to the pharmacy with a completed patient consent form with their prescription
- The patient co-payment only.

The changes do not apply to:

- Patients of private hospital prescribers
- Residents of other States or Territories
- Patients of public hospitals or community prescribers of other States or Territories
- s100 Highly Specialised Drugs or s100 injectable and infusible chemotherapy medicines dispensed prior to 1 October 2015
- Patients prescribed medications under other schedules
- Any other associated fees.
MORE INFORMATION

More information, including factsheets and the consent form are available on the NSW Health website: [http://www.health.nsw.gov.au/pharmaceutical/Pages/s100-copayments.aspx](http://www.health.nsw.gov.au/pharmaceutical/Pages/s100-copayments.aspx). Staff of LHDs/SHNs can seek advice regarding the changes from their Directors of Finance or Chief Executive in the first instance.

For more information about the policy please contact the Health System Planning and Investment Branch, NSW Ministry of Health on (02) 9391 9491.

General enquires can be emailed to: [NSWs100copayment@moh.health.nsw.gov.au](mailto:NSWs100copayment@moh.health.nsw.gov.au).

ATTACHMENTS

1. Claim reports for NSW public hospital pharmacies
2. Claim process in NSW public hospitals
3. Patient consent form
### PBS Postcode Report v6.2

**Period:** 01 October 2015 to 31 October 2015

#### Non-Inpatients

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date Dispensed</th>
<th>Suburb/Postcode</th>
<th>PBS Online Payment Code Approved</th>
<th>PBS Claim ID</th>
<th>Cal</th>
<th>Payment Status Code</th>
<th>Provider</th>
<th>Dispense Code</th>
<th>PBS Code</th>
<th>Protocol</th>
<th>Number</th>
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**Total:** $37.70

#### NSW Postcode - Eligible

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<th>PBS Claim ID</th>
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<th>Payment Status Code</th>
<th>Provider</th>
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<th>PBS Code</th>
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**Total:** $423.10

**Grand Total:** $460.80
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<td>General Benefit</td>
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<td>$37.70</td>
</tr>
<tr>
<td>01/10/2015</td>
<td>31/10/2015</td>
<td>PBS Claim ID</td>
<td>1</td>
<td>$37.70</td>
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**NSW Postcode - Eligible**

<table>
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<th>PBS Claim ID</th>
<th>Amount</th>
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<tbody>
<tr>
<td>01/10/2015</td>
<td>31/10/2015</td>
<td>General Benefit</td>
<td>1</td>
<td>$37.70</td>
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**Grand Total**: $460.80
Changes to co-payments in NSW

Changes to co-payments in NSW public hospital pharmacies

Ministry of Health

LHD/SIH Public hospital pharmacy

Patient script

Consent Form

Prescriber of ≤$100 HSDs

- Prescribes ≤$100 HSD.
- Assesses patient for eligibility.
- Patient receives script and consent form.

Pharmacist enters details into iPharmacy and checks details.
- Dispenses ≤$100 HSDs as per script.
- Co-payment is not charged to patient.

- Receives claims from LHD/SIHs for co-payments in NSW public hospital pharmacies.
- Reconciliation of claims.
- Processes claims and payment to LHD/SIHs for co-payments.

- Runs claim report for co-payments through NSW public hospital pharmacies.
- Claims based on PBS online claim periods in iPharmacy.

- Receives payment from the Ministry of Health.
- Undertakes reconciliation of monies received.

Safely net sticker issued.
12 MONTH PATIENT CONSENT FORM

Attach this form to prescriptions for s100 Highly Specialised Drugs

IMPORTANT INFORMATION FOR PATIENTS

Community pharmacists have to charge a co-payment when they sell medicines. The NSW Government has made changes to co-payments for Section 100 (s100) Highly Specialised Drugs for NSW residents who are patients of NSW public hospitals or authorised community prescribers in NSW. The NSW Government will now pay the co-payment. By signing this form, you agree that the co-payment you are charged for your medicine/s will be paid by the NSW Government.

When you fill your prescription at a NSW public hospital or community pharmacy you will need to present this form to the pharmacist with your prescription (including any repeats). If this form becomes lost, damaged, or illegible, it is your responsibility to obtain a new consent form from your prescriber/doctor.

It is important that you present this form with your prescription (including any repeats) each time.

PATIENT AGREEMENT

I agree to the NSW Government paying the co-payment on my behalf for my medicine/s. This is in line with the National Health Act 1953 (Cth) and the National Health (Highly Specialised Drugs Program for Hospitals) Special Arrangement 2010. I understand that:

- the pharmacist may collect health information about me and my medicine/s;
- this information will be given to the NSW Health to make the co-payment;
- NSW Health may also use this information to evaluate this program;
- my health information will be protected in accordance with NSW Health Information and the NSW Health Privacy Manual for Health Information.

SIGNATURE OF PATIENT OR AUTHORISED REPRESENTATIVE

Printed full name:

Signature:

Date signed:

FOR FURTHER INFORMATION PLEASE SPEAK WITH YOUR DOCTOR OR PRESCRIBER.

This patient consent form is valid for 12 months from the date of patient/authorised representative signature.

For more information about changes to Section 100 co-payments visit www.health.nsw.gov.au/pharmacy/Press/5100-co-payments.aspx

PRESCRIBER SIGNATURE

INFORMATION FOR PRESCRIBERS

By completing this form, I agree that the patient:

- is a NSW resident and patient of a NSW public hospital prescriber or authorised community prescriber in NSW;
- is eligible to have their s100 Highly Specialised Drug co-payment paid by the NSW Government.

PRESCRIBER USE ONLY

(Optional; affix patient details sticker)

PATIENT DETAILS

Patient's name:

Patient's address:

PRESCRIBER DETAILS

Prescriber's full name:

Prescriber number:

Hospita/practice name:

Prescriber's address and phone:

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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.

START

Is patient eligible for FULL Medicare coverage?

Is patient compensable?

For the purpose of medical billing ONLY determine the patient’s responsibility to pay. (Accommodation charges covered under bulk billing agreement)

Is patient a prisoner?

Is patient a victim of crime?

Is patient an organ donor? (conditions apply)

Is patient an infection control risk?

Is patient from a country with a RHCA?

Refer to RHCA ready reckoner and specific details on each country Section 3.5 RHCA

Is patient under involuntary mental health order?

Refer to Section 3.7 Mental Health

Does patient have urgent high risk pregnancy issues?

Refer to Section 3.8 High Risk Pregnancy

Is patient an asylum seeker?

Is patient ASAS or similar agreement?

Refer to Section 3.9 Refugees & Asylum Seekers

Is patient an immigration detainee?

Is patient subject to CAFAT or ROMAC arrangement?

Does patient hold a work visa or student visa?

Does patient hold eligible Australian insurance?

Charge insured

Is patient MAA at fault?

Charge contracted provider

Charge patient, insurer or responsible group

Charge patient or guarantor

Follow compensable process

No charge or waive fees

No

Yes

No

No

No

No

No

No

No

No

No

No

No
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 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.

### 3.5.2 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:
  o Yellow (RHC) Medicare card or
  o 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:
  - Yellow (RHC) Medicare card or
  - 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:
  - Yellow (RHC) Medicare card or
  - 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.

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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.

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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:
  o Yellow (RHC) Medicare card or
  o 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:
  o Yellow (RHC) Medicare card or
  o 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.
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:
  - Tuberculosis (TB)
  - Leprosy
  - 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 PMKeys 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
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- 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.
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 venesection
  - 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
- Owes 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.
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.
INPATIENTS 2.17

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.

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.

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.
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.

98(23/6/16)
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).
INPATIENTS

• 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.

20(1/95)
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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<tbody>
<tr>
<td>If no</td>
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</table>

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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<tr>
<td>If no</td>
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</table>
INPATIENTS

2.34

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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<thead>
<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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</table>

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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<th>If yes</th>
<th>Same Day Admission - Band 2,3 or 4</th>
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<th>If no</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.

<table>
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<tr>
<th>If yes</th>
<th>Same Day Admission - Band 1b. Other</th>
</tr>
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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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</table>

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**

<table>
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<th>Date of Service</th>
<th>FACILITY NAME</th>
<th>FACILITY PROVIDER NUMBER</th>
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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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<tr>
<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.
INPATIENTS

5.2 THIRD PARTY INSURANCE - MOTOR VEHICLES

POST JULY 1989 (It is imperative that all officers are aware of the provisions incorporated on the election form at Attachment H.)

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>Injured Employee</th>
<th>Charge Applicable</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>
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 2019 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 2019. This document replaces PD2018_024.
A case-mix charging model based on National Weighted Activity Units (NWAUs) and National Efficient Price (NEP) has recently been implemented for **Compensable Patients** in respect of Acute admitted and Emergency Department admitted and non-admitted patient services. In regard to Motor 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>362</td>
</tr>
<tr>
<td>Single Room</td>
<td>773</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.
- Patients from whom co-payment / excess is required or patients who elect to be private and who do not have private health insurance use normal methods of collection as appropriate for each health service to collect payment prior to or on admission where feasible.
- 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>1</td>
<td>262</td>
</tr>
<tr>
<td>2</td>
<td>294</td>
</tr>
<tr>
<td>3</td>
<td>322</td>
</tr>
<tr>
<td>4</td>
<td>362</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 Status Resolution Support Services (SRSS) previously known as the Asylum Seeker Assistance Scheme (ASAS).

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

Work Visa holders and Student Visa holders whose visa is subject to condition 8501 (*Condition 8501 – Health cover: The visa holder must maintain adequate arrangements for health insurance during their stay in Australia)*

4.1 **Hospital Classification**

<table>
<thead>
<tr>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient - Critical Care</td>
<td>3,437</td>
</tr>
<tr>
<td>Inpatient – Other than critical care</td>
<td>1,383</td>
</tr>
<tr>
<td>Inpatient</td>
<td>581</td>
</tr>
<tr>
<td>Inpatient</td>
<td>325</td>
</tr>
</tbody>
</table>

Critical Care for the purpose of this document is defined as patients treated in the following units: Intensive Care Unit (ICU), Paediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), Psychiatric Intensive Care Unit, Neonatal Special Care Nurseries, Coronary Care Unit (CCU) and High Dependency Unit (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>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,999</td>
</tr>
<tr>
<td>3,437</td>
</tr>
<tr>
<td>2,365</td>
</tr>
<tr>
<td>1,383</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 $5,999 plus 4 days at $3,437 plus 21 days at $2,365 plus 9 days at $1,383. 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 $3,437.

- Critical Care Critical Care for the purpose of this document is defined as patients treated in the following units: Intensive Care Unit (ICU), Paediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), Psychiatric Intensive Care Unit, Neonatal Special Care Nurseries, Coronary Care Unit (CCU) and High Dependency Unit (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>1,383</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Inpatient</td>
<td>581</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Inpatient</td>
<td>325</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>147</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Non-Inpatient</td>
<td>103</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Non-Inpatient</td>
<td>103</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>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</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) $ per day 267

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 $ per session 759

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 and Student Visa holders with visa condition 8501) 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) or credit card payment to cover estimated cost
  - 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.
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 STATUS RESOLUTION SUPPORT SERVICE (SRSS)

The Status Resolution Support Services (SRSS) is the program that supports vulnerable migrants who are waiting for the government’s decision on a visa application, including people seeking asylum, this was previously referred to as the Asylum Seeker Assistance Scheme (ASAS).

<table>
<thead>
<tr>
<th></th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Room</td>
<td>639</td>
</tr>
<tr>
<td>Single Room</td>
<td>966</td>
</tr>
<tr>
<td>One Day Admission</td>
<td>545</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1944</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(19)) with adjustments applied as applicable in accordance with the Independent Hospital Pricing Authority (IHPA) publication National Efficient Price Determination 2019-2020. The NWAU(19) 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 (19) 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 $5,134 as determined by the Independent Hospital Pricing Authority (IHPA).
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 (NWAU(18)) with adjustments applied as applicable in accordance with the IHPA publication National Efficient Price Determination 2019-2020.

The NWAU (19) 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 (19), which is applicable for the purposes of charging ED admitted compensable patients. The NWAU is rounded to the nearest 3 decimal places multiplied by

The National Efficient Price (NEP) of $5,134 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 (NWAU (19)) with adjustments applied as applicable in accordance with the IHPA publication National Efficient Price Determination 2019-2020. The NWAU is rounded to the nearest 3 decimal places multiplied by

The National Efficient Price (NEP) of $5,134 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>1,201</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Inpatient</td>
<td>504</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Inpatient</td>
<td>282</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>128*</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>Non-Inpatient</td>
<td>89*</td>
</tr>
<tr>
<td>Other (eg Residential Aged Care Facilities)</td>
<td>Non-Inpatient</td>
<td>89*</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, Chiropractic and Osteopathy Service Charges

<table>
<thead>
<tr>
<th>Normal Practice Item</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA001 Initial consultation and treatment</td>
<td>96.10</td>
</tr>
<tr>
<td>PTA002 Standard consultation and treatment</td>
<td>81.40</td>
</tr>
<tr>
<td>PTA003 Initial consultation and treatment of two distinct areas</td>
<td>145.00</td>
</tr>
<tr>
<td>PTA004 Standard consultation and treatment of two distinct areas</td>
<td>122.70</td>
</tr>
<tr>
<td>PTA005 Complex treatment</td>
<td>162.60</td>
</tr>
<tr>
<td>PTA006 Group/class Intervention (rate per participant)</td>
<td>57.70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Visit Item</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA007 Initial consultation and treatment</td>
<td>118.30</td>
</tr>
<tr>
<td>PTA008 Standard consultation and treatment</td>
<td>94.60</td>
</tr>
<tr>
<td>PTA009 Initial consultation and treatment of two distinct areas</td>
<td>174.60</td>
</tr>
<tr>
<td>PTA010 Standard consultation and treatment of two distinct areas</td>
<td>149.50</td>
</tr>
<tr>
<td>PTA011 Complex treatment</td>
<td>192.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Item</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA012 Case conference, Report Writing (per 5 minutes)</td>
<td>16.00</td>
</tr>
<tr>
<td>PTA012 Case conference (p/hour), Report Writing (p/hour - max)</td>
<td>192.00</td>
</tr>
<tr>
<td>PTA013 Activity assessment, consultation &amp; treatment</td>
<td>192.00</td>
</tr>
<tr>
<td>PTA014 Travel - In accordance with “use of private motor vehicle” rates as set out in Item 6 Table 1 of the Crown Employees (Public Service Conditions of Employment) Award 2009.</td>
<td></td>
</tr>
</tbody>
</table>

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

### 7.8 Non-Inpatient Psychology and Counselling Service Charges

<table>
<thead>
<tr>
<th>Item</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSY001 Initial consultation and treatment</td>
<td>229.00</td>
</tr>
<tr>
<td>PSY002 Standard consultation and treatment</td>
<td>190.80</td>
</tr>
<tr>
<td>PSY003 Report Writing (per 5 minutes)</td>
<td>15.90</td>
</tr>
<tr>
<td>PSY003 Report Writing (per hour / max 1 hour)</td>
<td>190.80</td>
</tr>
<tr>
<td>PSY004 Case Conferencing (per 5 minutes)</td>
<td>15.90</td>
</tr>
<tr>
<td>PSY004 Case Conferencing (per hour)</td>
<td>190.80</td>
</tr>
<tr>
<td>PSY006 Group / class intervention (per participant)</td>
<td>57.20</td>
</tr>
<tr>
<td>PSY005 Travel – In accordance with “use of private motor vehicle” rates as set out in Item 6 Table 1 of the Crown Employees (Public Service Conditions of Employment) Award 2009.</td>
<td></td>
</tr>
</tbody>
</table>

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

### 7.9 Non-Inpatient Exercise Physiology Service Charges

<table>
<thead>
<tr>
<th>Item</th>
<th>$ charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPA001 Initial consultation and treatment</td>
<td>153.60</td>
</tr>
<tr>
<td>EPA002 Standard consultation and treatment</td>
<td>153.60</td>
</tr>
<tr>
<td>EPA003 Reduced supervision treatment</td>
<td>67.00</td>
</tr>
<tr>
<td>EPA004 Group/class intervention (per participant)</td>
<td>48.80</td>
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<tr>
<td>EPA005 Additional Expenses (as agreed with insurer)</td>
<td>-</td>
</tr>
<tr>
<td>EPA006 Case Conferencing (per 5 minutes)</td>
<td>12.80</td>
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<tr>
<td>EPA006 Case Conferencing (per hour)</td>
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<tr>
<td>EPA007 Report Writing (per 5 minutes)</td>
<td>12.80</td>
</tr>
<tr>
<td>EPA007 Report Writing (max 1 hour)</td>
<td>153.60</td>
</tr>
<tr>
<td>EPA008 Travel – In accordance with “use of private motor vehicle” rates as set out in Item 6 Table 1 of the Crown Employees (Public Service Conditions of Employment) Award 2009.</td>
<td></td>
</tr>
</tbody>
</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 677

8. VETERANS’ AFFAIRS PATIENTS (DVA)

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 AND MEALS CHARGES FOR PARENTS, RELATIVES OR FRIENDS OF PATIENTS

Accommodation Only (excluding meals) $ per night 49

Maximum charge where accommodation is provided in a self-contained unit (including own kitchen and bathroom facilities).

Maximum charge per person for accommodation other than self-contained accommodation 25

Meals $ per meal 8

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

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:
12.1 Inpatient Services
Neither the prisoner, nor the Correctional Centre 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 Correctional Centre 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.

105(08/07/19)
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.

### 2.3 Patient Contribution Fees
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.

87(5/5/16)
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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

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/and 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.

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

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Services or interventions (related to acute care)</th>
<th>Frequency (e.g. daily/3xweek etc.)</th>
<th>Date ended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon/Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<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: ___ / ___ / ___
Attachment 2: Sample notification letter for Nursing Home Type Patients

AUlD: «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]  

87(5/5/16)
<table>
<thead>
<tr>
<th>Residents' Authority</th>
<th>(Name of Resident)</th>
<th>(Patient AUID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>«PatientForename» «PatientSurname»</td>
<td>«PatientID»</td>
<td></td>
</tr>
</tbody>
</table>

I, (Name of Debit User) APCA User ID No [XXXXXX] 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.

<table>
<thead>
<tr>
<th>Resident / Power of attorney</th>
<th>Signature</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Details of the Account to be Debited</th>
<th>Name of the Financial Institution</th>
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</thead>
<tbody>
<tr>
<td>(All details must be supplied)</td>
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</table>

<table>
<thead>
<tr>
<th>Account Name</th>
<th>BSB Number</th>
<th>Account number</th>
<th>Branch Name</th>
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<table>
<thead>
<tr>
<th>Payment Details</th>
<th>The payment is for</th>
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<tr>
<td></td>
<td>Accommodation Contribution</td>
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</table>

<table>
<thead>
<tr>
<th>Payment Options</th>
<th>I/We request that you debit my/our account in accordance with our Agreement and subject to the following conditions:</th>
</tr>
</thead>
</table>

- 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

<table>
<thead>
<tr>
<th>Financial Institution Consent</th>
<th>Signature</th>
<th>Date</th>
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<th>Financial Institution Consent</th>
<th>Signature</th>
<th>Date</th>
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</table>
Attachment 5: Implementation checklist

<table>
<thead>
<tr>
<th>LHD/Facility:</th>
<th>Date of Assessment:</th>
</tr>
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<tbody>
<tr>
<td>Assessed by:</td>
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</table>

<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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Notes:

87(5/5/16)
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

2 ELIGIBILITY

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

3 FUNDING ARRANGEMENTS

3.1 LHD funding
3.1.1 2014/15 – 2019/20 financial years
3.1.2 2020/21 financial year
3.2 Services funded
3.3 Fees
3.3.1 Services billed to DVA
3.3.2 Patient charges
3.4 Subcontracting of services
3.5 New technology
3.6 High cost admitted patient care

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
4.5 Transfer of Care
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

<table>
<thead>
<tr>
<th>Feature</th>
<th>Details</th>
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<tbody>
<tr>
<td>DVA has implemented national public hospital purchasing arrangements based on the funding model developed by the Independent Hospital Pricing Authority</td>
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<tr>
<td>2014/15 – 2019/20 funding to LHDs will continue to be based on the previous arrangements:</td>
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</tr>
<tr>
<td>Admitted activity funded using the service categories in the NSW Costs of Care Standards 2006/07</td>
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<tr>
<td>Non admitted activity block funded</td>
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</tr>
<tr>
<td>2020/21 funding to LHDs will be activity based using National Weighted Activity Units (NWAU)</td>
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</tr>
</tbody>
</table>
2 ELIGIBILITY

2.1 Who is eligible

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

- they elect to be treated as a public patient
- they elect to be a private patient, using their private health insurance
- 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.

104(10/10/18)
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](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>
</tr>
</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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</tbody>
</table>

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>
<thead>
<tr>
<th>Reporting Period</th>
<th>Data submission to MOH completed [LHD]</th>
<th>Data submitted to DVA [MOH]</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</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.

32(12/99)
2. CHARGES IN RESPECT OF NEWBORN BABIES (PD2019_030)

**PD2019_030 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.

5.3.2 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.
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.

Accommodation Only (excluding meals)  $ per night
- maximum charge where accommodation is provided in a self contained unit (including own kitchen and bathroom facilities). $49
- maximum charge per person for accommodation other than self contained accommodation. $25

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.

Meals  $ per meal
- maximum per meal per person and no greater than rates applicable to hospital employees. 8

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. Dependants 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 is 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 (PD2019_033)

PD2019_033 rescinds PD2018_026

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 2019.

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.

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 2019.

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 NSW Ambulance.

- **“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’”]

105(08/07/19)
• “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 $768 callout, plus an additional charge of $6.93 for each kilometre or part thereof, provided that such total fee shall not exceed $6,424.

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 $309 callout, plus an additional charge of $1.91 for each kilometre or part thereof, provided that such total fee shall not exceed $6,424.

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 $661 callout, plus an additional charge of $6.59 for each kilometre or part thereof, provided that such total fee shall not exceed $6,183

• Fixed wing ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of $4,072 callout, plus an additional charge of $1.90 for each kilometre or part thereof (road travel associated with fixed wing cases is charged at the $6.95 for each kilometre or part thereof), provided that such total fee shall not exceed $6,183.

• Helicopter - on a time basis calculated pursuant to section 4 on the scale of $6,991 for the first thirty (30) minutes or part thereof, with any further period charged at a rate of $153 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.

105(08/07/19)
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 $303 callout, plus an additional charge of $1.87 for each kilometre or part thereof, provided that such total fee shall not exceed $6,183. 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 $6,424); and in addition
- $55.36 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 Emergency</th>
<th>Non Emergency</th>
<th>Fixed Wing Emergency</th>
<th>Helicopter Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call-Out</td>
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<td>$'s</td>
<td>$'s</td>
<td>$'s</td>
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<td>768</td>
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<td>6.93</td>
<td>6.93</td>
</tr>
<tr>
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<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.
INPATIENTS

NSW NEWBORN AND PAEDIATRIC EMERGENCY TRANSPORT SERVICES (NETS) CHARGES (PD2019_031)

PD2019_031 rescinds PD2018_025

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 2019.

MANDATORY REQUIREMENTS
NETS charges as described in the attached procedures are to be applied by all LHDs from 1 July 2019.

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 2019.

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 $768 callout, plus an additional charge of $6.93 for each kilometre or part thereof, provided that such total fee shall not exceed $6,424.

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 $309 callout, plus an additional charge of $1.91 for each kilometre or part thereof, provided that such total fee shall not exceed $6,424.

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 $661 callout, plus an additional charge of $6.59 for each kilometre or part thereof, provided that such total fee shall not exceed $6,183.

- Fixed wing service - on a kilometre basis calculated pursuant to section 3, on the scale of $4,072 callout, plus an additional charge of $1.90 for each kilometre or part thereof (road travel associated with fixed wing cases is charged at the $6.59 for each kilometre or part thereof), provided that such total fee shall not exceed $6,183.

- Helicopter service - on a time basis calculated pursuant to section 4 on the scale of $6,991 for the first thirty (30) minutes or part thereof, with any further period charged at a rate of $153.00 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 $303 callout, plus an additional charge of $1.87 for each kilometre or part thereof, provided that such total fee shall not exceed $6,183. 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>
<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>Emergency</td>
<td>Emergency</td>
</tr>
<tr>
<td></td>
<td>$'s</td>
<td>$'s</td>
<td>$'s</td>
</tr>
<tr>
<td>Call-Out</td>
<td>768</td>
<td>309</td>
<td>768</td>
</tr>
<tr>
<td>Variable Rate</td>
<td>6.93</td>
<td>1.91</td>
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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.
BRAIN INJURY REHABILITATION PROGRAM (BIRP) – FEES POLICY AND SCHEDULE OF FEES (PD2019_029)

PD2019_029 rescinds PD2018_023

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 2019 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.

105(05/07/19)
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 2019. This document replaces PD2018_023. 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>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
<td>$1,262</td>
</tr>
<tr>
<td>Category B</td>
<td>$807</td>
</tr>
<tr>
<td>Category X</td>
<td>$1,795</td>
</tr>
</tbody>
</table>

4.2 Inpatient Transitional Living Units

<table>
<thead>
<tr>
<th>Category</th>
<th>Daily Bed Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
<td>$901</td>
</tr>
<tr>
<td>Category B</td>
<td>$447</td>
</tr>
</tbody>
</table>

4.3 Non-Inpatient Services Including Outreach

Charged at the cumulative rate of $86 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 $298.

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 $149.

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 $55.

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.
LIFETIME CARE & SUPPORT (LTCS) SCHEME – CHARGING POLICY AND RATES FOR DESIGNATED UNITS (PD2019_032)

PD2019_032 rescinds PD2018_022

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 iCare Insurance & Care NSW (Lifetime Care).

iCare Insurance & Care NSW (Lifetime Care) (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.

Detailed information in relation to eligibility for participation in the Scheme is available on the iCare website at https://www.icare.nsw.gov.au/treatment-and-care/who-we-carefor/motor-accident-injuries/

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 Lifetime Care. 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

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.

1.2 Legal and legislative framework

iCare Insurance & Care 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 Lifetime Care at applicable rates, as advised below, for admitted patient services provided in a designated Brain Injury or Spinal 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:-

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>$1,262</td>
</tr>
<tr>
<td>Category B</td>
<td>$807</td>
</tr>
<tr>
<td>Category X</td>
<td>$1,795</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>$901</td>
</tr>
<tr>
<td>Category B</td>
<td>$447</td>
</tr>
</tbody>
</table>

3.3 Non-admitted patient Rehabilitation Services, including Outreach
At the cumulative rate of $86 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 $298.

**Medical Consultation – (Review)** - applies to follow-up appointments of a patient by an attending medical officer - charged at the standard rate of $149.

3.5 Reports
The charging for reports is in accordance with the rates set out in NSW Health Information Bulletin IB2018_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 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 $55.

**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. Lifetime Care 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
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.
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 indemnnified 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 indemnnified 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

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate (updated of)</th>
<th>No.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>Critical care - 1st 21 days</td>
<td>55.416 / day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical care - over 21 days</td>
<td>53.103 / day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute non critical - 1st 21 days</td>
<td>52.135 /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute non critical - over 21 days</td>
<td>51.24 /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub acute (rehab, maintenance, palliative)</td>
<td>51 /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Psychiatric hospital</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hospital in the home – HITH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical treatment (hospital Dr)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist services (private Dr)</td>
<td>number /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td></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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy (if required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANA Rate Service</th>
<th>Procedures</th>
<th>ANA Item #</th>
<th>ANA 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/Bank Cheques/MA, Order</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit Card / EFTPOS</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand that the amount shown above is an estimate of fees that I am required to pay prior to discharge, and that there may be other charges incurred following my discharge. I authorize NSW Health to bill my credit card for all outstanding costs relating to my presentation.

Card Number: ___________________________ Date: ____________

Name printed on card: ___________________________

Cardholder / patient signature: ___________________________

A copy of the completed form supplied to patient by ___________________________ on __/__/____
(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

### Admitted Patient - estimate of cost and agreement to pay

**Medicare Ineligible with Visas 401, 403, 416, 457, 485, 500, 570 – 576 & 580**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Date</th>
</tr>
</thead>
</table>

**Patient information and declaration (to be complete by or on behalf of the patient)**

- **Patient name:**
- **AUID:**
- **Overseas Address:**
- **Phone Number:**
- **Email address:**
- **Address (local):**
- **Passport Number:**
- **Copied:**

I understand that the amount shown below is an estimate of fees that I am required to pay prior to discharge. I authorize NSW Health to bill my credit card for all outstanding costs relating to my presentation.

**VISA**

- **Card Number:**
- **Name printed on card:**
- **Cardholder / patient signature:**

### Service

<table>
<thead>
<tr>
<th>Service Description</th>
<th>D</th>
<th>Day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non critical care - acute &amp; sub acute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Psychiatric hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital in the home – RTH</td>
<td>Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient treatment fee (hospital Dr)</td>
<td>$258 per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist services (private Dr)</td>
<td>AMA item number/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td>AMA item number/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Transfer</td>
<td>Refer Summary fees and charges</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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy (if required)</td>
<td>Direct costs of items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

### AMA Rate Serv.

**Image / Procedures**

<table>
<thead>
<tr>
<th>Date</th>
<th>AMA Item #</th>
<th>AMA Rate</th>
</tr>
</thead>
</table>

### Payment Details

<table>
<thead>
<tr>
<th>Amount</th>
<th>Receipt Number</th>
<th>Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash / Blank Cheque / Money Order</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Credit Card / EFTPOS</td>
<td>$</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 _______ /___ / ___
(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

**Admitted Patient - estimate of cost and agreement to pay**
**Medicare Ineligible - Asylum seeker**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Date</th>
</tr>
</thead>
<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 my insurer will pay. If any amounts my insurer refuses to pay, I/ myself or my insurer, will be responsible.

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>$855</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>Other</td>
<td>Summary fees and charges</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 rate or procedures: if more than space allows, attach detail or record over page

<table>
<thead>
<tr>
<th>Date</th>
<th>Step / Procedures</th>
<th>MBS Item #</th>
<th>MBS Rate</th>
</tr>
</thead>
</table>

Payment details

<table>
<thead>
<tr>
<th>Amount</th>
<th>Receipt Number</th>
<th>Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash/Bank Cheque/Money Order</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Credit card / EFTPOS</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

*This form is for site/patient records only.

92(8/12/16)
(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

<table>
<thead>
<tr>
<th>Facility</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Information and declaration (to be complete by or on behalf of the patient)

<table>
<thead>
<tr>
<th>Patient name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overseas Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (local)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Passport Number</th>
<th>Consent [YES / NO]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As a Medicare Ineligible patient I understand I am responsible for all expenses associated with my presentation. I agree to pay in advance or prior to discharge by (tick one)

- [ ] Cash / bank cheque / money order / Eftpos
- [ ] Credit card

I authorize NSW Health to bill my credit card for any clinical, diagnostic and other services such as drug costs and equipment purchased for my presentation.

<table>
<thead>
<tr>
<th>Card Number</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name printed on card:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardholder / patient signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 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 A &amp; P psychiatric Hospital</td>
<td>$99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient A &amp; P public clinic</td>
<td>$133</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient O&amp;M – PRNP – AMA rate</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microsurgical setting – AMA rate</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy or aids (crutches, immobilisers, etc)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMA Services – Imaging and Minor Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Payment Details

<table>
<thead>
<tr>
<th>Mode 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 not eligible for Medicare and 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."
Execution of the Guarantee

Once a person has agreed to sign the Guarantee, you should state:

\[ \text{You understand that you are not obliged in any way to provide the Guarantee and may decline to do so.} \]

\[ \text{You confirm that you have read and understood this document.} \]

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;✓&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>
<tbody>
<tr>
<td>Does the translator certify that they have faithfully translated what has been said and the contents of any documents?</td>
<td>I certify I have faithfully translated any conversations and documents.</td>
<td>Translator Signature</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>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.</td>
<td>Translator Signature</td>
<td></td>
</tr>
</tbody>
</table>
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

Important Notice to the Guarantor

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] Alt 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] (Alt a/the Guarantor)</td>
</tr>
<tr>
<td>Details of Guarantor [complete only if there is a second 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>

THIS DEED is made on [year] between the Provider and the Guarantor.

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>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>
<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>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<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>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>
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<td>ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.</td>
</tr>
<tr>
<td><strong>Republic of Ireland:</strong></td>
<td>Must show a current Republic of Ireland passport. Not eligible for a RHCA Medicare card</td>
<td>ELIGIBLE for PUBLIC HOSPITAL ONLY, as long as the conditions to the left are met.</td>
<td>NOT ELIGIBLE</td>
<td>NOT ELIGIBLE</td>
<td>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td><strong>Italy:</strong></td>
<td>Must show a current Italian passport showing visitor is a Citizen of Italy (resident is not sufficient) EXCLUDES maintenance dialysis</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>
</tr>
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</tr>
<tr>
<td>Malta:</td>
<td>Must show a current passport issued in Malta showing visitor is a Citizen of Malta (resident is not sufficient) EXCLUDES maintenance dialysis</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>ELIGIBLE for full Medicare coverage</td>
</tr>
<tr>
<td>Sweden:</td>
<td>Must show a current Swedish passport and a valid Swedish National Board of Student Aid (CSN International) card</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>
</tr>
<tr>
<td>Belgium:</td>
<td>Must show a current Belgian passport and a current European Union Health Insurance card</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>
</tr>
<tr>
<td>Finland:</td>
<td>Must show a current passport issued in Finland. EXCLUDES maintenance dialysis</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>
</tr>
<tr>
<td>Norway:</td>
<td>Must show a current Norwegian passport</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>
</tr>
<tr>
<td>Slovenia:</td>
<td>Must show a current Slovenian passport and a current European Union Health Insurance card</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>
</tr>
<tr>
<td>Netherlands:</td>
<td>Must show a current Dutch / Netherlands passport and a current European Union Health Insurance card</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>
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</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

) 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).................................................
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)  /________/____
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.
(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 .../.../....
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>
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<tr>
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<tr>
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<td>NO CHARGE</td>
<td>NO CHARGE</td>
<td></td>
</tr>
<tr>
<td>VISITING DIAGNOSTICIANS</td>
<td>NO CHARGE</td>
<td>NO CHARGE</td>
<td>NO CHARGE</td>
<td></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.
**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:  
- [ ] PRIVATE (Chargeable) Patient  
- [ ] HOSPITAL (Non-Chargeable) Patient

( Signature ) / / ( Date )

( Name of person signing if not patient ) 7 (9/90)
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
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)......................
DAY ONLY PROCEDURES MANUAL

SEPTEMBER 1999

COMMONWEALTH DEPARTMENT OF HEALTH & AGED CARE
CONTENTS

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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
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><strong>Band</strong></th>
<th><strong>Description</strong></th>
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<tbody>
<tr>
<td>(i) <strong>Band 1</strong></td>
<td>which includes gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic.</td>
</tr>
<tr>
<td>(a)</td>
<td>is a definitive list of procedures with no flexibility for re-classifications to another band</td>
</tr>
<tr>
<td>(b)</td>
<td>professional attention that embraces all other day only admission to hospital not related to Bands 2, 3, or 4.</td>
</tr>
<tr>
<td>(ii) <strong>Band 2</strong></td>
<td>means procedures (other than Band 1) carried out under local anaesthetic, no sedation.</td>
</tr>
<tr>
<td>(iii) <strong>Band 3</strong></td>
<td>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) <strong>Band 4</strong></td>
<td>means procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time one hour or more.</td>
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</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 out-patient, 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>Health Systems Strategy Branch</td>
</tr>
<tr>
<td>NSW Department of Health</td>
<td>Queensland Health Department</td>
</tr>
<tr>
<td>Locked Bag 96l</td>
<td>7th Floor, State Health Building</td>
</tr>
<tr>
<td>NORTH SYDNEY NSW 2059</td>
<td>147-163 Charlotte Street</td>
</tr>
<tr>
<td>Ph 02 9391 9469</td>
<td>BRISBANE QLD 4000</td>
</tr>
<tr>
<td>Fax 02 9391 9615</td>
<td>Ph (07) 3234 1030</td>
</tr>
<tr>
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<td>Fax (07) 3234 1494</td>
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<thead>
<tr>
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<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>
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<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>
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<table>
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<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 0811</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>
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.
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

<table>
<thead>
<tr>
<th>Day Only Procedures</th>
<th>Day Hospital Based Building</th>
<th>Day Hospital Based Building</th>
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</table>

1. Patient Name:

2. Date of Service:

3. Day Only Procedure:

4. Over Night Stay Admit Date:

5. Over Night Stay Dismiss Date:

6. Operation Date:

7. Operation Time:

8. Name of Operating Surgeon:

9. Nature of Procedure:

10. Diagnosis:

11. Preoperative Medications:

12. Postoperative Medications:

13. Postoperative Complications:

14. Discharge Date:

15. Discharge Diagnosis:

16. Discharge Medications:

17. Discharge Activities:

18. Discharge Disposition:

19. Discharge Instructions:

20. Discharge Comments:

21. Original Health Fund Code:

22. Outpatient Based Facility:

33(5/00)
SECTION THREE TABLE OF CONTENTS

NIL

SEE DOHRS MANUALS
PUBLIC HEALTH ORGANISATIONS CHARGES FOR SURGICALLY IMPLANTABLE PROSTHeses AND MEDICAL DEVICES (PD2006_008)

Fees chargeable in respect of prostheses used in Public health organisations.

PD2006_008 rescinds PD2005_638.

Following ongoing negotiations between all States/Territories and Private Health Funds, it has been agreed by all parties to vary the benefit paid for cardio-thoracic and ophthalmic items as from 1 January 2006.

1. Background and Aims of the Commonwealth’s Prostheses Reforms

The Commonwealth Government recently passed a number of significant amendments to the National Health Act 1953 in respect to prostheses (National Health Amendment (Prostheses) Act 2005). The amendments regulate the benefits paid for prostheses and medical devices by private health funds to hospitals for private patients. It also permits the introduction of co-payments for private patients utilising some high cost prostheses.

The Minister for Health and Ageing has made a Determination (HIB 18/2005) under subsections 73AAG(6) and (7) of the National Health Act 1953 giving effect to the first prostheses list under the new arrangements for listing of products and setting benefits (“Prostheses List”).

2. Adoption by NSW of the Commonwealth’s Prostheses List

The NSW Minister for Health has adopted the Commonwealth’s scheduled benefits for items on the Prostheses List as the relevant fees and charges for the fitting of prostheses on the Prostheses List for public hospitals in New South Wales.

3. Commencement Date

The Prostheses List is effective from 31 October 2005 when the new arrangements commence ie applicable for prostheses and medical devices implanted on or after 31 October 2005.

However, commencing from 1 January 2006 a discount will be applicable to the Prostheses List for any cardio-thoracic or ophthalmic prosthetic claim for reimbursement processed from that date, subject to the conditions outlined in Clause 4 below.

4. Determination of the Prosthesis Benefit Level to be Charged

- Prostheses with Minimum Benefit Level Only

  For items with a minimum benefit only, (other than Cardio-thoracic and Ophthalmic items [as described under Categories in the Prostheses List]), the fee charged will be the minimum benefit. No invoices required.

  For Cardio-thoracic items on the list a discount of 7.5% applies and for Ophthalmic items on the List a discount of 20% applies. No invoices required.

45(11/07)
If a public hospital is unable to procure any cardio-thoracic or ophthalmic items on the Prostheses List at or below the agreed % discount from the Prostheses List minimum benefit, then that hospital may provide a supplier invoice to the relevant health fund for reimbursement. The health fund under the current legislation is able to pay a benefit for that prosthesis up to the minimum benefit level listed on the Prostheses list. Given the additional administrative and financial cost of procuring and sending an invoice to a fund, it is expected that hospitals will only provide an invoice where the cost is significantly above the discount level.

- Prostheses with Maximum/Minimum Benefit Level

Certain items on the Prostheses List have a maximum and minimum benefit. The maximum charge for these prostheses is the maximum benefit level.

Reimbursement from health funds above the minimum benefit is at the discretion of health funds.

Any prostheses charge above the benefit level paid by the health fund, will be the private patient’s responsibility. Therefore the public health organisation will need to ascertain from the relevant health fund for each prosthesis that has a maximum benefit, what benefit level above the minimum, if any, the health fund will pay. Note that discounts still apply to the minimum benefit level for cardio-thoracic and ophthalmic items as outlined above.

Public health organisations must comply with this Policy Directive with respect to charging for Prostheses on the Prostheses List and are required to cease other charging practices with private health funds such as charging the supplier invoice price for prostheses on the Prostheses List except in exceptional circumstances as outlined above.

For items that are not on the Prostheses List current charging arrangements remain.

5. Categories of Patients to be Billed

Hospitals are to ensure that the following categories of patients are billed:
- chargeable patients including day - only (with the exception of compensable patients);
- ineligible patients;
- DVA eligible patients

Note that for DVA eligible patients, charges are to be raised directly against DVA for minimum benefit prostheses. However invoices must be supplied to the DVA where prostheses with a maximum benefit are used in the treatment of DVA patients.

6. Informed Financial Consent

Hospitals are to ensure that patients in billed categories (excluding DVA) provide informed financial consent prior to surgery, and in doing so, understand that they are liable for any charges not covered by their health insurer for any prostheses items.

Public health organisations will need to review the wording of information provided to private patients to ensure that it reflects these revised arrangements.

7. **Web Link for the Latest Prostheses List**

The NSW Department of Health will continue to notify public hospitals of the effective date of future revised determinations and related information from the Commonwealth. However it remains the responsibility of the public health organisation to:

i. obtain all determination revisions directly from the Commonwealth (by accessing Commonwealth Circulars on their website [http://www.health.gov.au](http://www.health.gov.au); and

MORE INFORMATION ON INTERIM DISPUTE RESOLUTION PROCESS FOR ITEMS ON SCHEDULE 5 – BENEFITS PAYABLE FOR SURGICALLY IMPLANTED PROSTHESES, HUMAN TISSUE ITEMS AND OTHER MEDICAL DEVICES

At the commencement of deregulation, a process to resolve disputes on prices for items included on Schedule 5 – Benefits Payable for Surgically Implanted Prostheses, Human Tissue Items and Other Medical Devices (Prostheses Schedule) was established. Parties could approach the Private Health Insurance Ombudsman (PHIO) for his assistance in resolving the dispute. This process was intended to apply during the transitional period to the new arrangements, in the early stages of deregulation only. The Ombudsman considered a number of disputes and actively intervened in five during 2001.

Concerns continue to be expressed by the parties about avenues available to them to resolve disputes over prices. New arrangements for dispute resolution will be considered in the context of the Strategic Review of the Prostheses Arrangements that is presently underway.

At the industry’s request, the Department has put in place an interim dispute resolution process for items that have outstanding price agreements. The process involves an approach to the Department, on a voluntary basis by any of the parties, to request that the Department appoint an independent conciliator. Any agreement reached on item price resulting from the conciliation process will not be binding on the parties.

The process is to be used as a last resort only when agreement on item price cannot be reached and setting the price on a case by case basis is not appropriate due to volume. It will be appropriate only when all other avenues for reaching agreement on prices have been exhausted.

The steps in the process will be as follows:

- The parties may voluntarily agree to approach the Department to facilitate conciliation action.
- In this event, the Department will:
  1. require agreement from the parties to the payment of costs for the conciliator and the Department’s administration of the conciliation process (to be shared equally between the parties);
  2. engage a commercial conciliator to assist the parties to reach agreement on item price; and
  3. following conciliation, take action to recoup costs incurred during the conciliation process from the parties involved in the dispute, with costs shared in equal measure between the parties.

The interim process becomes effective immediately and will apply until new arrangements determined through the Strategic Review process are implemented.

In order to ascertain the extent of the problem, the Department will also be requesting information from (i) health funds and (ii) suppliers on items that are outstanding. For the February 2002 Schedule, the Department will request information from the parties showing the status of negotiations for all items on the Schedule that are genuinely in dispute as at cob 31 May 2002 (there will be no requirement to agree prices for items where suppliers and health funds agree that they can be negotiated on a case by case basis).

Please contact Catherine Rostron on (02) 6289 9462 or e-mail catherine.rostron@health.gov.au if you have any questions about this process, or e-mail the enquiry to Prostheses@health.gov.au

Perry Sperling
Assistant Secretary
Private Health Industry Branch
(authorised by P Sperling for electronic transmission)
13 March 2002
AIDS AND APPLIANCES

Following consultations with industry throughout 2000, and as previously advised in circulars HBF 668 PH/412 and HBF 678/PH 421 the list will only be distributed electronically in a new Access database format.

The new format was designed in consultation with industry to facilitate and assist new arrangements. The new format provides specific details for each item which will allow transparent identification of the item to a billing code. The names of some items have been changed for consistency with the Australian Register of Therapeutic Goods (ARTG). Each item is listed under the Therapeutic Goods Administration recognised sponsor and the relevant approval number (AustL or AustR) from the ARTG.

DETAILS EXPLAINING SECTIONS OF THE NEW DATABASE

For details of the different fields contained in the database please refer to circular HBF 678/PH 421 which contains the final report explaining the format of the database.

THE BILLING CODE

The billing code being used in the new format is a five-character code, the first two characters are alphabetical letters that identify the TGA recognised sponsor of the item, and the following three characters are numbers that identify each item.

The TGA recognised sponsor and the letters of the code that specifically identify them are included in the new Access database. The list of sponsor identifiers is found in the Report section of the new database, the report is labelled “Sponsors List”.

Please be aware that billing codes are tied specifically to the TGA sponsor identified in the code and are not for use by other companies. If a company is a distributor for the TGA recognised sponsor then they will require authorisation from the TGA recognised sponsor to use their codes. Where the code identifier is different from the company supplying the goods it is advisable that hospitals request evidence that they are authorised to do so by the identified sponsor.

Each item on Schedule 5 is coded so that it can be assigned a separate fee or charge. If a sponsor has indicated that they would like to charge a different fee or charge for different sized items then a different billing code will have to be allocated for each different fee or charge.

To help identify items during this changeover period, the billing code that was used prior to 2001 will also be included on the new Access database throughout 2001. This is to allow all stakeholders time to adjust their systems and assist you in linking items to new billing codes.

All items have been allocated a new single billing code that will be used by both the Private Health industry and the Department of Veterans’ Affairs. Previously there were two separate sets of codes. This will reduce the administrative burden on stakeholders.

THE ITEM NAME

Each billing code has a detailed description of the item(s) that are sold against that code. The revised naming of item(s) on the list will significantly reduce ambiguity as to which item(s) belong to which code.
As previously advised in circular HBF 687/PH427 hospitals will need to check their stock against specific billing codes to ensure they are correctly listed against the new codes as a significant number of items may have been deleted from the list and this will have obvious implications for hospital outlays. Items were deleted because they were not included on the ARTG, the item was obsolete, or because the manufacturer/supplier/sponsor requested the deletion.

If an item is implanted that was previously on the list and the hospital has not done a stocktake to check whether it is funded, then the hospital will be unable to pass the charge onto the patient as under the new arrangements there can be no patient gap.

Checking current stock against the new code and its description will avoid hospitals being in the position of implanting a non-rebatable device and thus not being eligible for a benefit. In this regard we remind all stakeholders there is no-gap payable by the patient.

Hospitals and manufacturers/suppliers/sponsors should note the legal implications of inaccurate use of billing codes. As hospitals are the agent that generally bill health funds, they will need to ensure their staff ensure correct billing codes are used.

Health funds are encouraged to check that item descriptions match the billing code, and manufacturers/suppliers/sponsors will also need to ensure accurate billing codes are supplied to hospitals.

All of Industry would be aware of the recent advice to the industry advising them of the serious nature of purposeful code misuse.

**THERAPEUTIC GOODS ADMINISTRATION (TGA) APPROVAL**

The TGA approval of all items on Schedule 5 has now been checked. The Aust L or the Aust R number of each item is contained in the database.

**SEARCHING ON THE NEW DATABASE**

The database contains detailed information of items; double clicking on the appropriately labelled button can access this information.

For assistance with the search functions provided. Open the Access database. Once an Appendix, either A or B is open, double click on the button labelled ‘Help on searching or filtering’ to access a manual to explain the different search options available.

**ITEMS NOT CONSIDERED PROSTHESES**

As industry is aware a review was undertaken to ensure that all items included in Appendix A met the departmental criteria for prostheses items. The review was able to identify many items that do not meet the departmental criteria for prostheses and these items are now targeted for deletion from Appendix A.

However, while checking the specific details of items for the new database it has become apparent that there may be further items that do not meet the departmental guidelines for prostheses and could be considered for inclusion on Appendix C - Other Medical Devices. The Department will be undertaking a further review to identify these items to refer them to the Expert Committee for possible deletion.
You will recall that the Department has given an undertaking to manufacturers/suppliers to give them six months notice prior to deleting items from Schedule 5.

**DEREGULATION OF THE BENEFIT LEVELS FOR PROSTHESSES ITEMS**

As previously outlined in Circular HBF 589/PH 345, HBF 651/PH 398, HBF 656/PH 403, HBF 667/PH 411, HBF 684/PH 425 and HBF 687/PH 427 full deregulation of the benefit level for Appendix A is effective as at 28 February 2001. As the benefit level is now deregulated there is no price field in the new database.

Under the new arrangements the benefit level is negotiated and agreed to between the health fund and the manufacturer/supplier/hospital, and clinical choice remains with the clinician in consultation with the patient.

As stated above, we advise health funds to negotiate only one benefit level for each item listed.

We also remind hospitals, manufacturers/suppliers and health funds that there can be no inadvertent introduction of a patient gap.

As payment of accounts should be within 2 months (Schedule l, paragraph (n) of the *National Health Act 1953*), under the determination health funds and manufacturer’s/suppliers must advise hospitals of the agreed fee or charge payable for prostheses within two weeks of the effective date. The health funds and the manufacturer/supplier will need to ensure that hospitals are informed of any changes to the agreed fee or charge.

We encourage industry to continue working together to ensure a smooth transition to the arrangements.

**SUPPLY CHARGE**

We remind the industry that the supply charge is an integral component of the benefit level, and where it has been incurred must be paid.

**DISPUTE RESOLUTION PROCESS**

Paragraph 5 of circular HBF 687/PH 427 outlines dispute resolution arrangements. We understand the Ombudsman will be advising the industry separately of his process should there be a dispute.

**TRANSITIONAL ARRANGEMENTS COMMITTEE**

A Transitional Arrangements Committee will be established to provide a forum for industry stakeholders and the Private Health Industry Ombudsman to raise difficulties being experienced with process issues associated with deregulation.

The Transitional Arrangements Committee will help establish communication channels between stakeholders and facilitate a smooth transition to industry acceptance of deregulation. The Committee will provide a forum for stakeholders to discuss, propose and recommend solutions to any difficulties, to work together to implement the recommendations within the industry and to facilitate new arrangement implementation.
The Committee will be a temporary committee, established for a set period of time - six months (until the distribution of the August edition of Schedule 5), and will consist of health fund representatives, manufacturer/supplier and private hospital representatives.

The Department will also have a representative present at Committee meetings as an adviser, but not as a member of the Committee.

It should be noted that the Committee is an industry working Committee and will not be able to change the arrangements, set benefit levels, or negotiate the actual price of items.

ITEMS WITH THERAPEUTIC GOODS ADMINISTRATION IPU’s, AUA’s AND CUSTOM MADE ITEMS

For items to be included on Appendix A they must meet the departmental criterion for Schedule 5. One of the departmental criterion for listing is that the item is listed on the ARTG. Medical Practitioners, in consultation with the patient, may choose an item that is custom made and is therefore exempt from listing on the ARTG, or an item that requires specific individual approval (IPU’s and AUA’s) from TGA may be used. These items are not eligible for inclusion on Schedule 5 as they are not listed on the ARTG and therefore health funds are not bound to fund them.

Items that are custom made differ from customised items in that custom-made items are specifically manufactured for the patients’ measurements/requirements. Customised items, which are listed on the ARTG usually under a ‘various’ listing, are items which are sold by the manufacturer/supplier/sponsor in a basic form and then subsequently altered/modified by the clinician. Customised items that meet all departmental criteria, which includes being registered on the ARTG are included on Schedule 5.

Health funds are free to choose to make discretionary payments for items that are not included on Schedule 5. The Department encourages health funds to assess each case on its merits and would strongly support a decision by a health fund to fund items that have been chosen for patients purely for clinical reasons provided those items are similar to items included on Appendix A. An example is custom made items that are exempt from listing on the Australian Register of Therapeutic Goods, these items include implantable facial prostheses that have been custom made for a specific patient. These are similar to facial implants included on Schedule 5 and therefore we would recommend reimbursement.

This approach by health funds would be consistent with the Government’s objective of providing quality care, which increases the value in the health insurance product and treats all contributors in an equitable manner.

BENEFIT PAYABLE FOR HUMAN TISSUE ITEMS

Human Tissue items arrangements are unchanged. The benefit payable for all items is specified in the amount field of Appendix B.

CONTACT DETAILS OF THE PROSTHESES TEAM

To facilitate communications with the Prostheses team who manage the list we have established an electronic mailbox with the e-mail address:

prostheses@health.gov.au
This mailbox is directly accessed by the prostheses team and will ensure that your enquires will be answered promptly.

**COPIES OF SCHEDULE 5**

Copies of the February 2001 Schedule 5 Circular HBF 692/PH 431 are only available on the internet. As previously advised in Circulars HBF 618/PH 372, HBF 651/PH 398 and HBF 656/PH 403, Schedule 5 circulars will not be available on disc or in hard copy.

The internet address for HBF/PH circulars is:


If you require further information please telephone: (02) 6289 7406/24 hr answering machine or E-Mail the enquiry to his@health.gov.au


Private Health Industry Branch

Date
I, PETER CALLANAN, delegate of the Minister for Health and Aged Care, acting pursuant to paragraph (bj) of Schedule I to the *National Health Act 1953* (the Act),

AMEND with effect from 28 February 2001, the determination made under paragraph (bj) of Schedule I to the Act dated 30 June 1999 (determination number IHS7/1999) by OMITTING Schedule 5 of that determination and SUBSTITUTING the attached Schedule 5.

Dated this day of 2001.

Peter Callanan
Delegate of the Minister for Health and Aged Care
SCHEDULE 5 - SURGICALLY IMPLANTED PROSTHESES AND HUMAN TISSUE ITEMS

5.1 This Schedule sets out the surgically implanted prostheses items and human tissue items provided to a private patient of a hospital or day hospital facility for which benefits must be paid. Clinical choice remains a matter between the doctor and the patient and is not to be influenced by the manufacturer or the Registered Health Benefits Organisation (Registered Organisation).

5.2 In this Schedule:

"human tissue items" means the items contained in the item field of Appendix B;

"supply charge" means a charge imposed by the hospital that is no more than 10% of the fee or charge agreed in paragraph 5.3(a). The supply charge can only cover the costs incurred by the hospital in relation to instrument kit hire, account processing, associated item storage, freight and sterilisation;

"surgically implanted prostheses" means the items contained in Appendix A.

Surgically implanted prostheses

5.3 The level of benefit payable in respect of a surgically implanted prostheses specified in Appendix A, is:

(a) the fee or charge agreed between the manufacturer/supplier/hospital and the Registered Organisation; and

(2) any supply charge.

Note: Other than the fees or charges and the supply charge permitted under this clause, no additional charges can be imposed on a patient by a manufacturer/supplier/hospital or a Registered Organisation.

5.4 If the benefit agreed under paragraph 5.3(a) is not agreed between the Registered Organisation and the patient’s hospital, then the Registered Organisation and the appropriate manufacturer/supplier will advise hospitals of the agreed benefit level payable for prostheses (Appendix A) within two weeks of the date of effect of this determination. The Registered Organisation and the manufacturer/supplier will ensure that the hospital is informed of any changes to the agreed benefit levels.

5.5 If the Registered Organisation cannot agree with the manufacturer/supplier/hospital on a fee or charge in accordance with paragraph 5.3(a), then the matter should be referred to the Private Health Insurance Ombudsman. The Ombudsman may recommend an appropriate fee or charge. If parties do not agree with the recommendation of the Ombudsman, then the dispute should be referred to the Minister and the Minister or the delegate of the Minister will determine the benefit payable for the item in dispute.
Human tissue items

5.6 The level of benefit payable in respect of a human tissue item specified in the item field of Appendix B provided by the organization specified in the facility field is the amount specified in the amount field corresponding to that item.

Notes: The organizations specified in the facility field of Appendix B must comply with any applicable State and Territory laws governing processing and manufacture of human tissue items.

Other than the fees or charges permitted under this clause, no additional charges can be imposed on a patient by a manufacturer/supplier/hospital or a Registered Organisation.
EnableNSW – ASSISTIVE TECHNOLOGY FOR COMMUNICATION, MOBILITY, RESPIRATORY FUNCTION & SELF-CARE (PD2011_027)

PD2011_027 rescinds PD2011_023.

PURPOSE

EnableNSW provides appropriate assistive technology devices and specialised support services to assist eligible residents of NSW with a permanent or long-term disability to live and participate in their family and community.

EnableNSW is a unit within Health Support Services, NSW Health, which was established to provide central administration of the services previously administered through the following NSW Health disability support programs:

- Program of Appliances for Disabled People (PADP)
- Home Respiratory Program (HRP)
- Adult Home Ventilation Program (AHVP)
- Children’s Home Ventilation Program (CHVP)
- Prosthetic Limb Service (PLS).

This policy has been developed in the context of the transition of the NSW Health disability support programs from administration by the former Area Health Services to consolidated state-wide administration under EnableNSW.

This policy introduces the role of EnableNSW and the establishment of the EnableNSW Advisory Council; updates terminology, organisational arrangements and financial eligibility criteria; and refers to new Prescription and Provision Guidelines for different categories of assistive technology.

MANDATORY REQUIREMENTS

All EnableNSW staff and other relevant NSW Health staff must comply with this policy directive and apply the updated financial eligibility criteria, except where stated otherwise in the policy directive.

IMPLEMENTATION

The attached policy procedures provide guidance to assist in processing applications and determining requests for EnableNSW services for people with permanent or long-term disability.

The Chief Executive, Health Support Services is to ensure that the requirements of this policy are communicated to all EnableNSW staff that have responsibility for implementing this policy.

The Local Health Network Chief Executives are responsible for ensuring that this policy is circulated to all clinical staff that need to be aware of the policy content (this includes allied health, medical and nursing staff).
1. INTRODUCTION

1.1 Introduction

This policy provides direction for staff of Health Support Services and other relevant staff for the effective management of EnableNSW services. This policy applies to all consumers of EnableNSW services, from the date of issue.

EnableNSW is a division of Health Support Services, NSW Health which was established to administer the NSW Health support programs for people with disability.

The services provided through EnableNSW were previously provided through the following five programs:

- Program of Appliances for Disabled People (PADP), including Specialised Equipment Essential for Discharge (SEED),
- Home Respiratory program (HRP),
- Adult Home Ventilation Program (AHVP),
- Children’s Home Ventilation Program (CHVP) and
- Prosthetic Limb Service (PLS)

These programs, now known collectively as the EnableNSW services, have been transitioned from administration by the former Area Health Services to central administration under EnableNSW.

1.2 Objectives of EnableNSW Services

The primary objectives of the EnableNSW services are:

a) to assist eligible residents of NSW, who have a permanent or long-term disability, to live and participate in their family and community, by providing appropriate assistive technology and specialised support services in the areas of core communication, mobility, respiratory function and self-care;

b) to ensure equity of access to assistive technology based on individual needs;

c) to provide effective management of available resources by providing devices or support that are cost-effective and meet the assessed functional need;

d) to provide timely, courteous and efficient service to consumers; and

to work in collaboration, wherever possible, with other State and Commonwealth government services and non-government organisations to promote continuity of care.

1.3 Information about EnableNSW

EnableNSW is responsible for disseminating information about its services on a state-wide basis.

EnableNSW utilises a variety of media to raise public awareness of its services, including posters, website details, fact sheets and cards.

Information regarding operational aspects of the EnableNSW services is available on the EnableNSW website: www.enable.health.nsw.gov.au. This includes information on topics such as what devices are provided through EnableNSW, how to submit an application through to how to provide feedback or lodge a complaint.
Consumers who do not have access to the internet can contact the Service Centre by phone and request that copies of this information be sent to them.

A free call information service is available on 1800 ENABLE (1800 362 253). People of linguistically diverse backgrounds may utilise the Telephone Interpreter Service on 131 450 when making inquiries to the EnableNSW free call service.

Fact sheets are available in common community languages for consumers from a culturally and linguistically diverse background. They are also available in HTML for consumers who use screen reader software.

**Related Documents**

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<td>• NSW Health PD2015_020, Lifetime Care and Support Scheme (LTCS Scheme) - Charging Policy and Rates for Designated Units</td>
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<td>• NSW Health, PD2012_070, Isolated Patient Travel &amp; Accommodation Assistance Scheme Policy Framework</td>
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<td>• NSW Health, GL2008_006, Amputee Care - The Use of Post-Operative Rigid Dressings for Trans-Tibial Amputees</td>
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2. **ELIGIBILITY**

2.1 **Eligibility Criteria**

The following criteria apply to all applications for EnableNSW services:

- the person is a permanent resident of NSW, or a refugee residing in NSW;
- the person has a permanent or long-term disability (i.e. a disability likely to last more than 12 months regardless of the cause of the disability);
- the person has long-term assistive technology needs that have stabilised and allow them to remain in a community setting;
- the person has not received compensation or damages in respect of the disability for which the assistive technology device or support is required; and
- the person is not eligible to receive the assistive technology under any other government-funded program.

56(21/04/11)
2.2 Ineligible Groups

EnableNSW excludes the provision of assistive technology and specialised support services that can be funded from other government programs or from other sources.

The following groups are ineligible to receive assistance under EnableNSW:

- People who are resident in a group home operated by Ageing, Disability and Home Care (ADHC) as the Department of Family and Community Services is responsible for the provision of assistive technology for clients living in the accommodation services it operates. This is done through the program known as Aids for Individuals in DADHC Accommodation Services (AIDAS).

- Patients who require assistive technology on a temporary or short-term basis either as part of a treatment intervention for an acute or chronic care episode, or whilst an acute illness or injury is resolving. This assistance is provided by the treating hospital or Local Health Network Equipment Loan Pool. Exceptions to this are oxygen and some respiratory devices, however, in the case of patients who need oxygen equipment, the discharging hospital is required to supply the first month of oxygen supply post-discharge.

- Patients with far advanced progressive disease, including cancer, HIV/AIDS, end stage respiratory disease, cardiac and liver disease, or any other palliative care group, as hospitals are required to provide equipment for palliative care on loan for short-term use (approximately three months).

- People who have received compensation or damages in respect of the disability for which the assistive technology has been prescribed. In exceptional circumstances where an applicant has received a compensation payment, some years have elapsed since receipt of the payment, and the applicant is able to demonstrate financial hardship, discretion may be exercised to provide assistance under EnableNSW.

- People receiving Commonwealth-funded aged care services: People who live in a residential aged care facility (RACF) or who qualify for an Extended Aged Care at Home (EACH) or Extended Aged Care at Home - Dementia (EACH-D) package. This group may be eligible for devices such as prosthetic limbs and power wheelchairs through EnableNSW.

- Younger people with disability who are approved for assistance under the Younger People in Residential Aged Care program (YPIRAC) should apply to Ageing, Disability and Home Care (ADHC), Department of Family and Community Services, to establish their eligibility for assistive technology under that program. Under an internal agreement between ADHC and NSW Health, EnableNSW administers the equipment provision for approved YPIRAC clients after their equipment needs have been assessed and recommended.

In exceptional circumstances, discretion may be exercised by the Manager, EnableNSW to approve an application that otherwise does not meet the eligibility criteria.

Consumers with private health insurance are required to ascertain whether their health fund will cover all, or part, of the cost of the prescribed device, before they apply to EnableNSW, in which case EnableNSW will fund the gap.

2.3 Equitable Access

Eligible consumers of EnableNSW services can expect fair and equitable access, wherever they live in NSW and regardless of their cultural or linguistic background.
EnableNSW needs to be aware of the barriers that may impede access to services for Aboriginal people and people from culturally and linguistically diverse backgrounds. This is particularly important in rural areas of NSW where communities may be small and isolated from other community support structures.

The EnableNSW Service Centre will take a pro-active and collaborative approach to the delivery of services to Aboriginal and multicultural communities. Statistics on the extent to which EnableNSW services are utilised by these target groups will be collected and used to guide the development of future strategies designed to improve access for these communities. Multicultural Health Managers, Aboriginal Health Managers and Aboriginal Medical Services may be of assistance in the development of strategies designed to improve access to EnableNSW services.

2.4 Financial Criteria

As a service directed to people who are financially disadvantaged, access to EnableNSW is means tested for adults for most categories of assistive technology. Children up to the age of 16 years with a long-term disability are eligible for EnableNSW, regardless of parental income.

The EnableNSW income bands for all assistive technology devices, except prosthetic limbs, are based on the former PADP income bands and allowances, with adjustments for increases in the Australian Consumer Price Index since December 1998. No changes have been made to the level of consumer co-payments.

The EnableNSW income bands for prosthetic limbs remain the same as the previous criteria for the Prosthetic Limb Service.

2.5 Income Bands and Consumer Co-payments

Table 1: EnableNSW Income Bands for all assistive technology devices except for prosthetic limbs

| Band 1 – Adults on full pension and children under 16 years | $100 each year accessing services |
| Band 2 – up to $42,000 (single) or $70,000 (couple) + $2,100 per dependent | $100 each year accessing services |
| Band 3 – above $42,000 (single) or $70,000 (couple) + $2,100 per dependent | 20% of devices costing $800 and above. N.B. Consumers in Band 3 are not eligible for devices under $800. |
Table 1: EnableNSW Income Bands for all assistive technology devices except prosthetic limbs

**Band 1:**
Adults in receipt of a full pension from Centrelink and all children aged up to 16 years of age are eligible as Band 1 consumers.

For the purpose of establishing financial eligibility for Band 1, a pensioner is defined as a person who holds a Centrelink Pensioner Concession Card. Other concession cards, such as the Commonwealth Seniors Health Care Card, or the NSW Seniors Card, are not sufficient. Receipt of Mobility Allowance alone will not qualify a person for Band 1.

In the case of refugees, an interim concession card or a letter issued by Centrelink must be produced.

In the case of people receiving an overseas pension, evidence of pension entitlement from Centrelink must be produced.

Consumers in Band 1 are eligible to receive assistance for all devices costing over $100.

Consumers in Band 1 are required to pay a $100 co-payment per annum for any year in which they receive assistance, including assistance with repairs and maintenance.

**Band 2:**
Adults aged 16 years and above whose taxable income in the preceding financial year was less than or equal to $42,000 (single) or $70,000 (couple or family) are eligible as Band 2 consumers. A further $2,100 per dependent person is to be added to the single and family income figures for applicants with dependents.

Consumers in Band 2 are eligible to receive assistance for all devices costing over $100.

Consumers in Band 2 are required to pay a $100 co-payment per annum for any year in which they receive assistance, including assistance with repairs and maintenance.

**Band 3:**
Adults aged 16 years and above whose taxable income in the preceding financial year was above $42,000 (single) or $70,000 (couple or family), with adjustments of $2,100 per dependent, are eligible to apply for high cost items (over $800) only.

Consumers in Band 3 are only eligible to receive assistance for high cost devices over $800 and are required to pay 20% of the cost of the device.

Table 2: EnableNSW Income Bands for prosthetic limbs

| Band 1 – | Persons holding a valid Pensioner Concession Card, a valid Health Care Card or a valid Commonwealth Seniors Health Card | Nil |
| Band 2 – | All persons not holding valid Pensioner Concession Card, a valid Health Care Card or a valid Commonwealth Seniors Health Card | 15% of the scheduled cost of the provision, maintenance and repair of prostheses up to a maximum of $200 per financial year. |
Prosthetic Limbs - Band 1:
Consumers holding a valid Pensioner Concession Card, a valid Health Care Card or a valid Commonwealth Seniors Health Card.

No co-payment is required for consumers in this band receiving prosthetic limbs.

Prosthetic Limbs - Band 2:
All consumers who do not have a valid Pensioner Concession Card, a valid Health Care Card or a valid Commonwealth Seniors Health Card are assessed as Band 2.

Consumers in Band 2 receiving prosthetic limbs are required to pay 15% of the scheduled cost of the provision, maintenance and repair of their prostheses up to a maximum of $200 per financial year.

2.7 Validation of Income Band

An applicant’s income band is to be verified by the production of:
- A statement of full pension entitlement from Centrelink; or
- Copy of a Centrelink Pensioner Concession Card; or
- A valid Australian Taxation Office (ATO) Notice of Assessment for the preceding financial year.

Discretion may be applied in instances where an ATO Notice of Assessment is not available, for example, for some 16 year olds who have yet to be assessed and for newly-arrived migrants or refugees.

Consumers who are over 16 years of age and are applying for assistive technology devices other than prosthetic limbs are required to submit a valid ATO Notice of Assessment to establish access to the appropriate income band, including:

- Applicants with taxable incomes who are part-pensioners;
- Commonwealth Seniors Health Care Card holders; and
- Self-funded retirees.

Applicants who do not provide verification of income will be considered as a Band 3 consumer.

3. ASSISTANCE PROVIDED

3.1 Categories of Assistive Technology provided by EnableNSW

EnableNSW provides assistive technology devices in four categories:
- Communication;
- Mobility;
- Respiratory function; and
- Self-care.

A summary table of the assistive technology devices provided in each category is available at www.enable.health.nsw.gov.au.

Devices provided may be new or recycled.
The EnableNSW Prescription and Provision Guidelines have been developed in consultation with stakeholders and outline specific information regarding the functional and clinical criteria and the supply limits that apply for each device.

The Professional Criteria for Prescribers provides information about the professional qualification and level of experience required by eligible prescribers for each device.

These documents can be found at www.enable.health.nsw.gov.au.

EnableNSW provides the most cost-effective, clinically appropriate devices that meet a person’s assessed functional need and that are consistent with the EnableNSW Prescription and Provision Guidelines for those devices.

Devices provided must primarily promote long term functioning in the community, rather than provide treatment for acute and chronic care episodes, except for oxygen and some respiratory devices.

Where a consumer wishes to upgrade the device beyond that determined by the prescriber to meet their basic needs and approved by EnableNSW, they are required to pay the additional cost of that device.

The Chief Executive of Health Support Services may seek advice from an EnableNSW Appeal Panel and may exercise discretion regarding the provision of specific devices and quantities to be supplied when a request falls outside, or exceeds the supply limits in the relevant Prescription and Provision Guidelines.

### 3.2 General Exclusions

EnableNSW does not provide the following:
- Devices costing less than $100, unless approved as a recurrent consumable.
- Assistive technology devices that do not comply with Australian Standards where these exist or devices that are not registered with the Therapeutic Goods Administration, as applicable.
- Assistive technology devices primarily for sport, recreational, educational or employment purposes.
- Non-disability specific items that are commercially available.
- Installation of some items such as ceiling hoist tracking.
- Reimbursement for devices already purchased or for repairs completed without approval.
- Devices used for the administration of medications.

### 3.3 Accessing EnableNSW Services

Access to EnableNSW is based on assessed functional or clinical need by an eligible prescriber (see section 3.1). This involves the submission of an EnableNSW Application Form and an Equipment Request Form. Both forms must be submitted to determine eligibility and funding approval. Relevant forms are available at www.enable.health.nsw.gov.au.

The Application Form should be completed by the consumer or their representative. This form provides personal and demographic information and details of the consumer’s disability and is the basis for determining eligibility.

An Equipment Request Form must be completed by the relevant eligible prescriber. The request form provides information regarding the assessment and prescription of the assistive technology device/s recommended. This form is the basis for determining approval of the device/s to be funded.
3.4 Processing of Applications and Prioritisation of Requests

All completed applications and requests submitted to EnableNSW will be assessed for eligibility and consumers will be notified in writing of the outcome of their application.

Requests will be prioritised and EnableNSW will endeavour to give an indication of the time-frame for when the device will be funded.

The prioritisation process will give consideration to:

a) whether the device is necessary to maintain life or ensure safety of the consumer or carer and
b) whether the device is essential for a primary communication, mobility or self-care task.

Requests outside this criteria will be provided as funds become available.

3.5 Replacements and Repairs

Replacement devices require the submission of an equipment request form.

Replacement devices may be issued when:

- Assistive technology has worn out by natural use and is no longer usable;
- It is more economical to arrange for the supply of a new device rather than to arrange repairs;
- A consumer’s condition has altered to the point where replacement of the assistive technology is required.

EnableNSW provides assistance to meet the cost of regular servicing, maintenance and reasonable repairs to devices supplied by EnableNSW. No prescription is necessary for servicing, maintenance and repairs. Arrangements for the servicing, maintenance and repair of a device are to be made by the EnableNSW Service Centre.

EnableNSW will pay for repairs and maintenance costing $800 or more per financial year for consumers in Band 3, except for repairs to prosthetic limbs, which are provided free, upon approval of EnableNSW. Consumers with prosthetic limbs should contact the manufacturer regarding repairs and maintenance.

EnableNSW will provide repairs and maintenance to items and features that it has funded. Where the total device has been upgraded, the consumer is responsible for the repairs and maintenance for the device. Consumers must clarify in advance with EnableNSW their responsibilities for ongoing maintenance and repairs of discretionary features as these may not be covered.

EnableNSW may also assist with the cost of repairing a device supplied by another organisation, where the same or equivalent device would otherwise have been supplied by EnableNSW.

EnableNSW consumers are required to contact the EnableNSW Service Centre for approval of any regular maintenance and for any repairs to devices before these are undertaken. If an urgent repair is required out of office hours, consumers can arrange this however are required to notify EnableNSW on the next business day.
3.6 EnableNSW Service Centre Operating Hours

The EnableNSW Service Centre will be staffed during business hours from Monday to Friday.

Contact details for the Service Centre are:
E: enable@hss.health.nsw.gov.au
P: FreeCall 1800 ENABLE (1800 362 253).
Website: www.enable.health.nsw.gov.au

3.7 Ownership of Devices

Most devices issued through EnableNSW remain the property of NSW Health. Consumers are expected to return devices issued through EnableNSW when the devices are no longer required or being used.

NB: exceptions include prosthetic limbs, orthotic devices and special footwear which become the property of the consumer.

3.8 Change of Address

Consumers are required to notify the EnableNSW Service Centre of any change of address within NSW or to another State so that EnableNSW can update its records and negotiate transfer of ongoing responsibility for repairs and maintenance of devices.

3.9 Interstate Portability

Consumers planning to move interstate should notify EnableNSW in writing and request that their assistive technology be transferred to the other state’s aids and equipment scheme or to their ownership.

EnableNSW will not be responsible for ongoing repairs or maintenance for assistive technology devices taken interstate. EnableNSW will not pay the freight costs for assistive technology to be taken outside of NSW.

In the event that a person moves interstate/overseas prior to their requested assistive technology being provided, EnableNSW will cancel the order/delivery of the requested device.

When an eligible person moves into NSW, EnableNSW will fund repairs and maintenance of assistive technology provided interstate where the device is consistent with the EnableNSW Prescription and Provision Guidelines.

If a person moving into NSW has outstanding applications to the equipment scheme in their state/territory of origin, EnableNSW will take into account the original application date to the interstate scheme when an application for the device is submitted to EnableNSW.

3.10 EnableNSW Data Collection

The EnableNSW information system will capture information such as consumer demographic information, details of assistive technology devices provided including service and maintenance history, as well as other statistical information used by NSW Health.
4. RIGHTS AND RESPONSIBILITIES

People seeking or receiving assistance from EnableNSW can expect to be treated in a way that is consistent with the *Australian Charter of Healthcare Rights*.


4.1 Rights of Consumers of EnableNSW Services

**Respect**
The right to be treated with respect and dignity.

**Communication**
The right to be given clear and accessible information about the EnableNSW services, including the eligibility criteria and copayments, assistance options available, and administrative processes.

**Participation**
The right to be included in decisions regarding what assistance will be provided and to be consulted about any changes in the way that assistance is provided.

**Privacy**
The right to privacy and confidentiality regarding personal information held by EnableNSW.

**Comment/Feedback**
The right to be given clear information about how to provide feedback and the right to have any concerns addressed in a timely and courteous manner without fear of discrimination.

This includes the right to be given information about how to appeal any decisions made regarding their application or requests for assistance.

4.2 Responsibilities of Consumers of EnableNSW Services

- To provide the information required to accurately assess applications for assistance.
- To accept that the available assistive technology device to meet their assessed needs may be recycled rather than new.
- To notify the EnableNSW Service Centre of a change of address or residential status.
- To meet the freight costs involved in taking any assistive technology items interstate once transfer of ownership has been determined.
- To notify the EnableNSW Service Centre of any change to financial circumstances that may affect their eligibility for assistance from EnableNSW or alter their status in relation to the making of a co-payment.
- To properly care for devices received and to notify the EnableNSW Service Centre if repairs or maintenance are needed.
- To fund the full cost of repairs if these result from wilful neglect or damage.
- To agree to reimburse EnableNSW for the cost of assistive technology devices provided (including the cost of any repairs and maintenance) in the event that a compensation claim results in a settlement relating to the disability for which devices were issued.
5. GOVERNANCE

5.1 Role of Health Support Services

Health Support Services is responsible for the development of Key Performance Indicators, for monitoring the performance of EnableNSW, service planning and state-wide administration of EnableNSW services.

5.2 Role of EnableNSW Advisory Council

The role of the EnableNSW Advisory Council is to provide advice to the Chief Executive, Health Support Services and the Director-General, NSW Health regarding the development of strategic policies, plans and initiatives relating to EnableNSW.

The Council reports to the Director-General, NSW Health through the Chief Executive, Health Support Services.

The ENAC Charter is available on the EnableNSW website at www-enable-health.nsw.gov.au. Council members are appointed by the Director-General of NSW Health following an Expression of Interest process. Membership includes representational positions for the Disability Council of NSW, NSW Department of Health and Ageing Disability and Home Care, Department of Family and Community Services.

5.3 Role of the NSW Department of Health

The Department of Health has responsibility for policy development relating to the EnableNSW services.

5.4 EnableNSW Review and Appeal Panels

Information on how to request a review or appeal, including any forms that need to be submitted, is to be available on the EnableNSW website.

In the first instance, consumers can request that a decision regarding their application/request be reviewed internally if there is additional information, a change of circumstances, or if they feel the application/request was not given due consideration.

Following this internal review process, consumers can request that the decision be reviewed by an external Appeal Panel if they feel they have not been given due consideration. These panels consist of clinical experts and consumers and assist EnableNSW in reviewing applications that are complex in nature, or that fall outside program guidelines.

Appeal Panel members are appointed by the Chief Executive, Health Support Services following an Expression of Interest process which is advertised through stakeholder networks and on the EnableNSW website.

EnableNSW Appeal Panels consist of expert clinicians and consumers, to provide advice and assist in managing formal appeals in relation to applications that have not been approved. This would include decisions made by Statewide Advisors and internal reviews in relation to administrative and clinical matters.
5.5 Provision of Feedback

Comments, concerns and complaints regarding EnableNSW may be made

- by phone on FreeCall 1800 ENABLE (1800 362 253);
- by fax on 02 8797 6543;
- by post to Locked Bag 5270 Parramatta NSW 2124; or
- by email to enable@hss.health.nsw.gov.au.

The EnableNSW website will include information on how to provide feedback. Consumers can request assistance with providing feedback if required.
A. COMMONWEALTH LIVING LONGER LIVING BETTER

B. INFORMATION MANAGEMENT REQUIREMENTS FOR RESIDENTIAL AGED CARE CLIENTS ACCOMMODATED IN FEDERAL FUNDED BEDS – PUBLIC FACILITIES - FROM 1 JULY 2004
A. COMMONWEALTH LIVING LONGER LIVING BETTER (IB2014_043)


With the changes to fee structures in residential aged care facilities introduced by the Commonwealth Living Longer Living Better aged care reforms being introduced from 1 July 2014 the policy directive is out of step with national policy and practice. Rescinding the policy allows State Government Residential Aged Care Facilities to charge new residents fees in accordance with Commonwealth regulations from 1 July 2014.

It should be noted however that residents who entered facilities prior to 1 July 2014 will have their fee arrangements grandfathered.

It should also be noted that rescinding Policy Directive PD2005_122 does not affect current fee arrangements in Multipurpose Services. PD2010_049 Multipurpose Services - Policy and Operational Guidelines outlines the fees policy which Multipurpose Services must comply with.
This circular supersedes 2000/94.

1. Purpose

1.1 This circular sets NSW Health information management policy for clients who are accommodated in Federal Government funded residential aged care beds in public hospitals, Multi Purpose Services and Public Nursing Homes from 1 July 2004. This circular supersedes Circular 2000/94.

2. Audience

2.1 It is essential that this circular be distributed to all staff involved in collecting and supplying data at facilities that are directly funded (partly or fully) by the Federal Government for the provision of Residential Aged Care services. These include:

- Admissions Staff
- Medical Records Staff
- Patient Administration System Administrators
- Residential Aged Care Collection Coordinators
- DOHRS Collection Coordinators
- Inpatient Statistics Collection Coordinators, and
- Health Information Exchange Coordinators

3. Definition of Federal Funded Residential Aged Care Activity

3.1 The policy described in this circular applies to facilities that receive direct Federal funding for activity provided in Residential Aged Care beds. These facilities may be a:

- Federal Approved Multi Purpose Service, or
- Public Nursing Home, or
- Residential Aged Hostel, or
- Selected General Hospital.

3.2 Within those facilities, the policy described in this circular only applies to Federal funded Residential Aged Care clients. These clients are those persons who:

- are in receipt of Hostel Care (Low Care), Nursing Home Care (High Care), or Respite care; AND
- have been identified as requiring residential aged care (high or low) either through ACAT approval; AND
are accommodated in (or eligible to be charged a daily accommodation fee for) either:
- a bed in a public nursing home or residential aged care hostel; OR
- a bed (regardless of its usual designation) in a Multi Purpose Service; OR
- a designated Federal funded residential aged care bed in a general hospital.

4. Criteria for Transition from Admitted Patient Care to Residential Aged Care

4.1 Where a client is being accommodated in a Multi Purpose Service and the appropriate type of care for the client is believed to be residential aged care, for the days the client is not covered by ACAT approval for accommodation in a Federal Government funded residential aged care bed, the client:
- should not be reported, or charged, as a Federal Funded Residential Aged Care client under the Residential Aged Care Facility Code;
- should be classified and reported as an admitted patient under the Admitted Patient Facility Code, with a Service Category of “Maintenance Care”;
- must elect to be treated as either a public or private admitted patient;
- qualifies for the first 35 days exemption from any client contribution accommodation charge if the client has elected to be treated as a public patient (in line with the standard rules for admitted patients);
- should be classified as a “nursing home type” patient and charged the “nursing home type” patient accommodation contribution rate once the standard criteria for classifying an admitted patient as a “nursing home type” patient has been met.

4.2 Where the appropriate type of care is believed to be residential aged care, an ACAT assessment should be conducted as soon as possible to determine the appropriate type of care for the patient.

4.3 When ACAT approval has been provided, clients in an admitted patient setting who are classified as “Maintenance Care” patients, should be formally discharged as an admitted patient, registered as a Residential Aged Care client, and charged the appropriate Residential Aged Care accommodation rate from the date accommodation in the Federal Funded Residential Aged Care Bed commences. For Multi Purpose Services, the date of formal discharge as an admitted patient (and registration as a Residential Aged Care client) should be the date of ACAT approval, regardless of the usual designation of the bed the client is being accommodated in. For other facilities, the date of formal discharge as an admitted patient (and registration as a Residential Aged Care client) should be the date a Federal Government Funded Residential Aged Care bed becomes available and the patient is moved into that bed.
5. Cessation of Previous NSW Health Department Reporting Requirements

5.1 From 1 July 2004, it is no longer a NSW Health Department reporting requirement to complete:
   • the NSW Health Department Residential Aged Care Collection paper form (as previously prescribed in Circular 2000/94), OR
   • the spreadsheet of the Resident Classification Scale for each calendar day by client.

5.2 A facility may choose to continue to complete the above forms to meet local reporting requirements.

5.3 The reporting requirements of other agencies, including the Federal Department of Health and Aging, continue (as specified by those other agencies).

5.4 The reporting requirements of other NSW Health Department data collections continues.

6. Recording of Activity on Patient Administration Systems

6.1 While this circular ends the previous reporting requirements for Federal Government funded residential aged care activity at the unit record level, the reporting requirements are currently under review and a replacement minimum data set for reporting in an electronic format will be announced in a later circular. In addition, Federal Government funded residential aged care facilities have local operational requirements for registering, billing and administering clients.

6.2 For the reasons outlined above, sites with Federal Government funded residential aged care activity should continue to record residential aged care activity on their patient administration system, if this is an existing practice. Any activity recorded on a patient administration system will continue to be reported to the Health Information Exchange and thus be available for analysis and reporting.

6.3 Where Federal Government funded residential aged care activity is recorded on a patient administration system, it is important that the activity is clearly identified as non-admitted community residential aged care activity. This means the activity should be reported under a separate facility code to admitted patient activity, so the residential aged care activity can be easily excluded. Despite having two facility codes, both facility codes should be built under the same patient registration module (patient master index) to ensure the patient has the same local Medical Record Number in both settings within the same facility.

6.4 To ensure the activity can be clearly identified, any record that is recorded on a patient administration system for a Federal funded residential aged care client must also have the following values recorded:
   • Service Category must be either “6 – Other Care”
   • Collaborative Care Status must be set to “R – Community Residential”
7. Recording of Aged Care Residents who require Admitted Patient Care

7.1 Clients who are registered on a patient administration system in a Federal Government funded Residential Aged Care beds, and who are determined to require admitted patient care, should remain attached to their residential aged care bed under the residential aged care facility code throughout the admitted patient episode. This applies if the admitted patient service is delivered to the patient’s usual residential bed, or is delivered in a different bed (either at the same facility or at a different facility).

7.2 Where admitted patient service is provided to clients in their usual residential aged care bed, the system administrator must establish the bed twice in the patient administration system – once as a residential aged care bed under the Residential Aged Care facility code, and once as a “virtual” admitted patient bed under the admitted patient facility code.

7.3 HOSPAS and WinPAS allow the patient to be attached to both an admitted patient bed (under an admitted patient facility code) and a Federal Funded Residential Aged Care bed (under a residential aged care facility code) if the “Collaborative Care Status” field is set to “R” in the Residential Aged Care facility record, and a different value (e.g. “0 – Direct Admitted Patient Service”) in the admitted patient facility record. Other patient administration systems use slightly different methods (such as collaborative care leave) to allow the patient to be attached to two beds simultaneously. This means a “formal discharge” transaction from the residential aged care facility is not required in order for the patient to be admitted under an admitted patient facility code that shares the same Patient Master Index. To ensure correct billing during absences, sites using HOSPAS and WinPAS should not place patients on leave from their residential aged care bed.

8. Rules for Newly Established Multi Purpose Services

8.1 When a public hospital converts to a Federal Government approved Multi Purpose Service, all nursing home type patients with a Service Category of “Maintenance Care” and current ACAT approval must be formally discharged under the admitted patient facility code, effective at 23:59 of the day prior to commencement of the Multi Purpose Service status. Those discharged records must be coded and reported as admitted patient activity under the admitted patient facility reporting code.

8.2 If the facility wishes to continue to manage their residential aged care activity using their patient administration system the following must occur:

• a new facility must be established in the patient administration system under the same patient master index (contact the NSW Health Department’s Metadata Manager to obtain the new facility code), and
the AHS HIE Coordinator must be advised of the new facility code so that extract loading to
the HIE can be organised, if the AHS wants the activity available for analysis and reporting
in the HIE, and
all beds/wards used to accommodate residential aged care clients must be built under the new
facility code with an assigned Bed Type of either:

- 14 – Residential Aged Care – High (Nursing Home)
- 23 – Residential Aged Care – Low (Hostel)
- 51 - Federal Residential Aged Care Respite – High
- 52 - Federal Residential Aged Care Respite – Low

8.3 The following are recommendations for patient administration system administrators, for
establishing wards/beds within the residential aged care facility:

- For HOSPAS sites, create four wards:
  - “High Care” – Map to Bed Type 14
  - “Low Care” – Map to Bed Type 23
  - “Respite High” – Map to Bed Type 51
  - “Respite Low” – Map to Bed Type 52

- Within each ward, establish the maximum number of beds that may be required for that
  level/type of care. This means the same physical bed may be set up multiple times, once
  under each type of ward.

- For sites using other patient administration systems, either:
  - **Option 1:**
    - Create two wards: one called “High Care” and one called “Low Care”.
    - Within each ward, establish the maximum number of beds that may be required
      for that level and type of care (permanent or respite).
    - In the “High Care” ward, map the permanent high care beds to Bed Type 14 and
      respite high care beds to Bed Type 51.
    - In the “Low Care” ward, map the permanent high care beds to Bed Type 23 and
      respite high care beds to Bed Type 52.
  - **Option 2:**
    - Create one ward:
• Within each ward establish the maximum number of beds that may be required for that level and type of care (permanent of respite). Label each bed clearly such that the user can easily identify which bed is designated to high care permanent, high care respite, low care permanent, low care respite.
• Map each bed to the appropriate Bed Type.
• For iPM (I-soft) and HNA Millennium (Cerner) sites, do not show any Service Category other than “6 – Other Care” (or “0 – Boarder” activity if relevant) under the Facility established for the Federal Government funded Residential Aged Care activity.

8.4 There is no requirement to enter clinical coding for residential aged care activity. However, if the system forces the user to code, “R54” may be entered as the mandatory principal diagnosis.
DIAGNOSTIC SERVICES

A. GENERAL PRINCIPLES

I. Charging Procedures and Collection of Fees

1. General 6.1
2. Invoicing and Accounting Procedures 6.1
   - Manual System 6.4- 6.12
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B. RADIOLOGY/RADIO THERAPY SERVICES

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C. PATHOLOGY SERVICES

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II. Exemptions from Pathology Charges - Institute of Clinical Pathology and Medical Research 6.58

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

38(5/02)

(terminology change July 2019)
A. GENERAL PRINCIPLES

I. CHARGING AND COLLECTION OF FEES (77/148, 76/279, 76/280); (77/148) (76/279, 76/280, 79/315 OBSOLETE)

1. GENERAL

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

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

Rates of Fees Charged

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

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

2. INVOICING AND ACCOUNTING PROCEDURES

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

- Doctor’s full name
- Practice Address
- Provider Number
- Hospital to which Agreement applies
Subject to receipt of the necessary authority, hospitals will issue invoices on stationery which shows clearly the full name and initials of the visiting diagnostician or the salaried diagnostician, his/her degree (desirable), provider number, and his/her address as being care of the hospital issuing the invoice.

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

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

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

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

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

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

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

For the purposes of banking receipts there shall be opened a separate trust account, within the Special Purposes & Trust Fund, which should be opened in an appropriate name linking the medical practitioner with the address of the hospital. The signatories to cheques drawn on the account shall be responsible senior officers of the hospital.

From this account shall be withdrawn, by cheque, the fee due to the hospital for the use of its facilities by the doctor.

One trust account may be opened to account for all doctors involved or there may be separate accounts for individuals or groups, to meet circumstances at each hospital.

Bank deposit books of the same type used by hospitals shall be used for these accounts.

A subsidiary cash book and ledger (or on line cash transaction file) shall be kept to record the transactions on behalf of each doctor, i.e. the charges invoiced, the fees collected, and disbursements to the hospital for the use of its facilities and to the doctor.

The hospital shall submit the records to its auditor during every audit of the hospital's accounts and records.

The doctor/s may also have the records audited by a registered public accountant of their choice at their own expense.

Proper records shall be maintained of the stocks of unused invoices and receipts and of the invoices and receipts which have been used. Stocks of unused forms shall be kept in a secure place.

The onus of specifying the tests/examinations and their item numbers for which charges should be made is on the diagnostician. This applies to both visiting and salaried diagnosticians.

Items of diagnostic services are those included in the appropriate parts of the Medical Benefits Schedule Book issued by the Commonwealth Department of Health.

In the case of medical officers in a particular laboratory or department electing to charge and receipt as a "group", one invoice and one receipt can be issued for all the diagnostic services supplied by these medical officers to private inpatients.
Where a medical officer elects to have all fees charged and receipted in his or her name, separate accounting systems will have to be maintained for each medical officer concerned.

The forms as described in the following sections have been designed to produce as many as possible of the necessary accounting documents at the one time. The system is designed for a peg-board application with all but one of the forms using carbon impregnated paper. The exception is the Bank Deposit Slip, which will utilise a carbon backing sheet.

Hospitals or Area Health Services with Computer Facilities should have regard to the requirements of the Manual System the Computerised Billing System as well as the Section on Internal Control-Computer Systems included in the Accounting Manual.

FORMS FOR CHARGING FEES (Manual System)

3.1 When raising charges, the following forms will be used:

3.1.1 Invoice.
3.1.2 Patient's Ledger Card.
3.1.3 Patient's Reminder Notice.
3.1.4 Medical Officer's Ledger Card.
3.1.5 Diagnostic Fees Charged Journal.
3.1.6 Statements (follow-up notices)
3.1.7 Debt Collection Notices (if applicable)

3.2 Forms 3.1.1, 3.1.2 and 3.1.3 will make up a three part set, with provision for easy detachment of forms 3.1.1 and 3.1.2 from the set.

4. FORMS FOR RECEIPTING FEES

4.1 When remittances are receipted, the following forms will be used:

4.1.1 Receipt Form.
4.1.2 Patient's Ledger Card.
4.1.3 Patient's Reminder Notice.
4.1.4 Medical Officer's Ledger Card (optional).
4.1.5 Bank Deposit Slip (optional).
4.1.6 Diagnostic Fees Receipts Cash Book.

4.2 Forms 4.1.2 and 4.1.3 will at this stage form a two part set.
5. FORM DESCRIPTIONS

Comments regarding the nature and contents of the forms mentioned above are given below:

5.1 Invoice

5.1.1 Invoices will be raised for each private inpatient in the name of the medical officer or group of medical officers who perform the diagnostic service. Where patients have had X-ray examinations, pathology tests and other diagnostic services performed during their stay in hospital, they will receive separate invoices for the various types of service. On each of the separate invoices for each type of service, all X-ray examinations, pathology tests and other services will be noted even if examinations, tests and other services of the same category, e.g. pathology, are performed by different medical officers. **Note that the Hospital must obtain written authority from a diagnostician before issuing any invoices in his name.** This is usually carried out when the doctor's contract of appointment is signed.

5.1.2 In the case of pathology services, in order to conform with the requirements set out in the Commonwealth Medical Benefits Schedule Book, Category 6 etc. certain information needs to be entered on the invoice, as set out below:-

5.1.2.1 Name and Medical Record Number of Patient - self explanatory.

5.1.2.2 Name of Patient or Debtor and full address.

5.1.2.3 Date of Request - self explanatory.

5.1.2.4 Date of Service - date on which the examination or test is performed.

5.1.2.5 Invoice Number.

5.1.2.6 Requested by - name and provider no. of the medical practitioner who requested any pathology or diagnostic tests.
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5.1.2.7 Reported by - name of the medical officer who renders the service.

5.1.2.8 Description of Service - description associated with the item number as given in the Index to the Medical Benefits Schedule Book.

5.1.2.9 Item No. - this will be found in the Medicare Benefits Schedule Book beside the appropriate examination or test. *Must have an asterisk beside each item number for private inpatients.

5.1.2.10 Amount Charged - the appropriate schedule fee listed in Medicare Benefits Schedule Book.

5.1.2.11 Date of Admission and Discharge.

5.1.2.12 Where the same test is required to be carried out more than once on the same day for the same patient and the circumstances require a further charge of the same item number, the times of completion of each such test should be stated to indicate that it is a separate request and not part of a combination test provided by another item number. Sub-items should be included where appropriate as some benefits are dependent on it.

5.1.2.13 Footnote on the Invoice must indicate that the service was provided to a private patient at the hospital name concerned.

5.1.3 In the case of services other than pathology, and diagnostic imaging services the information mentioned in paragraphs 5.1.2.3, 5.1.2.6 and 5.1.2.12 need not be supplied, but the other information is required.
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5.1.4 The blank space in the top right hand portion of the invoice form will be used to show, by means of a rubber stamp or preprinting, information as under:-

5.1.4.1 Medical Officer's name and qualifications;
5.1.4.2 Medical Officer's Provider Number;
5.1.4.3 C/o Hospital name, address and telephone number;
5.1.4.4 Type of service, e.g. pathology.

5.1.5 All invoice forms should be numbered when printed or computer generated.

5.2 Patient's Ledger Card

This card will provide a complete record of charges raised and remittances receipted for each individual patient. It will also supply all the relevant data if the invoice needs to be reconstructed. Each patient will have one of these cards created for every invoice issued. It is envisaged that these will be brought together for each patient and filed alphabetically (in a tub file) according to the patient's name.

5.3 Patient's Reminder Notice

5.3.1 The inclusion of this form in the set will allow at least one follow-up notice to be sent in the case of outstanding amounts. Any further follow-up needed will have to be done from the Patient's Ledger Card. Any legal action in regard to follow-up requires the written authorisation of the medical officer(s) in whose name the account was rendered.

5.3.2 The blank space in the top right hand portion of the reminder form will be used to show the same information as that mentioned in paragraph 5.1.4 relating to the invoice form.
5.4 Medical Officer's Ledger Card (optional)

5.4.1 If all medical officers in a particular group of diagnosticians have no objection to each knowing the amounts charged and received in respect of the others, there is no need for the Medical Officer's Ledger Card. The information regarding charges and receipts can be supplied to medical officers by means of photocopies of the Diagnostic Fees Charged Journal and the Diagnostic Receipts Cash Book. Even if one or more medical officers in a group do object, it would be possible to supply details of charges and receipts for each officer alone by using a paper template to cover unwanted information during the photocopying process. Two advantages of not using the Medical Officer's Ledger Card are that, firstly, the labour involved in handling the Ledger Card for each accounting operation is avoided, and, secondly, it becomes possible to incorporate the Bank Deposit Slip in the receipting process, the inclusion of this slip being otherwise impracticable owing to the limitations of the copying capacity of the forms system.

5.4.2 If it is necessary to use the Medical Officer's Ledger Card, one of these cards will ordinarily be maintained for each medical officer whether medical officers are charging individually or in a group. This form will provide a record of all charges raised and all remittances receipted in that medical officer's name. The card can either be shown to the individual medical officer or a photocopy can be made. However, should all the medical officers in a particular group agree to share receipts equally, there would be no need to have separate Ledger Cards for each medical officer in the group, one Ledger Card being sufficient.

5.5 Diagnostic Fees Charged Journal (backing sheet)

5.5.1 The information noted on this sheet will be used to provide the following:-

5.5.1.1 an audit trail for all charges raised.

5.5.1.2 a dissection of all charges raised according to each medical officer's name or each group of medical officers.
5.5.1.3 a dissection of all charges raised according to the diagnostic group involved; this will facilitate calculation of the proportion to be paid to the hospital in accordance with the rules set out in this section and facilitate a comparison of fees received with fees charged. If the number of columns provided is insufficient, the hospital will need to arrange for an enlargement of the form.

5.5.1.4 a separate journal should be used for adjustments of charges. It is suggested that the stationery for the Diagnostic Fees Charged Journal be employed, but that it be marked clearly "Adjustments". The Adjustment of Diagnostic Fees Charged Journal should be submitted to the Chief Executive Officer or other appropriate senior administrative officer for scrutiny and endorsement with his signature and the date prior to the journal being raised.

5.5.1.5 one or more of the Diagnostic Fees Charged and Diagnostic Fees Adjustment Journals may be needed according to the circumstances existing at each hospital.

5.6 Receipt

5.6.1 In respect of all remittances received, receipts will be issued in the name of the medical officer or group of medical officers who performed the diagnostic service.

5.6.2 All receipt forms should be numbered when printed or computer generated.

5.7 Bank Deposit Slip (optional)

This Bank Deposit Slip needs no explanation. It will be used in the receipting process when a Medical Officer's Ledger Card is not used; when the latter form is used, a Bank Deposit Slip must be made out as a separate process.
5.8 **Diagnostic Fees Receipts Cash Book**

5.8.1 The receipts entered in the Diagnostic Fees Receipts Cash Book will be dissected as in the Diagnostic Fees Charged Journal.

5.8.2 Where money is received on behalf of a group of medical officers, the amount should be entered in the column for that group. The distribution of the money is a matter for determination by the medical officers in the group.

5.8.3 Money received will be dissected over the diagnostic groups involved. Information in the Patient's Ledger Card and, if necessary, the Diagnostic Fees Charged Journal will assist in this regard.

5.8.4 In the case of a part payment, the amount will need to be apportioned over the dissection columns. If the part payment is made by a medical benefits fund, the apportionment can be made on the basis of the information supplied by the fund with the payment. If the payment comes from a different source, generally the patient or contributor, the apportionment will need to be made, in the absence of specific instructions from the person paying, in the same proportion as the dissection of the charges in the Diagnostic Fees Charged Journal.

5.8.5 As with the Diagnostic Fees Charged Journal, one or more Cash Books may be needed according to the circumstances existing at each hospital.

5.9 **Balancing**

Both the Diagnostic Fees Charged Journal and Receipts Cash Book are self-balancing in that the total charges raised and the total remittances received, noted on the respective backing sheets, will equal the total of the amounts dissected according to the medical officers' names and the total of the amounts dissected according to diagnostic groups.
6. **PAYMENTS**

A Diagnostic Fees Payments Cash Book will be needed to record refunds and the distribution of moneys available to the medical officers and the hospital. Each hospital should obtain a suitable cash book; a columnar cash book may assist with any dissections necessary. A separate cash book will be needed for each trust bank account.

7. **INTEREST ON BANK ACCOUNTS**

In the absence of written agreement to some other arrangements, interest earned on bank account relating to the diagnostic fees must be apportioned monthly amongst the medical officers and the hospital in proportion to the dissection of the fees received. However, it is suggested that an endeavour be made to obtain the written authority of the medical officers to the use of the interest earned for some suitable purpose, such as study tours or the purchase of capital equipment, thus avoiding the necessity for apportionment.

8. **SPECIAL PURPOSES AND TRUST FUND**

All accounting for diagnostic fees for private and chargeable inpatients shall be recorded within the Special Purposes and Trust Fund.

9. **METHOD OF USING STANDARD FORMS**

9.1 **Charging**

9.1.1 It is envisaged that the information in the first six columns of the invoice will be recorded continually as the source documents become available to the clerk involved. The "Amount Charged" column of the invoice will only be noted after all diagnostic tests within the hospital system have been entered on the invoice.

9.1.2 On completion of the invoice, it will be totalled and detached from the three part set and sent to the person in whose name the account has been raised.

9.1.3 The Patient's Ledger Card and Reminder Notice are then to be placed on the Diagnostic Fees Charged Journal along with the Ledger Card, if needed, for the particular medical officer or group of medical officers. The total of the
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account on the Patient's Ledger Card is to be entered in the Amount Charged column of the Diagnostic Fees Charged Journal. The date, invoice number and patient's name are also to be noted. In this operation, all the following forms will have been noted:-

9.1.3.1 Patient's Ledger Card.
9.1.3.2 Patient's Reminder Notice.
9.1.3.3 Medical Officer's Ledger Card (if needed).
9.1.3.4 Diagnostic Fees Charged Journal.

9.1.4 Finally, the charge is to be dissected over the columns for medical officers and diagnostic groups.

9.2 Receipting

9.2.1 When payment is received for a diagnostic service, a receipt will be issued in the name of the medical officer, or group of medical officers who performed the service.

9.2.2 The clerk concerned will obtain the appropriate Patient's Ledger Card, with Reminder Notice attached, if available, and place this two part set on the Receipts Cash Book. The same procedure will be followed for the relevant Medical Officer's Ledger Card or Bank Deposit Slip. A blank receipt will then be placed on top and the following information noted:-

9.2.2.1 Date.
9.2.2.2 Receipt No.
9.2.2.3 Patient's Name.
9.2.2.4 Cheque, Cash, Money Order, etc. (may be indicated by suitable abbreviation, e.g. Ch, Csh, M.O.).
9.2.2.5 Bank and Branch (if in cheque form).
9.2.2.6 Amount Received.

9.2.3 Finally, the amount received is to be dissected over the columns for medical officers and diagnostic groups.
Content of the section is primarily meant as a guide to the procedures and controls that should be present in a computerised patient billing system and should be used in conjunction with the part on charging and collection of fees in this section which, even though orientated to a manual diagnostic fees billing system, incorporates data that is common to both systems.

Even though this part is incorporated in the Diagnostic Fees section of the Manual it also contains procedures applicable to general patient billing, e.g. accommodation.

**COMPUTER USER PROCEDURES**

**Introduction**

User procedures have been prepared to document how each transaction is to be processed. Procedures have been prepared for:

1. Patient and Schedule Debtors Billing.
2. Unbilled Services.
3. Receipting.
5. Standing Data Maintenance.

In designing these procedures, consideration has been given to ensuring that adequate internal controls have been included. The term 'internal controls', as used in this section, refers to any procedures which ensure the completeness, accuracy, validity and proper maintenance of the transactions processed through the computer system. These concepts are further explained below.

**Completeness**

Completeness refers to the need to ensure that all transactions are input to and processed by the computer system.

Taking patient billing as an example, there is a need to ensure:

(i) a log sheet is completed for all services performed by the hospital;
(ii) all log sheets raised are input to the computer system; and,

(iii) all log sheets input are accepted by the system so that the hospital can bill patients for all services that the hospital has performed for them.

Only if there are controls over the completeness of input and processing can it be assured that the hospital is billing all patients for all services.

**Accuracy**

Controls over accuracy are designed to ensure that the information input to and processed by the computer system is correct.

Using patient billing as an example, we need to ensure that:

(i) the information on the log sheet is accurate, e.g. the override price is correct; and,

(ii) when entering the log sheet, the information is input correctly, e.g. not entering 00573901 as the medical record number when it should be 00573109.

**Validity**

Controls over validity are designed to ensure that the transaction input, (e.g. a log sheet) and the information on that transaction (e.g. medical record number or provider number) is genuine. The transaction being input must represent an event which actually occurred and is properly authorised. Edits ensure validity and accuracy.

**Maintenance**

Once all the transactions have been completely and accurately input and processed by the computer system controls are required to ensure that they remain there until they are changed, deleted or added to during subsequent authorised processing.

Maintenance controls ensure that the information retained (both standing and transaction data) by the computer system remains correct and current. In other words, the information on the system must be kept up-to-date and must not be changed other than through the normal data entry and processing procedures.
1. PATIENT AND SCHEDULE DEBTORS BILLING

DIAGNOSTIC AND CLINICAL BILLING

Procedure Description

1. A prenumbered log sheet is completed for the services performed by the staff specialist during the day. Depending on the classification of the patient and the type of service performed, a different format of log sheet is to be completed, i.e.:

   (i) inpatient medical;
   (ii) inpatient anaesthetic;
   (iii) private outpatient;
   (iv) outside hospital; or
   (v) non-inpatient services.

2. Where an anaesthetist performs a service other than the administration of anaesthetics; e.g. a pre-op visit or a blood transfusion, these services should be recorded on a medical log sheet. Only anaesthetic services should be recorded on an anaesthetic log sheet.

3. If the log sheet contains services provided during an initial consultation, either the date of the letter of referral from the referring doctor is written against the appropriate patient's name. The staff specialist or secretary signs and dates the log sheet.

4. On receipt of diagnostic and clinical log sheets, the log sheet number is marked off as received on the appropriate staff specialist's log sheet control register. The date of receipt by revenue is stamped on the log sheet. A new log sheet control register is used each month.

5. The log sheet is reviewed to ensure that it is legible, that all the required information is on the log sheet and that it has been signed by the staff specialist or secretary. Where override prices have been used, the senior fees clerk ensures that the price used is correct. The appropriate computer system data entry screen is pre-printed on the log sheet and doctor/specialist code is then written on the log sheet.

6. The batch header information, i.e. the specialist code and the number of line items on the log sheet, are written on the log sheet. The log sheet must be signed and dated as evidence of the check performed.
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7. The checked log sheets are written up in the batch control register and forwarded to Data Entry Operators for input. The data entry operator inputs the log sheets stamping each with the date of input after entry.

8. When all log sheets have been input they are returned to the fees clerk for matching with the appropriate Batch Edit Report. The edit report is generated automatically by the system when a batch is posted.

9. If there are no error messages on the edit report, it is test checked to the appropriate log sheet. Any errors are investigated and, if necessary, the error is reversed using a journal when the invoice is raised and then resubmitted for input. (The journal procedures should be followed in this case.) The edit report signed and dated as evidence of the test check. The Batch Edit Reports are reviewed regularly by an appropriate officer to ensure that Procedures are being followed. This review is evidenced by the signature of that officer.

10. Any error messages appearing on the log sheet or the edit report are investigated, corrected and the affected log sheet resubmitted for input.

11. The fees supervisor ensures that for each log sheet, i.e. each batch, the number of line items and the specialist code input agrees to that written on the log sheet.

12. The batch edit report is filed in date order. The log sheets are filed in specialist code sequence.

13. After the weekly invoicing run, the Diagnostic and Clinical Billing (DCB) invoices are forwarded to the senior fees clerk who reviews them to verify the accuracy of information.

14. Invoices to be paid by the Commonwealth Department of Veteran Affairs (DVA) are separated from all other DCB invoices, which are mailed off. (See DVA Billing Requirements.)

15. A Schedule of Diagnostic Services and, for each service performed for each DVA patient, a Treatment Service Voucher is prepared. These forms are sent to the appropriate staff specialist for signing as evidence of the performance of the service.

16. The signed forms are returned to DCB, who forward a carbon copy of the Treatment Service Voucher and a photocopy of the Schedule of Diagnostic Services to the Cashiers' Department awaiting payment from the DVA. The originals are sent to the DVA with the related invoices.

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17. On a daily basis, the log sheet register and batch control register are reviewed and any unprocessed log sheets are followed up.

18. On a monthly basis, the log sheet register is reviewed to ensure that all log sheets not yet received from the staff specialists are followed up.

PATHOLOGY SERVICES BILLING

1. Three times a week, the fees clerk goes to each of the pathology laboratory/s to collect the test requests and (computer generated) log sheets.

2. The test requests and log sheets are sorted into "your hospital" patients and "Outside" patients. "Your hospital" patients are sorted into:

   (i) private and ineligible inpatients;
   (ii) privately referred outpatients;
   (iii) Commonwealth Department of Veteran Affairs (DVA) patients.

3. The "Outside" patients are sorted into:

   (i) private and ineligible patients in a recognised hospital or institution;
   (ii) hospital or outpatient in a recognised hospital or institution;
   (iii) privately referred outpatient of a recognised hospital or institution;
   (iv) DVA patients.

4. As the test requests and (computer generated) log sheets do not contain all of the information required for the billing of pathology services, the coding clerk should:

   (a) use the Patient Details data file to obtain the following information for "your hospital" patients:

      (i) medical record number,
      (ii) financial status code;
      (iii) requesting doctor's specialist code and provider number,
      (iv) episode admission and discharge dates.

   (b) for "Outside" patients:

      (i) ensure that the requesting doctor's provider number is valid by using the Provider Match Enquiry screen;

      (ii) allocate the appropriate hospital's or other institution's schedule debtor code to enable direct billing of the outside hospital.

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(c) in all cases, for Department of Veteran Affairs patients, record the DVA file number on the test request or the log sheet.

5. Once all the required information has been obtained the test requests and log sheets are batched in batches of not more than 50 line items. A batch header is prepared and all completed batches filed pending review by the batching clerk.

6. The batch clerk scans each test request and log sheet to ensure that all the required information has been written on them, allocates a batch number and enters the number in the batch register. The completed batches are then forwarded to Data Entry Operators for input.

7. The batches are input and each stamped with the date of input after entry.

8. When all the test requests and log sheets have been input, they are returned to the batch clerk. The edit report is generated automatically by the system when a batch of log sheets and/or test requests are posted.

9. The batch edit report is reviewed to ensure that the batch header details agree to the report. Any error messages appearing on the edit report are investigated, corrected and the affected batch resubmitted to data entry for input. Successful edit, reports are test checked for accuracy of input. An appropriate officer reviews the test checks regularly to ensure the continued operation of this control.

10. Batch edit reports are signed and dated as evidence of the review and the batch register is updated to reflect the input of the accepted batches.

11. The batch edit report is filed in date order. The test requests and log sheets are temporarily filed in batch order awaiting the printing of the invoices. After the invoices have been printed, the batches which relate to these invoices are placed into storage. In order to find the batch an invoice relates to, the batch edit reports will need to be used.

12. After the weekly invoicing run, the pathology services invoices are forwarded to the fees clerks who scan the invoices to ensure that the patient's/debtor's name and address, description of services, requesting doctor's name and provider number and the episode admission and discharge dates appear on them.

13. Any invoices with obvious errors on them are separated and subsequently followed-up.
14. Where there are more than one invoice for the same patient or debtor, they are
collated, stapled and remitted together.

15. Invoices for the DVA are separated and given to the batch clerk who prepares a
Schedule of Diagnostic Services.

16. The Pathology Accounts section forward a photocopy of the Schedule of Diagnostic
Services to the Cashiers' Department awaiting payment from the DVA. The originals
are sent to the DVA. (See DVA Billing Requirements.)

17. Schedules are produced for the other hospitals or institutions. A covering letter is
attached to the schedules and then mailed out.

18. On a regular basis, the pathology batch register is reviewed for long outstanding
batches and unresolved reported errors. Appropriate action should be taken to resolve
the above.

ACCOMMODATION CLAIMS

1. During the daily invoicing run, accommodation invoices will be generated
automatically for all patients who have been discharged.

2. After the daily invoicing run, all accommodation invoices are separated and classified
into the following categories:
   (i) Ineligible
   (ii) private chargeable (including DVA patients who elect single room
        accommodation and DVA NHT patients); and,
   (iii) compensable.

3. The various categories of accommodation invoices are then distributed to the
appropriate person:

4. DVA patients are covered under a bulk agreement except where the patient elects
single accommodation (not for medical reasons) and where the patient becomes a
"nursing home type". In both these cases the patient is charged the difference between
shared and single accommodation and the patient contribution rate for a NHT.
Private Chargeable Accommodation Invoices

10. On receipt of the private chargeable accommodation invoices, the officer obtains the related records and, using the information contained in the records, checks the financial status code and admission and discharge dates.

11. A HC21 claim form is then completed, signed and dated by the claims clerk for each patient. (The HC21 claim form is to be signed by the patient at the time of discharge. Fund details should be obtained at the time of admission.)

12. Where a patient has not signed the HC21 claim form or not given membership details, the form and the invoice are mailed to the patient, with a standard covering letter. The patient can then claim a refund from the health fund on his/her own behalf or sign the claim form to indicate approval for the hospital to claim on the health fund on behalf of the patient.

13. The copies of the invoices are filed in a Claims cabinet.

14. The HC21 claim forms are input to the accommodation claims register using the screen. All authorised claim forms and their related invoices are then sent to the appropriate health fund.

Day Only Patients

15. On receipt of the Day Only invoices, a Day Only Procedure Form is completed by the clerk after specific details (i.e. banding) are obtained from the operating suite.
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16. A HC21 Claim Form is also completed (for all funds except Medibank Private who have their own) along with the day only procedures form and sent to the respective health fund.

17. On receipt of the compensable accommodation invoices (i.e. invoices relating to Public Liability, or Workers' Compensation Claims), the related records are obtained and checked to ensure that the financial status code and admission and discharge dates are correct.

18. For Workers' Compensation Claims, the patient completes an election form, nominating their solicitor/insurance company and giving their employers' name and address. Wherever possible, the claim number is also noted on the form. A copy of the election form is given to the patient and the original of the election form and the invoice sent to either the insurance company or employer concerned.

19. The compensable accommodation claims are input, using screen to the accommodation claims register.

20. The copies of the invoices are filed in the Workers' Compensation and Public Liability and other Compensable section of Outstanding Accounts.

Follow-Up Procedures

21. On an ongoing basis, the Accommodation Claims reports are reviewed for all claims paid. Where a claim has been paid, the appropriate patient's record is obtained, the payment details are written on the invoice and the invoice filed in secondary storage.

22. On an ongoing basis, the Accommodation Claims reports are reviewed and all long outstanding claims followed up.

23. On a weekly basis, the current Accommodation Claims reports are reviewed to ensure that all long outstanding claims are being followed up.
RE-INVOICING PROCEDURES FOR MEDICAL AND PATHOLOGY

1. Re-invoicing refers to the situation where a schedule debtor does not pay all the invoices listed on a schedule. Where appropriate, the unpaid invoices may need to be cancelled from the schedule and re-raised as an invoice to the patient for whom the service(s) was performed. This would normally occur where an invoice was charged to a schedule debtor for a patient who was a private patient at the time the service(s) was performed.

2. Where the cashiers become aware that a schedule debtor has short paid, the remittance should be posted to the actual invoices being paid. On-line Batch Receipts screen or On-line Receipts screen.

3. The schedule which has been short paid, together with any supporting documentation should then be forwarded to Fees Revenue Section/officer for subsequent follow-up.

4. On receipt of the short paid schedule, the fees clerk investigates whether there is a valid reason why the unpaid invoices should not have been charged to the schedule debtor.

5. Where the invoice(s) should have been made out to the Fees Clerk patient, all the necessary information required to re-raise the invoice is obtained. The schedule and all supporting documents are given to the appropriate officer for authorisation.

6. The schedule and supporting documents are reviewed. If the cancellation and recharge are authorised, the schedule and supporting documents are returned to the fees clerk for input. If it is not approved, a photocopy of the schedule and all supporting documents and a covering letter explaining why the disputed invoices are not to be cancelled will be sent to the schedule debtor.

7. Where authorised, the appropriate invoices are cancelled and re-raised as private patient invoices.

8. The schedule and supporting documents are files in billing run order.

DEBT COLLECTION PROCEDURES

1. On an on-going basis, all patients records that have reached over 60 days are recorded which require further follow-up to that which is produced by the computer (i.e. Statement, Notices) and hands it over to the Debt Collection Department.
2. The Debt Collection Clerk acknowledges receipt of these files and registers it in a registration book. The files are then actioned by direct correspondence to ascertain the current status.

3. These files are reviewed by an independent officer regularly.

**Accommodation Accounts for Overseas Visitors**

1. Ineligible patient records (i.e. overseas visitors) are handed to the Debt Collection Department immediately if payment has not been received in advance. (See Fees Policy for Ineligible patients page 2.5 of this Manual.)

2. The Debt Collection Clerk acknowledges receipt of the files by signing a register Clerk listing all the files given.

3. All of these patients are then flagged on the system as a credit risk. A credit risk report is to be prepared.

4. The Credit Risk Report is reviewed by an independent officer regularly.

5. The patients are contacted by the Debt Collection Clerk to arrange payment prior to returning to their country.

6. If full payment of the account cannot be obtained alternative arrangements are made (i.e. payment by instalment).

**General**

1. On a monthly basis, a report is requested to review all accounts in excess of a specified amount, e.g. $500.

2. Problem areas are highlighted and actioned accordingly.

**UNBILLED SERVICES**

1. On a weekly basis, the summary for the Unbilled Services Report is produced by the system. (Note: This report will list all unbilled services with the exception of accommodation). All long outstanding services are referred for follow up.

2. This report should be checked to identify any long stay patients in order that they can be invoiced on a regular basis throughout their stay in hospital rather than at the end of the episode.
3. In addition, the Unbilled Services report is checked to the Patient Details screen and the Discharged Patients report to ensure that the patients appearing on the report are still inpatients.

4. A control report is to be produced weekly prior to pricing, after pricing and after billing, detailing the total number of unbilled tests by type (i.e. medical, pathology etc). These details are balanced to the Unbilled Services Report.

5. After the invoicing run a pricing audit trail is to be produced detailing the application of MBS Billing Rules. The number of items deleted or added is recorded on the billing reconciliation sheet.

6. The number of tests billed is recorded on the Billing Reconciliation Sheet. An overall Reconciliation should then be carried out as follows:

   Unbilled Tests (prior to billing).

   + tests added by Billing Rules
   - tests deleted by Billing Rules
   = unbilled tests (after billing)

7. This reconciliation is reviewed regularly by an independent officer.

OVER-THE-COUNTER PAYMENTS

1. If the cheque, money order, etc is for a patient's account, the invoice number is obtained in order to allocate the payment to the appropriate invoice.

2. The payment is input using On-line Receipting. After input, the remittance is stamped with the date of input and "NOT NEGOTIABLE - HOSPITAL NAME". The payment is then placed in the over-the-counter receipts tray. A computer-generated receipt must be issued to the person making the payment.

3. If the payment is for a sundry item, the payment is input using On-line Sundry Receipts and stamped with the date of input. Cheques, money orders and the like are stamped "NOT NEGOTIABLE HOSPITAL NAME". A suitable narration should be entered in the description field giving full details of the receipt (e.g. donation, interest, any reference Numbers, etc.). The computer-generated receipt is issued to the person making the payment.

4. For the steps regarding the balancing of the cash refer to the balancing procedures for Mailed Cash Remittances.
MAILED CASH REMITTANCES

1. All mailed remittances are received in the central records office, where, upon opening of the mail, they are stamped with the date of receipt and "NOT NEGOTIABLE HOSPITAL NAME".

2. The remittances are separated into the following broad categories:
   
   (i) Private Practice Trust Fund;
   (ii) Special Purpose & Trust Fund; and,
   (iii) General Fund (Sundry receipting).

3. Remittances in the form of bank notes, coins/or postage stamps are separated from cheque, money order and credit card payments and the details entered in the mail cash register.

4. All cash remittances for the Revenue Account, Special Purpose Trust Fund, General Fund and Private Practice Trust Funds are processed by the counter cashiers.

   Special Purpose & Trust Fund and General Fund Remittances

5. All cash remittances for Special Purpose and Trust Fund, General Fund and Private Practice Trust Fund are collected on a daily basis. The remittances including notes, coins or stamps, should be checked to the mail cash register and the register is signed and dated as evidence of receipt. After these remittances have been receipted the receipt numbers must be entered in the mail cash register and the receipt is mailed out to the payer.

6. The General Fund remittances are divided into:
   
   (i) accommodation;
   (ii) non-inpatients; and
   (iii) Sundry (non-patient) payments.

7. If the remittance advice is not returned with the payment, a pro-forma payment advice is completed. This will contain, at the very least, the name of the patient/debtor and the amount tendered.

8. The remittances are input using On-line Batch Receipts or On-line Sundry Receipts. The bank deposit sheet number to which the remittances are being entered is written on the batch header. On completion of keying the remittances the batch total and the number of remittances processed is recorded on the batch header. The cashier then dates and signs the batch header as evidence.
9. On-Line receipts are printed at the counter by the cashier receiving payment. The receipt is signed and issued to the payer immediately.

10. If insufficient information has been included with the remittance to allocate it to an invoice and the payment relates to a non-inpatient or accommodation account, the computer system should provide assistance in identifying invoice numbers. For sundry receipts affecting the General Fund, Private Practice Trust Fund or Special Purpose & Trust Fund, the account codes can be obtained by reference to the chart of accounts.

11. If money orders, bank cheques or other remittances are received without adequate details (usually for accommodation or non-inpatient fees) and all possible steps that have been taken to identify the payment are not successful, they are receipted to the General Ledger Suspense Account (using On-Line Sundry Receipts).

12. All such payments remain in the General Ledger Suspense Account until identified. Once identified, a journal is prepared to credit the outstanding invoice. In addition, a journal is prepared to adjust the accounts in the General Ledger. (See the Cashiers' Journals procedures for further detail.)

13. Once all receipts in a batch have been entered, the bank deposit sheet is closed and the bank deposit sheet printed.

14. Daily balancing of cash takings is performed by each cashier and includes over the counter payments.

15. Each morning the deputy chief cashier updates the ledger records with details of cash input of that particular day. This should result, in the printing of the following reports the following morning at the local printer:

- Receipt Audit Listing
- Receipt Summary Audit - By Ledger
- Bank Deposit Summary - By Bank Sheet
- Ledger Summary Report
- Invoices in Credit Listing
- Receipt Listing - General Ledger
- Receipt Listing - Other Receipts (for future use)
- Receipt Listing - SP & T Fund
- Summary Sundry Bank Sheets
- Edit Report Journals

16. All sundry batches processed in the previous day are accumulated and agreed in total to the Summary Bank Deposit Sheets. The GL receipts is reviewed for accuracy and agreed in total to the batches processed in the previous day.
17. All patient account batches (Accommodation and Non-Inpatients) are then accumulated similar to the above procedure and agreed in total to the cash collected column of the Ledger Summary Report for the particular ledger concerned.

**Private Practice Trust Fund Remittances**

18. All mail remittances for the Private Practice Trust fund are divided into two categories, i.e.

(i) Pathology; and
(ii) Diagnostic and clinical.

19. The remittances are counted and the total number of remittances is recorded in the "Mail Remittances Received Book". The remittances are further sorted into:

(i) credit card payments - accepting major credit cards, receipting procedures vary from other payments.

(ii) payments by pensioners - personal payments made by pensioners are checked for need to pay gap; and

(iii) hospital cheques - payments by other hospitals, institutions and government departments.

20. If a remittance advice is not returned with a payment, a pro-forma payment advice is completed for future reference. This will contain, at the least, the name of the patient/debtor and the amount tendered.

21. The batches are then processed by individual cashiers who will be responsible for identifying and inputting the remittances.

22. All remittances are checked to ensure that there is sufficient information to identify the patient and the invoice(s) the payment relates to. Identification will usually be possible by reference to the name on the cheque or credit card or because of the inclusion of the original invoice(s) or remittance advice(s), health fund or Medicare benefit statement, a covering letter or other appropriate documentation.

23. All identified remittances are then input. The bank deposit sheet number to which the remittances are being entered is written on the batch header.
A. GENERAL PRINCIPLES

24. Once the remittances have been identified the batch header is completed, detailing the batch total and number of remittances in the batch. The person preparing the batch header signs and dates it.

25. If money orders, bank cheques or other remittances are received without essential details (e.g. invoice number) all possible steps are taken to identify the payment. If the payment is not identified, it is recorded in the Unidentified Status Payments Register.

26. The unidentified payments are then receipted to the Private Practice Trust Fund Suspense Account until the patient supplies the required details.

27. All such payments remain in the suspense account until identified. Once identified, a journal is prepared to credit the outstanding invoice. In addition, a journal is prepared to adjust the accounts in the Private Practice Trust Fund. (See the Cashiers' Journals procedures for further detail.) The Unidentified Status Payments Register is also updated to reflect the change in status of the receipt.

28. Receipts for personal payments are printed by the computer system as part of normal end of day procedures. The receipts are signed and placed in envelopes for postage to the patient/debtor.

29. Similar to the procedures followed at the Counter, all batches for a particular day are agreed to the total of batches processed which is then agreed to the cash collected column of the Ledger Summary Report for the particular ledgers concerned.

Banking

30. Once a bank deposit sheet is produced, the bank deposit sheet and corresponding cheques are passed to the banking clerk. The cheques are add-striped and checked to the total of the bank column on the bank deposit listing. Any discrepancies should be followed up at this point.

31. Once all bank deposit sheets have been agreed a manual bank deposit slip is prepared and the remittances are banked in the local hospital branch of the bank.

Follow-Up Procedures

32. At the end of each month, the Unidentified Payments Register is reconciled to the Private Practice Trust Fund Suspense Account.

33. On a daily basis a check is made to ensure that all batches have been appropriately completed and closed prior to updating ledger accounts.
A. GENERAL PRINCIPLES

34. At the end of each month, the Unidentified Payments reconciliation is reviewed to ensure that any discrepancies are cleared on a timely basis.

35. At the end of each month, the total of the Bank Deposit Summaries and the total of the batch control register is reconciled to the appropriate General Ledger account. Any discrepancies are investigated and corrected.

36. At the end of each month the reconciliation is reviewed and authorised.

JOURNALS

1. Journals may be raised to write-off bad debts, to correct invoicing and pricing errors, or to correct patient classification codes or patient episode admission and discharge dates.

See Accounts & Audit Determination for write-off delegates.

2. The Fees Supervisor prepares the journal, signs and dates it and forwards it, along with any supporting documentation, to a senior officer for review.

3. The journal, along with all supporting documentation, is reviewed and then forwarded for authorisation. Where the journal is for a write-off, the hospital should have several levels of authorisation, e.g.:

   (i) up to $1,000 - the Director of Finance and Budget;

   (ii) up to $2,000 - the Chief Executive Officer;

   (iii) $2,000 and over - the Area/hospital board.

4. All other journals are to be authorised by either the Revenue Manager or the Financial Controller. Supporting documentation is to be sent with journals in all cases for review and authorisation.

5. After authorisation the journals are batched, a batch header prepared and the batch register updated. The batch header details the batch number, the net value of the batch and the number of documents and line items in the batch. The strip list used to total the journals is stapled, with the batch header, to the journals. The journal batches are then input to the system by the data entry operator.

6. When all journals have been input, they are returned to the fees clerk. The edit report is generated automatically by the system when a batch is posted.
A. GENERAL PRINCIPLES

7. If there are no error messages on the edit report, it is agreed on a one-for-one basis to the journal documents that were included in the batch. Any errors are investigated and, if necessary, the appropriate line item reversed using a journal and the resubmitted for input. All fields checked should be ticked and the edit report signed and dated as evidence of the one-for-one check.

8. Any error messages appearing on the edit report are investigated, corrected and the affected batch resubmitted to data entry for input.

9. The Fees Supervisor ensures that for each batch input, the net value of journals and the number of line items input shown on the edit report agrees to that shown on the batch header.

10. The batch edit report is signed and dated as evidence of the review and the batch register is updated to reflect the acceptance of the input journal batches. (Note - the batch register is not to be updated until all line items in a batch have been cleared of any keying of other errors.)

11. On a weekly basis, the journal batch register is reviewed and any long outstanding journal batches are investigated.

12. On a monthly basis, the journal batch register is reviewed to ensure that any long outstanding journal batches are being investigated.

13. On a daily basis, the journal batch edit reports are reviewed to ensure that they have been checked and that any reported errors are being resolved within a reasonable time period.

14. On a monthly basis a Small Balance Write-Off is to be carried out by the system. This involves the write-off of outstanding amounts less than say $10.00, where the balance is not equal to the original invoice amount.

15. A report is to be produced of all balances written off. This report is then submitted by an officer delegated to do so for approval, along with the summary sheet.

CASHIERS' JOURNALS

1. Journals raised by the cashiers' department would normally relate only to remittances received and input by them rather than to adjustments made to invoice values.

2. The necessity for raising journals is brought to the attention of the Journals cashier during normal day-to-day operations and may be to correct over-payments, process refunds, reverse dishonoured cheques or reverse inaccurate input.
3. A journal form is raised, providing the following information:

(i) Sub-ledger,
(ii) invoice number,
(iii) journal value;
(iv) debit/credit;
(v) journal transaction code;
(vi) surname of patient or debtor; and,
(vii) narration

4. The net value of the journals's line items are totalled and the journal form is signed and dated by the person completing the form. Journals are then batched detailing batch number, batch total and number of line items in the batch. The batch with all supporting documentation, is then forwarded for review and authorisation.

5. The batch and its supporting documents are reviewed to ensure validity. The individual journals are then signed.

6. The completed batches are written up in the batch control register, providing the following details:

(i) batch number;
(ii) batch type;
(iii) batch total; and
(iv) overall total.

7. The completed batches are then input to the system. Each journal is stamped with the date of input after entry.

8. When all journals have been input, they are returned to the senior cashier with the Journal Batch Edit report. The edit report is generated automatically by the system when a batch is posted.

9. If there are no errors on the edit report, it is agreed on a one-for-one basis to the journal documents that were included in the batch. Any errors are investigated and, if necessary, the appropriate line item reversed using a journal and then resubmitted for input. All fields checked should be ticked and the edit report signed and dated as evidence of the one-for-one check.

10. Any error messages appearing on the edit report are investigated, corrected and affected batch resubmitted for input.
11. The senior cashier ensures that for each batch input the net value of journals shown on
the edit report agrees to that shown on the batch header.

12. The batch edit report is signed and dated as evidence of the review and the batch
register is updated to reflect the acceptance of the input journal batches.

13. On a weekly basis, the batch control register is reviewed and any long outstanding
batches are followed up.

14. On a monthly basis, the batch control register is reviewed to ensure that any long
outstanding batches are being investigated.

15. On a monthly basis, the journal batch edit reports are reviewed to ensure that they
have been checked and that any reported errors are being resolved within a reasonable
time period.
II. INFRASTRUCTURE CHARGES

Infrastructure charges are deductible from fees raised by visiting medical practitioners or salaried medical specialists (exercising rights of private practice) for the use of hospital facilities and/or staff (including clerical services provided by hospital staff). Listed hereunder are the percentages to be deducted from fees collected that are to be remitted to revenue.

**RADIOLOGY/RADIO THERAPY SERVICES - VISITING MEDICAL PRACTITIONERS**

<table>
<thead>
<tr>
<th>Medicare Benefits Schedule Book Reference</th>
<th>Hospitals Share of Fees Collected Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATEGORY 2 – DIAGNOSTIC PROCEDURES AND INVESTIGATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>11600 Vascular - Blood Pressure Monitoring</td>
<td>20%</td>
</tr>
<tr>
<td>11900 – 11921 Genito/Urinary Physiological Investigations</td>
<td>40%</td>
</tr>
<tr>
<td><strong>CATEGORY 3 – THERAPEUTIC PROCEDURES</strong></td>
<td></td>
</tr>
<tr>
<td>15000 – 15115 Radiation Oncology - Superficial/Orthovoltage</td>
<td>50%</td>
</tr>
<tr>
<td>(60% for privately referred outpatients)</td>
<td></td>
</tr>
<tr>
<td>15203 – 15272 Radiation Oncology - Megavoltage</td>
<td>20%</td>
</tr>
<tr>
<td>15303 – 15339 Insertion, implantation or removal of sealed radioactive source</td>
<td>10%</td>
</tr>
<tr>
<td>15342/45/51/54 Construction with / without application of radioactive mould</td>
<td>50%</td>
</tr>
<tr>
<td>15348/57 Subsequent application of radioactive mould</td>
<td>20%</td>
</tr>
<tr>
<td>15500 – 15562 Radiotherapy planning</td>
<td>20%</td>
</tr>
<tr>
<td>16003 – 16012 Administration of therapeutic dose of radioisotope</td>
<td>10%</td>
</tr>
<tr>
<td>16600 – 16636 Interventional techniques</td>
<td>20%</td>
</tr>
<tr>
<td>35200 Arteriography – Venography</td>
<td>40%</td>
</tr>
<tr>
<td><strong>CATEGORY 5 - DIAGNOSTIC IMAGING SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>55028 – 55085 Ultrasound - General</td>
<td>40%</td>
</tr>
<tr>
<td>55113 – 55135 Ultrasound - Cardiac</td>
<td>20%</td>
</tr>
<tr>
<td>55238 – 55296 Ultrasound - Vascular</td>
<td>20%</td>
</tr>
<tr>
<td>55600 – 55603 Ultrasound - Urological</td>
<td>20%</td>
</tr>
<tr>
<td>56001 – 57356 Computerised Tomography</td>
<td>84%</td>
</tr>
<tr>
<td>57506 – 58527 General Radiology Services</td>
<td>60%</td>
</tr>
<tr>
<td>58700 – 58721 Radiographic examination of urinary tract</td>
<td>40%</td>
</tr>
<tr>
<td>58900 – 58939 Radiographic examination of alimentary tract &amp; biliary system</td>
<td>40%</td>
</tr>
<tr>
<td>59103 – 59303 General Radiology Services</td>
<td>60%</td>
</tr>
<tr>
<td>59312/14/18 General Radiology Services</td>
<td>60%</td>
</tr>
<tr>
<td>59306 – 59309 Mammary Ductogram</td>
<td>40%</td>
</tr>
</tbody>
</table>

54(04/11/10)
(Terminology change July 2019)
### A. GENERAL PRINCIPLES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>59503</td>
<td>Radiographic examination in connection with pregnancy</td>
<td>40%</td>
</tr>
<tr>
<td>59700 – 59763</td>
<td>Radiographic examination with opaque or contract media</td>
<td>40%</td>
</tr>
<tr>
<td>59903 – 60078</td>
<td>Angiography with / without Digital Subtraction Technique</td>
<td>40%</td>
</tr>
<tr>
<td>60100</td>
<td>Tomography</td>
<td>40%</td>
</tr>
<tr>
<td>60500 – 60509</td>
<td>Fluoroscopic examination</td>
<td>40%</td>
</tr>
<tr>
<td>61109</td>
<td>Examination not otherwise covered</td>
<td>40%</td>
</tr>
<tr>
<td>60918 – 60927</td>
<td>Preparation for radiological procedure</td>
<td>10%</td>
</tr>
</tbody>
</table>

**NOTE:** For those services where the charge is 10%, the charge is only to apply where the practitioner wishes the hospital to issue accounts for these services. Where the practitioner does not wish the hospital to issue accounts for these specific services, no Infrastructure charge should be made.
A. GENERAL PRINCIPLES

PATHOLOGY

Visiting Pathologists

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

CATEGORY 6 – PATHOLOGY SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65060 – 65082</td>
<td>Haematology</td>
<td>80%</td>
</tr>
<tr>
<td>65084 – 65087</td>
<td>Bone Marrow examination</td>
<td>10%</td>
</tr>
<tr>
<td>65090 – 65181</td>
<td>Haematology</td>
<td>80%</td>
</tr>
<tr>
<td>66500 – 66900</td>
<td>Chemical</td>
<td>90%</td>
</tr>
<tr>
<td>69300 – 69500</td>
<td>Microbiology</td>
<td>80%</td>
</tr>
<tr>
<td>71057 – 71203</td>
<td>Immunology</td>
<td>80%</td>
</tr>
<tr>
<td>72813 – 72857</td>
<td>Tissue pathology (Histopathology)</td>
<td>10%</td>
</tr>
<tr>
<td>73043 – 73065</td>
<td>Cytology – Scanning only</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Cytology - Involving review and report</td>
<td>10%</td>
</tr>
<tr>
<td>73287 – 73324</td>
<td>Genetics</td>
<td>10%</td>
</tr>
<tr>
<td>73521 – 73529</td>
<td>Infertility and pregnancy tests</td>
<td>80%</td>
</tr>
<tr>
<td>73801 – 73811</td>
<td>Simple basic pathology tests</td>
<td>10%</td>
</tr>
</tbody>
</table>
Infrastructure Charges for Staff Specialists on Level 2 to 5 arrangements

There shall be paid into the Private Practice Trust Fund 100% of fees received arising from the rendering of accounts to private patients seen by those specialists who are working under this arrangement.

From the fees so paid into the Private Practice Trust Fund, there shall be paid as a first charge the following Infrastructure charges to the hospital for the provision of services and facilities, which will be a percentage of the gross fees received.

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

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

(iii) fees received for pathology services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histopathology</td>
<td>20%</td>
</tr>
<tr>
<td>(including cytolopathology)</td>
<td></td>
</tr>
<tr>
<td>Microbiology (78/236)</td>
<td>60%</td>
</tr>
<tr>
<td>Immunology</td>
<td>60%</td>
</tr>
<tr>
<td>Haematology</td>
<td>80%</td>
</tr>
<tr>
<td>Chemical Pathology</td>
<td>90%</td>
</tr>
</tbody>
</table>

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

(v) for Radiation Oncology (Group T2) the Infrastructure charge is by local agreement.

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

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

**Infrastructure Charges for Scheme “D”**

Infrastructure charges for staff specialists/visiting medical officers operating under scheme “D” are to be applied on the same basis as those percentages applying to visiting medical officers.
B. RADIOLOGY/RADIOOTHERAPY SERVICES

I. SCHEME FOR REMUNERATION OF VISITING RADIOLOGISTS IN RECOGNISED HOSPITALS

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

1.1 fees collected in respect of private and Veterans' Affairs and ineligible inpatients and privately referred non-inpatients less charges for the use of hospital facilities and/or staff;

1.2 a percentage of the appropriate scheduled fee for services to compensable inpatients; and

1.3 contractual payments for services to other patients and for administrative duties. (See points 7 and 8.)

2. Accounts for radiological services to private inpatients as per 1.1 above (other than compensable inpatients) and privately referred non-inpatients will, subject to agreement in each case by the radiologist concerned, be issued by the hospital in the name of the radiologist. Receipts will likewise be issued by the hospital in the name of the radiologist. See point 11 re Circular 2000/93.

3. The fee charged for each service will be no higher than the fee listed for that service in the current Medical Benefits Schedule issued by the Commonwealth Department of Health.

4. Hospitals will be wholly responsible for issuing accounts, collecting fees and maintaining records.

5. A charge will be made by the hospital to the visiting radiologist for the use of hospital facilities and/or staff, including clerical services provided by hospital staff, in respect of radiological services to private, Veterans' Affairs and ineligible inpatients and privately referred non-inpatients.

6. A special trust account will be created for fees collected either for each individual radiologist or for a group of radiologists as agreed between the hospital and the practitioners concerned. Fees collected on behalf of visiting radiologists will be disbursed monthly.

7. For a diagnostic radiologist, contractual payments should be negotiated yearly in advance, on the basis of one session per 1,000 examinations per year in respect of hospital inpatients and registered non-inpatients, with an additional allowance (if appropriate) for approved administrative duties not directly associated with
patients' examinations. An examination is equivalent to a single Medical Benefit Schedule item. The figure of 1,000 examinations is an overall figure, and has been arrived at taking into account leave, call back, after hours work and other factors; consequently additional payment will not be made. The Chief Executive Officer/General Managers' agreement to the contractual payments for each radiologist should be obtained.

8. "Contractual payment shall be based on the base rate of remuneration of visiting specialists as agreed from time to time between the Department and the Australian Medical Association. To the base rate shall be added agreed loadings for superannuation and private practice. The aggregates shall then be multiplied by 3.5 to calculate the weekly contractual payment per 1,000 examinations per annum. The rate of remuneration shall be subject to periodic review and variation by agreement between the Department and the Royal Australasian College of Radiologists".

The Department will automatically advise hospitals of variations in payment to visiting radiologists following any review of the base hourly rate of remuneration of visiting specialists generally.

9. For services to compensable inpatients, the visiting radiologist should be paid the appropriate Medical Benefit Schedule fee from the hospital's General Fund less a charge for the use of hospital facilities and/or staff.

10. The hospital will submit records relating to fees to its own auditor during every audit of the hospital's accounts and records. The radiologist may also have the records audited by a registered public accountant of his own choice at his own expense.

11. Where the Chief Executive Officer of the Area Health Service or the General Manager of the District Health Service agrees that it is not possible or practicable for X-ray examinations to be carried out at the hospital, the patients may be transferred to the radiologist's own practice for such examination. It is understood that this would be a very rare occurrence. Hospital classified inpatients and registered non-inpatients would not be charged but the hospital would be charged by the radiologist at no more than the Medical Benefits Schedule fee. In respect to referral of private inpatients to private radiology providers of x-rays and CT scans there are no restrictions. (2000/93)

12. Prior notice of termination of the agreement would be three months from either party except where radiologists have held the appointment for more than three years, when six months notice of termination should be given by either party.

13. Upon termination of the agreement in accordance with paragraph 12. above or upon the death of the radiologist, the radiologist or his/her estate should continue to receive monthly his/her share of revenue from accounts sent on his/her behalf.
II. VISITING RADIOTHERAPISTS AND SPECIALISTS IN DIAGNOSTIC ULTRASOUND

(81/334, 89/126)

Following negotiations with the Royal Australasian College of Radiologists, the following has been agreed:

(1) These specialists may charge private referred outpatients as defined for visiting radiologists.

(2) Payments for the treatment of hospital patients and registered non-inpatients should be made as follows:

"Specialists in Diagnostic Ultrasound:

(i) **Either**, Hourly rates as agreed upon between the Health Administration Corporation and the Australian Medical Association (NSW Branch). Such rates shall be subject to periodic review and variation by agreement between the Corporation and the Association.

(ii) **or**; if a visiting radiologist reports on radiology and ultrasound, the ultrasound examinations should be included in his/her entitlements under the contractual arrangements for visiting radiologists."

If option (i) is applicable the hourly rates of remuneration in respect of Medical Services provided by Medical Officers under Sessional Contracts as defined in Section 29K of the *Public Hospitals Act*. However, if option (ii) is applicable the contractual payments should be the same as those outlined for visiting radiologists.

"Radiotherapists: contractual payments as agreed for visiting radiologists, except that the basis of (prospective) calculations should be 300 occasions of treatment per annum. Consultations are not to count in this calculation."

(iii) The following policies should apply in relation to referral of patients to CT Scanning units:-

1. Where a Scanner exists within the hospital no inpatients or registered outpatient should be referred elsewhere other than in exceptional circumstances."
2. For hospitals without a Scanner, referrals of the above categories of patients should be to another public hospital wherever possible.

3. Before any patient is referred to a private Scanner, hospitals should ensure that the approval of a designated senior hospital officer is obtained.

4. Hospitals should maintain a register of patients referred to private scanning units, and a related register of patients referred to other public hospital units.

5. Referral of patients for CT Scanning should continue to be restricted to appropriate clinical specialists, except in emergency situations. **There are no restrictions on the referral of private inpatients to private radiology providers of x-rays and CT scans.** (2000/93)

### III. CHARGING ARRANGEMENTS FOR PRIVATELY REFERRED OUTPATIENTS AS RECOGNISED HOSPITALS - VISITING RADIOLOGISTS

(80/252 - 18.8.80 - C.2071)
(81/355, 80/290, 86/175)

**Definition of a Private Referred Outpatient**

Patients who are not inpatients of a recognised hospital may be regarded as privately referred outpatients only if they satisfy the following conditions:-

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

e.g. The referral must be to radiologist **by name**, not to the hospital or the radiology department.

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

3. No patient who presents at casualty or an outpatient clinic is to be privately referred for treatment of, or examinations relating to, the episode of illness which caused him/her to present at casualty; or the outpatient clinic. Unless such a referral is specifically agreed to by the patient and it is brought to the attention of the patient that he/she will be responsible for the charges raised by private practitioners.
4) Referrals are to be genuine referrals, made "at arms length", i.e. the referral letter shall be completed before the patient's first appointment is made for an examination, treatment or consultation.

5) At the time that the appointment is being made, patients are to be advised that they will not be treated as registered outpatients of the hospital, and that they will be charged by the attending specialists as well as for diagnostic services ordered by that specialist.

Privately referred outpatients must not be registered as non-inpatients.

The radiologist should advise the hospital of those privately referred outpatients for whom he/she wishes accounts to be raised. It is the radiologist's responsibility to ensure that the criteria for a privately referred outpatient have been met.

All other patients who are not inpatients of a recognised hospital should be registered as non-inpatients, and must not be charged by the radiologist. Of course, patients who satisfy the conditions to be a privately referred outpatient need not be charged by the visiting radiologist. In this case, they should be registered as non-inpatients.

**Principles Applied in Drafting Arrangements**

The Department and the College have been anxious to promote good patient care and efficiency in the provision of radiological services. The following principles were applied in drawing up the arrangements:-

a) To avoid unnecessary hospitalisation, there should not be a financial penalty to a radiologist for providing treatment to privately referred patients on an outpatient basis rather than on an inpatient basis;

b) Radiologists should be able to offer a full range of services to privately referred outpatients in an area in which they work, provided proper equipment is available;

c) It is possible that duplication of radiology equipment in hospitals and private rooms will be discouraged if mutually acceptable and secure conditions of service can be arranged.

**Services for Which Visiting Radiologists May Charge Privately Referred Outpatients**

Radiologists may charge for those items in Section 5 Category 5, Section 2 Category 3, Section 5 Category 5 Group 14 of the Medicare Benefits Book plus item number 55006, except items in Group 13 Subgroups 1 to 6, 9 and 11 of Section 5 Category 5. The exclusions cover relatively uncomplicated diagnostic radiology services.

**For items 15000 - 15115 (General Radiotherapy Services) the hospital is to take a 60% facility charge.** (80/253)
The exclusions do not apply to:

1) A visiting radiologist who conducts his whole practice in recognised hospitals.

2) A radiologist in respect of services to privately referred outpatients at a hospital in an area in which the radiologist does not have private rooms and which is so distant from his/her private rooms that it would not be feasible for patients to attend the rooms. This provision should normally only apply to hospitals outside Sydney, Newcastle and Wollongong, where the visiting radiologist does not have rooms in the area; in Sydney, Newcastle or Wollongong, the Areas' Chief Executive Officers' agreement must be obtained before the exclusions can be waived.

IV. RADIOGRAPHIC AND RADIOPHYSICAL SERVICES AT HOSPITALS WITHOUT THE REGULAR SERVICE OF A RADIOLOGIST

In hospitals where there is no regular service provided by a Specialist Radiologist and X-rays are interpreted by a medical practitioner without higher qualifications in radiology, the following financial arrangements should apply:

i) where the medical practitioner both takes and interprets the X-ray, the fees collected should be divided 60% to the medical practitioner and 40% to the hospital.

ii) where a member of the hospital staff takes the X-rays and the medical practitioner interprets them, the fees collected should be divided 60% to the hospital and 40% to the medical practitioner.

Where it is considered necessary to refer X-rays to a radiologist for a second opinion, charges at the rate set by the Schedule of Medical Benefits should be raised and 80% of the fees collected divided between the hospital and the medical practitioner as appropriate in i) and ii) above. The remaining 20% should be paid to the Specialist Radiologist who provided the second opinion.

The above provisions only apply to those country hospitals which neither employ Salaried Radiologists nor have arrangements for regular visits by a Specialist Radiologist.

V. INTRAVENOUS PYELOGRAMS

When the contrast medium for an intravenous pyelogram is injected by a medical practitioner other than the radiologist reporting on the film or a salaried hospital doctor then that medical practitioner would receive 25% of the scheduled fee collected with the radiologist receiving 30% and the hospital 45%.

The medical practitioner's percentage (25%) covers the injection itself and the time necessarily spent with the patient after the injection to treat any adverse reaction.
B. RADIOLOGY/RADIOThERAPY SERVICES  6.43.1

MAGNETIC RESONANCE IMAGING - FINANCIAL ARRANGEMENTS (PD2005_557)

THIS POLICY DIRECTIVE HAS BEEN MADE OBSOLETE – PLEASE SEE IB2010_018.
I. PATHOLOGY SERVICES - GENERAL PROCEDURES

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

   - Fees collected in respect of services to private inpatients including ineligibles less charges for the use of hospital facilities and/or staff;
   - A percentage of the appropriate scheduled fee for services to compensable inpatients;
   - Sessional fees for services to other patients (including organ donors) and for managerial, administrative and consultative duties; and
   - A fee for each autopsy performed on behalf of the hospital.

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

   2.1 Chargeable Patients

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

   - in the requesting practitioner’s own handwriting -
     “the individual pathology services, or recognised groups of pathology tests of particular organ or physiological function to be rendered”. The description must be sufficient to enable the item in which the service is specified to be identified;
   - the requesting practitioner’s signature and date of request;
   - the surname, initials of given names and practice address of the requesting practitioner (the practitioner’s surname and initials will be satisfactory unless there is more than one practitioner with the same surname and initials at the same address); and provider number - the provider number may be obtained by enquiry to the Commonwealth.
   - the name and address of the patient;
   - the date the pathology services were determined to be necessary;
where the patient is attending a recognised hospital, or Central Service the classification of that patient as a private inpatient, or hospital (public) inpatient, non-inpatient or compensable patient; and

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

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

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

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

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

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

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

     (ii) date of initial request.

2.2 Specific provisions for Group Services.

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

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

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

• the patient’s name;

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

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

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

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

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

OR

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

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

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

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

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

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

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

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

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

**OR**

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

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

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

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

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

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

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

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

(SEE 3.1 FOR CHARGING ARRANGEMENTS)

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

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

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

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

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

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

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

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

General

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

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

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

1 Introduction:

1.1 All health services are required to operate their pathology services (one per health service) as a Business Unit.

1.2 The accounting and reporting guidelines for business units are prescribed in Section 9 of the Area Health Service and Public Hospitals Accounting Manual. Revenues collected will include all facility fees and research monies (exclude Special Purpose & Trust Account (SP&T) funds) and expenses will include all direct and indirect costs.

1.3 The Accounting Guidelines require a determination of charge out rates (or Prices) on different products with prices to be approved by the CE or delegate as appropriate. Charge out rates for non-NSW Health activities are to include a component to cover assessed Crown Liabilities.

1.4 The Peak Pathology Council has considered the matter of charge out rates for Pathology Services to establish a standard methodology across all services but at the same time recognising the right of Area Boards or Area Networking Boards to make the final decision on prices.

1.5 When a conflict in policy exist, the contents of this section takes precedence over existing NSW Department of Health policy in regards to NSW Public Health Sector Pathology charging.

2 Pathology Charge Out Pricing Principles:

2.1 All pathology services will have available for distribution to users a schedule of rates and prices for provided services such a schedule to be predominantly based upon the Pathology Service Table (PST) (See Clause 3 below for further explanations). Only one charge can be raised for any one test, such a charge is to cover both the performance and interpretation.

2.2 Where the NSW Department of Health issues any direction on pathology fees that direction will be observed and take precedence over Principle 2.1 above.

2.3 All services provided by pathology services will be charged in accordance with clauses 2.1 and 2.2 above unless:

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

2. a health service provides a block grant to cover services not normally associated with the PST (eg forensic pathology, HIV confirmation).
2.4 Where a reasonable number of tests are being referred out from a pathology service in one health service to another health service, the referring Area Pathology Service may periodically undertake a “contestability” study to determine if it would be more effective or efficient to do such tests in its own laboratories, such studies to be fully documented by a business case with the final decisions to be made locally. It is emphasised that the selection of providers external to the Area should remain subject to any agreements existing concerning “networking” of pathology services.

2.5 Pathology services have a responsibility to ensure timely provision of invoices and other information to enable a journalisation of internal revenues or claims to be issued to other health services and users.

2.6 Health services will process internal journals upon receipt from their pathology service. Payments by one health service to a pathology service in another health service for services provided will be within normal trading terms (ie within 45 days of receipt of invoices).

2.7 Where a dispute over payment exists within a health service, that dispute will be resolved in accordance with instructions issued by the Chief Executive Officer. Where a dispute over payment exists between two health services that will be resolved in accordance with advice issued by the NSW Department of Health or where a dispute over payment exists with a non NSW Health user, normal debt recovery procedures are to be followed.

3 Guidelines for Determination of Pathology Charges:

3.1 Where the services are of a type described in the PST of the Medicare Benefits Schedule (MBS) the following should apply:

3.1.1 Unless otherwise agreed and stated explicitly by the provider, the service will be provided in accordance with the description of the item in the PST.

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

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

3.2.1 Where the fee is expressed as a percentage of the current MBS fee that percentage should be determined after due process to determine what is required for adequate total cost recovery and not arbitrarily. This should include not only direct costs but also an appropriate moiety for equipment replacement and other infrastructure costs as specified in the “Accounting and Reporting Guidelines for Business Units”
3.2.2 When charging internally an “episode fee” should be used in addition to the test fee(s) the Medicare Benefits Schedule (e.g. “coning rules” and “inbuilt multiple services rule”) should not apply automatically but the issues which these present should be addressed explicitly in the policy document approved by the relevant Area Health Service.

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

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

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

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

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

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

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

Notes:

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

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

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

3.5.3 In arriving at a fee in this clause the charge shall be fair, competitively neutral and have regard to indirect and overhead costs.
3.6 Where it has been determined that some activities provided by Area pathology Services are to be funded other than using the PST approach:

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

3.6.2 The Services covered by this clause may include:

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

3.7 This documentation should include

- An adequate description of the activity/activities (see clause 14.2 for examples)
- the organisation(s) funded to provide them
- the dollar amount of funding allocated and the number of services to be provided for this funding.
- the identity of the person(s) or bodies corporate who may access these services without attracting a “user charge” as specified in clauses 3.5 and 3.6 above.
- the duration for which the arrangement remains in force and the circumstances which would result in re-negotiation between the funder and the provider.

4 Transitional Arrangements for clauses 3.5 and 3.6:

4.1 Where parts of Clauses 3.5 and 3.6 impact upon more than one health service, a service level agreement must exist between the provider health service and the user.

4.2 Provider and referring health services are not to take unilateral action that will adversely affect the other.

4.3 Where agreement cannot be reached (including a meeting of relevant Chief Executive Officers) the matter is to be referred to Finance & Commercial Services of the Department for consideration of resolutions.

4.4 Departmental health policies exists as at 1 July 2000 for the following services:

- Genetics (Specialised Testing for Genetic Disorders)
- HIV Testing (in accordance with the formula in “A Guide to Aids program for Area Health Services and Districts 1993/94” as varied from time to time by changes to Department policy).

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

5 Charging of Pathology Services

5.1 The attached schedule outlines the NSW Department of Health’s charging policy.
### Charging Policy for Pathology Services

#### Non Admitted Patients

<table>
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<tr>
<th>Patient Classifications</th>
<th>Notes</th>
<th>Charging Policy</th>
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| Public (Including Prisoners) and all no charge patients eg reciprocals | (4) | **Within Health Service**  
Rates by mutual agreement approved by AHS Board  
**External to Health Service**  
Charge facility MBS rate |
| Privately Referred Non-Inpatients | | Charge patient up to the MBS rate |
| Veterans’ Affairs | | **Within Health Service**  
Rates by mutual agreement approved by AHS Board  
**External to Health Service**  
Charge facility MBS rate |
| Ineligible/Overseas | (2) | Charge patient cost recovery |
| Compensable 3rd Party (NSW) (Bulk Agreement) | (4) | **Within Health Service**  
Rates by mutual agreement approved by AHS Board  
**External to Health Service**  
Charge facility cost recovery rate |
| 3rd Party External NSW | (2) | Charge insurer cost recovery rate |
| Workers Comp. | (1) | Charge insurer occasions of service rate |
| Other | (2) | Charge insurer cost recovery rate |

#### Admitted Patients

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<tr>
<th>Patient Classifications</th>
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<th>Charging Policy</th>
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<tr>
<td>Private Patients</td>
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<td>Charge patient MBS rate</td>
</tr>
</tbody>
</table>
| Public (Including Prisoners) and other non chargeables eg reciprocals | (4) | **Within Health Service**  
Rates by mutual agreement approved by AHS Board  
**External to Health Service**  
Charge facility MBS rate |
| Veterans’ Affairs | | Charge Veterans’ Affairs MBS rate |
| Ineligible/Overseas | (2) | Charge patient cost recovery |
| Compensable 3rd Party (NSW) | (4) | **Within Health Service**  
Rates by mutual agreement approved by AHS Board  
**External to Health Service**  
Charge facility cost recovery rate |
| 3rd Party (External NSW) | (3) | **Within Health Service**  
Rates by mutual agreement approved by AHS Board  
**External to Health Service**  
Charge facility cost recovery rate |
| Workers Comp. | (1) | Charge insurer occasions of service rate |
| Other | (2) | Charge insurer cost recovery rate |
All Patients

Service is of a type not listed in the PST (but similar)
Agreed in advance with the user of the service.

Public Health, infection control etc (Clause 14)
Memorandum of Understanding between all relevant parties.

Notes:

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

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

   Within Health Service
   • Charge facility rates by mutual agreement approved by the AHS Board

   External to Health Service
   • Charge facility cost recovery rate

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

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

2. The Department of Health in its allocation letter 97/98 indicated that staff specialists could set own fees in respect of services they provide to ineligible and compensable patients or the OOS rate whichever is the higher.

3. The accommodation rates set by the Department of Health incorporate all diagnostic services. Charges have to be raised against facility.

4. Present policy indicates that charge is to be cost recovery rate.
1. Introduction


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

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


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

These tests are used to:

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

using the following techniques or processes:

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

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

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

2.1 Funding of testing

The following funding policy takes precedence over PD2005_533 “Principles for Funding of NSW Public Health Sector Pathology Services”

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

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

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

2.2 Cost recovery processes


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

2.3 Responsibility for authorising tests


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

In some instances, the specialty of genetics overlaps with other specialties for example, oncology, gastroenterology or neurology. Where this occurs it may be appropriate for responsibilities to rest also with such units.

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2.4 Public patients where public sector services are not available

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

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

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

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

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

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

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

2.6 Cost recovery processes and patient privacy and confidentiality

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

3. Charging for Patients in the Private Sector

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

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

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

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

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

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

3.7 Privacy and confidentiality of test results – see 2.6.

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

Private patients are responsible for their own test costs.


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<tr>
<th>Patient Classification</th>
<th>Pathology Collection</th>
<th>Costs to be met by:</th>
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<tr>
<td>Eligible patients</td>
<td>Public hospital patholgy collection service</td>
<td><em>Area Health Service/public facility requesting the test</em></td>
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<td>Private pathology collection service (only where initial referral is from a public sector specialist clinic)</td>
<td><em>Area Health Service/public facility requesting the test</em> provided there is written authorisation indicating its agreement to meet the test cost. Otherwise patient to be considered private and billed accordingly.</td>
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<tr>
<td>Non-Eligible Patients</td>
<td>Public hospital pathology collection service</td>
<td><em>Private patient - bill</em> the patient direct.</td>
</tr>
<tr>
<td></td>
<td>Private pathology collection service</td>
<td><em>Private patient</em> the patient direct.</td>
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**Note:** some tests provided by public sector laboratories shall only be undertaken when requested by clinical geneticists or other specialists with expertise in the genetics of the specific disorder.
The NPAAC document *Laboratory Accreditation Standards and Guidelines for Nucleic Acid Detection Techniques* recognises that many human genetic tests simply require the patient’s verbal consent after the provision of appropriate information by a qualified practitioner. There are however other human genetic tests where pre- and post-test genetic counselling as well as formal consent and confidentiality procedures are appropriate parts of the testing process and are required for optimal patient care. The current definitions of testing classes are as follows.

**Class A: Diagnostic Genetic Tests**

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

**Class B: Predictive, Carrier and Prenatal Genetic Tests**

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

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

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

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

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

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

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

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

*Responses were received from: the Human Genetics Society of Australasia, Royal College of Pathologists of Australasia, Australasian Association of Clinical Geneticists, Australian Society of Genetic Counsellors, Genetic Services Advisory Committee of the New South Wales Department of Health, Victorian Clinical Genetics Service, Queensland Clinical Genetics Service.
Appendix 2

Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Disorders

- Must be used for non-Medical Benefits Schedule items
- Before testing is commenced, the laboratory may require additional details (see *Guidelines for Specialised DNA Testing for Genetic Disorders* www.health.nsw.gov.au/health-public-affairs/publications/gentest/)

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<th>Send by courier/express post to:</th>
<th>Patient ID</th>
<th>MRN</th>
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<th>Sample</th>
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<th>Pre-natal</th>
<th>Sample</th>
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<td>amniotic fluid</td>
<td>CVS sample</td>
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<td>cultured amniocytes</td>
<td>x725 Flask(s)</td>
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<td>CVS sample</td>
<td>on ice</td>
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<td>clean</td>
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<th>Test requested</th>
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<td>PLEASE ATTACH FAMILY/PEDIGREE INFORMATION</td>
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<th>Purpose of test</th>
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<tr>
<td>Confirm clinical diagnosis</td>
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<tr>
<td>Predictive/presymptomatic testing</td>
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<td>Carrier Status</td>
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<td>Carrynt diagnosis - complete box below</td>
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<td>Determine feasibility of prenatal dx</td>
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<tr>
<td>Family study (no report for this individual)</td>
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<td>For research (no report for this individual)</td>
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<td>Bank DNA until further notice</td>
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<td>Other:</td>
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<th>Pregnancy Information (if applicable)</th>
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<tr>
<td>Is this individual or the partner of this individual currently pregnant</td>
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<td>LMP (dd/mm/yyyy)</td>
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<th>Family Information</th>
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<tr>
<td>Have samples from this family been sent to a DNA lab before?</td>
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<tr>
<td>Yes</td>
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<td>If Yes, specify</td>
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<td>Date of birth or age</td>
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<td>Ethnic background</td>
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<th>Genetic Counselling</th>
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<td>Has the individual been offered counselling consistent with Specialised/DNA Testing for Genetic Disorders?</td>
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<td>Yes</td>
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<th>Consent to testing</th>
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<tr>
<td>Has a Consent Form for Specialised/DNA Testing been completed?</td>
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<td>Yes</td>
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<th>Consent to payment</th>
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<td>Public patient, or</td>
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<td>Payment to be made by Area Health Service by arrangement</td>
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<td>Authorised by:</td>
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C. PATHOLOGY

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

Association of Genetic Support of Australasia Inc.

66 Albion Street
SURRY HILLS NSW 2010
Tel. 9211 1462
Fax. 9211 8077
Email agsa@ozemail.com.au
Web http://www.agsa-geneticsupport.org.au

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

NSW Genetic Education Program
PO Box 317
ST LEONARDS NSW 2065
Tel. 9926 7324
Fax. 9906 7529
Web http://www.genetics.com.au
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4. PERFORMANCE OF 11 BASIC TESTS BY NON-APPROVED PATHOLOGY PRACTITIONERS

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

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

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

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

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

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

GENERAL

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

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

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

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

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

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

Each hospital will submit accounting documents and records relating to fees for pathology services to its auditor during every audit of the hospital’s accounts and records. A visiting pathologist may also arrange an independent audit, at his/her own expense, of the special account into which fees collected on his/her behalf are paid. Access by a registered public accountant nominated by a pathologist for this purpose should be permitted.
PROVISION OF PATHOLOGY SERVICES TO PRIVATE IN-PATIENTS IN PUBLIC HOSPITALS (PD2010_048)

PURPOSE

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

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

MANDATORY REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

Introduction

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

The authorisation by the Tribunal expired on 7 April 2009.

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

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

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

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

**Procedure for referral to private pathology providers**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) identifying the pathology test requested;

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

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

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

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

This will ensure that the hospital staff will have a record that the patient’s specimen has been sent outside the Hospital to a private pathology provider.

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The referring medical practitioner must make his or her own arrangements for collection, storage and transportation of the specimen by the private pathology provider or the private pathology provider’s staff.

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

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

Deed of Indemnity

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

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

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

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

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

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

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

- any failure by the private pathology provider to perform services in accordance with best practices; or
- the private pathology provider’s negligence, wrongful act or omission in providing services to private in-patients at the hospital.

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

(b) Hospitals are not out of pocket

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

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

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

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

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

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

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

Related Policy Directives

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

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

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

[insert doctor’s name] [provider no]
to refer …………………………………………………………………………………………………

[insert patient’s name] [other patient details]
to Dr…………………………………………... for………………………………………………….

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

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

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

• A lower price is charged by the private pathologist *

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

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

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

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

• Other reason/s (please specify):

…………………………………………………………………………………………
…………………………………………………………………………………………

I have:

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

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

• satisfied myself that the private pathology provider:
  o is able to perform the test, and report test results, in a timely, prompt, safe and efficient
    manner;
  o is capable of interfacing with the hospital’s current clinical information systems and will
    provide the test results in a way that is compatible with the hospital’s systems and existing
    pathology test reporting practices; and
  o has entered into a Deed of Indemnity with the public health organisation.

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

Referring medical practitioner
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PART B – Patient’s Financial Consent [to be completed and signed by patient]

I, …………………………………… …understand that Dr ………………………………………

(insert name of patient/guardian) (insert name of patient’s doctor)

considers it is in my best interests to obtain the services of

……………………………

(insert name of private pathology provider)

for my pathology test(s) for the reason/s stated above.
I understand that I will be billed directly by the private pathology provider and that I will be responsible for payment of this bill. I understand that I will incur any costs which are not met by Medicare or my private health insurance fund.

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

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

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

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

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

Signed …………………………………………… Date……………………………………

Patient/guardian

53(08/07/10)
In order to ensure that PHOs and patients are not adversely affected by the use of private pathology providers by private in-patients, the Policy requires PHOs to have signed Deeds of Indemnity in place with any private pathology provider engaged by a private in-patient. The Deed of Indemnity must include the model clauses set out in this document.

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

### MODEL CLAUSE

<table>
<thead>
<tr>
<th>1. INDEMNITY AND LIABILITY INSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Indemnity relating to Services</td>
</tr>
<tr>
<td>[Private Pathology Provider] must indemnify and keep indemnified [PHO] from and against all actions, suits, claims, demands and proceedings for which [PHO] or any of its employees, contractors or agents shall or may become liable and from and against all losses, damages, compensation, costs (including legal costs on a full indemnity basis), charges and expenses whatsoever which [PHO] or any of its employees, contractors or agents may suffer:</td>
</tr>
<tr>
<td>(a) in respect of the failure by [Private Pathology Provider] to carry out the Services in accordance with Best Practices; or</td>
</tr>
<tr>
<td>(b) as a result of [Private Pathology Provider]’s negligence, wrongful act or omission in providing the Services.</td>
</tr>
<tr>
<td>[Private Pathology Provider] agrees that this indemnity will be a continuing indemnity and will survive the termination of this Deed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.2 Indemnity relating to other costs incurred by [PHO]</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Private Pathology Provider] must indemnify and keep indemnified [PHO] from and against any cost, expense or liability incurred by [the PHO] in connection with the provision of Services, including, but not limited to:</td>
</tr>
<tr>
<td>(a) administrative costs associated with creating and providing a system of dealing with the multiple ordering and reporting of pathology tests in the hospital clinical environment;</td>
</tr>
<tr>
<td>(b) costs incurred as a result of the interaction of the pathologists’ information reporting systems with the systems employed by the hospital; and</td>
</tr>
<tr>
<td>(c) costs incurred as a result of delays in the reporting of results by private pathologists.</td>
</tr>
</tbody>
</table>

53(08/07/10)
MODEL CLAUSE

1.3 Liability Insurance

(a) [Private Pathology Provider] must effect and maintain, and must ensure that each [Pathologist] employed or engaged by [Private Pathology Provider] maintains, liability insurance which must:
(i) be written for professional indemnity on a claims made basis;
(ii) contain a minimum limit of indemnity in respect of professional indemnity for any one occurrence or a series of occurrences arising out of any one event of [$20 million] and an aggregate limit of indemnity in respect of professional indemnity in respect of any one year of [$20 million] or as reasonably required by [PHO]; and
(iii) in the case of liability insurance maintained by each [Pathologist] employed or engaged by [Private Pathology Provider], be approved professional indemnity insurance under the Health Care Liability Act 2001 (NSW).

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

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

(d) A [Private Pathology Provider] will satisfy the obligation to ensure that each [Pathologist] employed or engaged by [Private Pathology Provider] maintains the insurances referred to in clause 1.3(a) in force for a period of 7 years after ceasing to provide the Services contemplated by this Deed if the [Pathologist]:
(i) is covered for the entirety of that period under the run-off cover scheme established under the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (Cth); or
(ii) maintains in force for the entirety of that period run-off cover or tail cover (howsoever described) of an equivalent limit of indemnity in respect professional indemnity as the insurances referred to in clause 1.3(a).

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

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

1.4 Termination and Suspension

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

(a) [Private Pathology Provider] either:
(i) fails to comply with any obligation under this Deed (including carrying out the Services in accordance with Best Practices); or
(ii) [Private Pathology Provider] is negligent, or commits a wrongful act or omission, in providing the Services, and

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

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

#### MODEL CLAUSE

<table>
<thead>
<tr>
<th><strong>1.5 Effect of termination</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If this deed is terminated, then all rights and obligations under it terminate other than:</td>
<td></td>
</tr>
<tr>
<td>(a) The rights or obligations of the parties under clauses 1.1-1.3 [indemnity and insurance clauses] or any other clauses expressed to survive termination or expiry; and</td>
<td></td>
</tr>
<tr>
<td>(b) The rights of the parties that accrued on or before that termination.</td>
<td></td>
</tr>
</tbody>
</table>

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

- (a) with due care and skill and administered in a timely and efficient manner and without unnecessary or unreasonable delays;
- (b) in accordance with all relevant or applicable codes of practice (including Occupational Health and Safety Codes), accreditations, authorisations, statutory, regulatory or professional requirements or practices for the delivery of pathology services, including the Services, and such other standards, requirements and guidelines as [the PHO] may nominate and notify to the [Private Pathology Provider] from time to time;
- (c) in accordance with any standards, guidelines or requirements in respect of pathology services which are issued or endorsed by the NPAAC or the Therapeutic Goods Administration from time to time;
- (d) in accordance with any standards and guidelines in respect of pathology services, as may be published from time to time by the Clinical Excellence Commission, the Australian Council on Health Care Standards (ACHS), or the Royal College of Pathologists of Australasia (RCPA);
- (e) in accordance with the New South Wales Ministry of Health’s Employment Checks - Criminal Record Checks and Working with Children Checks (PD2013_028) and any other policy or guideline of the New South Wales Department of Health or of the [PHO], which relates to the safety and care of patients, and which is notified to [Private Pathology Provider] by [PHO] from time to time;
- (f) complying with all NSW Health data collection and other requirements with regard to the Services, and those required to enable [the PHO] to comply with its reporting requirements to NSW Health, as notified by [the PHO] to [Private Pathology Provider], including those in relation to the performance standards required under the NSW Health quality and safety framework and complying with NSW Health’s Booked Patient Management Operating Guidelines;
- (g) in accordance with the Hospital’s security and identification requirements, as notified to [Private Pathology Provider] from time to time;
- (h) causing as little disturbance as possible to the operation of the Hospitals or [the PHO];
- (i) in accordance with any Performance Criteria agreed in writing between [PHO] and [Private Pathology Provider];
- (j) [complying with [the PHO]’s Code of Conduct as in force from time to time and notified to [Private Pathology Provider];] and
- (k) [complying with the reasonable directions of [PHO]’s Chief Executive or delegate (but not so as to derogate from [Private Pathology Provider]’s obligations under this Agreement).]

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

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

**Pathologist** means a registered Medical Practitioner holding specialist qualifications in pathology (Fellowship or other specialist recognition) for the purposes of the Health Insurance Act 1973 (Commonwealth) [approved in writing by [PHO] (such approval not to be unreasonably withheld).]
Patient means private inpatient, being a patient who is an eligible person under the provisions of the Health Insurance Act 1973 (Commonwealth) and who elects to receive treatment or services as a private patient (as defined in the National Healthcare Agreement between the Commonwealth of Australia and the States and Territories, including the State of New South Wales) at the Hospitals.

Performance Criteria may be agreed between the Hospital and [Private Pathology Provider], and include criteria such as turn around times. If the parties have agreed to Performance Criteria, the criteria must be set out in Schedule [1] to this deed.

Policy means the policy issued by the New South Wales Department of Health in relation to the provision of pathology services to private in-patients in public hospitals.

Services means pathology services to be provided by [Private Pathology Provider] to a Patient upon referral by the Patient’s treating doctor in accordance with the Policy.
The Institute of Clinical Pathology and Medical Research is granted approval to charge for pathology services to patients of recognised hospitals and of private practitioners. However, the approvals related to those services “other than those of public health significance”.

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

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

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

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

**TABLE 1**

<table>
<thead>
<tr>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arbovirus infection (including Dengue)</td>
</tr>
<tr>
<td>Diphtheria</td>
</tr>
<tr>
<td>Leprosy</td>
</tr>
<tr>
<td>Poliomyelitis</td>
</tr>
<tr>
<td>Smallpox</td>
</tr>
<tr>
<td>Sexually Transmitted Disease (all forms)</td>
</tr>
<tr>
<td>Tuberculosis (all forms)</td>
</tr>
<tr>
<td>Typhoid and Paratyphoid fever</td>
</tr>
<tr>
<td>Typhus (all forms)</td>
</tr>
</tbody>
</table>
### TABLE 2

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired immunodeficiency syndrome (AIDS)</td>
</tr>
<tr>
<td>Acute viral hepatitis</td>
</tr>
<tr>
<td>Arboviral infections</td>
</tr>
<tr>
<td>Brucellosis</td>
</tr>
<tr>
<td>Diphtheria</td>
</tr>
<tr>
<td>Foodborne illness in two or more related cases</td>
</tr>
<tr>
<td>Gastroenteritis among people of any age, in an institution</td>
</tr>
<tr>
<td>Gonorrhoea</td>
</tr>
<tr>
<td>Haemophilus influenzae type B:</td>
</tr>
<tr>
<td>Hepatitis A</td>
</tr>
<tr>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Hepatitis C</td>
</tr>
<tr>
<td>Hepatitis D (Delta)</td>
</tr>
<tr>
<td>Hepatitis E</td>
</tr>
<tr>
<td>Human immunodeficiency virus (HIV) infection</td>
</tr>
<tr>
<td>Hydatid Disease</td>
</tr>
<tr>
<td>Legionella Infections</td>
</tr>
<tr>
<td>Leprosy</td>
</tr>
<tr>
<td>Leptospirosis</td>
</tr>
<tr>
<td>Listeriosis</td>
</tr>
<tr>
<td>Malaria</td>
</tr>
<tr>
<td>Measles</td>
</tr>
<tr>
<td>Meningococcal infections</td>
</tr>
<tr>
<td>Mumps</td>
</tr>
<tr>
<td>Mycobacterial infections including M tuberculosis</td>
</tr>
<tr>
<td>Ornithosis</td>
</tr>
<tr>
<td>Paratyphoid</td>
</tr>
<tr>
<td>Pertussis (Whooping Cough)</td>
</tr>
<tr>
<td>poliomyelitis</td>
</tr>
<tr>
<td>Q Fever</td>
</tr>
<tr>
<td>Rubella</td>
</tr>
<tr>
<td>Salmonella infections</td>
</tr>
<tr>
<td>Syphilis8</td>
</tr>
<tr>
<td>Tetanus</td>
</tr>
<tr>
<td>Typhoid</td>
</tr>
<tr>
<td>Any other infectious conditions as determined from time to time.</td>
</tr>
</tbody>
</table>

### TABLE 3

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis (epidemic)</td>
</tr>
<tr>
<td>Chorioretinitis (Toxoplasmosis)</td>
</tr>
<tr>
<td>Erythemata/Rashes Unknown aetiology</td>
</tr>
<tr>
<td>Glandular fever</td>
</tr>
<tr>
<td>Pediculosis</td>
</tr>
<tr>
<td>Methicillin Resistant Staph. Aureus in Hospitals</td>
</tr>
<tr>
<td>Primary Meningoencephalitis (Amoebic)</td>
</tr>
<tr>
<td>Post vaccination, seroconversion</td>
</tr>
<tr>
<td>Nosocomial infections</td>
</tr>
<tr>
<td>Scabies</td>
</tr>
<tr>
<td>Diseases caused by Coxsackie, Adenovirus, or other viruses</td>
</tr>
<tr>
<td>Any other conditions as may be determined from time to time.</td>
</tr>
</tbody>
</table>
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.
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1. Introduction

2. Arrangements Prior to 1st January 1985

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5. On-Call and Recall

6. Conference Leave

7. Study Leave

8. Subsistence Allowance (Conference and Study Leave)

9. Travel Insurance

10. Privately Referred Non-inpatients

11. Accounting Instructions

12. Disputes Procedures
1. INTRODUCTION

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

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

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

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

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

2. ARRANGEMENTS PRIOR TO 1ST JANUARY 1985

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

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

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

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

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

3. CURRENT ARRANGEMENTS

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

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

3.1 Scheme “A”

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

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

3.1 (ii) It is a requirement of participation that the payment of the Scheme “A” allowance is conditional upon the Specialist Medical Officer giving the hospital written authority to render accounts in his name to all chargeable patients he/she might see in the course of his/her duties.
(iii) Study Leave and Conference Leave shall be accrued on the same basis as for Scheme “B” and paid out of the General Fund.

3.2 **Scheme “B”**

This Scheme will include the following features:

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

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

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

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

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

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

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

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

(Terminology change July 2019)
(iv) Where sufficient Trust Funds are available from the individual or agreed group contributions after payment of the initial drawings, further drawings (to be made calendar monthly) up to a maximum of 15 per cent of salary may be permitted by way of a private practice expenses payment.

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

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

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

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

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

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

Staff specialists are permitted to elect to take leave without pay subject to the following conditions:

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D. SALARIED MEDICAL SPECIALISTS – RIGHTS OF PRIVATE PRACTICE  6.64

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

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

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

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

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

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

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

3.4 Half-time Employment (Scheme “D”)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. SPECIAL ALLOWANCE

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

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

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

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

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

5. **ON-CALL AND RECALL**

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

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

6. **CONFERENCE LEAVE**

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

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

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

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

   (ii) Subsistence allowance in accordance with Clause 8.1.

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

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

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

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

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

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

8. **SUBSISTENCE ALLOWANCE (CONFERENCE AND STUDY LEAVE)**

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

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

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

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

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

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

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

9. TRAVEL INSURANCE

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

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

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

10. PRIVATELY REFERRED NON-INPATIENTS

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

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

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

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

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

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

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

10.3 In General

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

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

11. DISPUTES PROCEDURES

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

(i) concerning rights of private practice;
(ii) concerning an interpretation of this Circular;
(iii) concerning this agreement or its interpretation;
(iv) concerning any breach or alleged breach of any of the provisions of this Circular

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

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

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

(i) make a joint determination as to the matter in which the matter in dispute may be solved;
(ii) refer the matter to a person selected by them for determination in which case the determination of such person shall be final.

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

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

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

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

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

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

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

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

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

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

12.9 Expenditure from Private Practice Trust Fund

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

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

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

(iii) fees received for pathology services:

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

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

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

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

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

(Terminology change July 2019)
D. SALARIED MEDICAL SPECIALISTS – RIGHTS OF PRIVATE PRACTICE

12.9.2 **Infrastructure Charges for Scheme “D”**

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

12.9.3 Secondly, from the Trust Fund shall be paid to each participating specialist (“C” and “B”) a % of base award salary, as varied from time to time, for the period of participation in that year. (77/15) (PD2005_499)

12.9.4 Thirdly, for grants, (other than salary whilst on conference or study leave) for participating specialists. (77/15) (PD2005_499)

12.9.5 Residues remaining in the Trust Fund after payment of the amounts mentioned in 12.9.1, 12.9.3 and 12.9.4 may be used at the direction of the trustees for travel, research and equipment. (77/15) (PD2005_499)

12.9.6 All recommendations for disbursements are to require approval by the Board of Directors which shall have a right to disallow or vary these recommendations. Operation of trust funds are to be subject to audit annually with the cost thereof being met by the trust funds. (85/4, 87/94, 90/39) PD2005_429?

D2. RIGHTS OF PRIVATE PRACTICE - SALARIED DIAGNOSTIC SPECIALISTS IN RESPECT OF COMPENSABLE PATIENTS

(C78/141 - 24/4/78 - 3313) (c.c. 1.3.2.3.) PD2005_007

Under the present arrangements accounts can be issued in respect of clinical services to compensable inpatients, but not in respect of diagnostic services to such patients. Therefore staff clinicians can receive separate remuneration for such services in accordance with the appropriate arrangement under the provisions of Part D1, but staff diagnosticians cannot.

The Department has approved of the following action in respect of services to compensable inpatients by staff diagnostic specialists in accordance with the various arrangements under the provisions of Part D1 of this section.

Arrangement A  No specific action required.

Arrangement B  Hospitals should pay into the appropriate Private Practice Trust Fund(s) amounts equal to the particular scheduled benefit for each service provided (through appropriate items within subgroup 1640 - Payments for Purchases of Special Services or like items under accrual accounting arrangement). Distribution will be in accordance with section 3.2 of Part D1

Arrangement C  Same as for Arrangement B except that distribution will be in accordance with section 3.3 of Part D1

. (Terminology change July 2019)
Arrangement D  (Part-time arrangement)

Hospitals should pay direct to the diagnostic specialist (through Maintenance Account 1640) the appropriate scheduled fee for each particular service provided less a charge for the use of hospital facilities and/or staff in accordance with the percentages listed in section 12.9.1 of Part D1.

Charges cannot be made for medical services to compensable non-inpatients and no payments (other than salary) are to be made to staff specialists for services to non-inpatients.
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Appendices 48(12/09)
1. ADMISSION AND FEES CHARGING ARRANGEMENTS

1.1 Introduction

Persons treated in wards of psychiatric hospitals are to be charged maintenance (fees are all inclusive and hospitals are not to raise charges for any specific service provided e.g. Radiology, Pathology, Theatre, etc.) in accordance with rates as gazetted from time to time subject to the granting of free treatment during the first sixty (60) days of admission and after 60 days certification of need of acute care by Medical Superintendent.

Persons admitted to psychiatric wards of public hospitals (recognised by Medicare and private health funds for the payment of accounts, etc.) are to be charged fees on the same basis as other patients admitted to a recognised public hospital.

The term “pensioner” when used refers to persons who receive any type of Social Security Benefit (eg. Invalid Pension, Old Age Pension, Sickness Benefits, Unemployment Benefits).

1.2 Admission and Assessment of Fees

As the Department of Social Security will not pay benefits on a group schedule to short-stay patients. It will be necessary to collect the maintenance charges from these patients by the rendering of accounts and subsequent follow up procedures in accordance with the procedures detailed in this Manual.

**Patients who are under sixteen years of age should not be charged.**

**Other patients should receive free care and treatment for the first sixty days of their stay. On and from the sixty-first day, both pensioner and non-pensioner patients should be charged rates as specified in Information Bulletins issued by the Department of Health annually and that apply to Patients of Public Psychiatric Hospitals (formally 5th Schedule Hospitals), unless they are classified by the Medical Superintendent as still being in need of acute care, in which case they should continue to receive free care and treatment.**

If any two periods of hospitalisation are separated by less than seven days, the periods are to be combined in calculating the sixty days. (It is therefore possible for a patient to receive free treatment for several periods of up to 48(12/09))
sixty days each in any one year, provided that each period is separated by at least seven days from the previous period of hospitalisation). No extension of the free period should be allowed for any leave taken during the first sixty (60) days of treatment.

Time spent in admission wards before transfer to other wards is to be counted when calculating the sixty days.

All fees payable by patients should be raised and collected by individual hospitals.

IF A PERSON IS INELIGIBLE TO RECEIVE THE FULL STANDARD RATE OF PENSION AND/OR RENT ASSISTANCE ON THE GROUNDS OF ADDITIONAL INCOME OR RENT TEST, THEN THAT PERSON IS TO BE CHARGED AS IF HE/SHE WAS RECEIVING THE MAXIMUM RATE OF STANDARD PENSION WITH FULL RENT ASSISTANCE.

If however the person is ruled ineligible to receive the standard rate of pension on the grounds that he/she is a married person and the admission is not indefinite or permanent then charges are to be raised at the rate for a person receiving the married rate of pension.

However, an amount of up to the maximum rate of rent assistance charged may be reduced in case of married pensioner patients if the hospital considers that financial hardship is being caused to the pensioner partner remaining at home.

Married Pensioners receiving part pension only are to be charged the married rate as gazetted.

Hospitals are to encourage and assist pensioner patients and/or their relatives to claim the single rate of pension from the appropriate Government Department when one member of a married couple is admitted. Patients should also be encouraged to apply for rent assistance which is payable to persons in "eligible" institutions (which include psychiatric hospitals and nursing homes) who satisfy an income test.

In the case of pensioners who receive less than the full rate of benefit and or rent assistance on grounds other than the additional income or rent test, fees are to be determined by ascertaining the amount retained for a patient on a full pension and applying that retained amount to the reduced pension received. The sum determined is to be rounded off to the nearest 5c to provide a daily rate.

26(12/96)
Patients transferred from another psychiatric hospital having been granted sixty (60 days) free treatment thereat, are to be charged maintenance as from the date of admission at the receiving hospital. If a portion only of the free treatment period has been granted at the transferring hospital, the balance only of the period of free treatment is to be granted at the receiving hospital. Patients transferred from a psychiatric unit of a recognised hospital are to have the period of stay at that psychiatric unit counted as part of the sixty (60) days free treatment period.

**Psychiatric Facilities**

Patients granted leave for periods in excess of four continuous calendar days are not to be charged for maintenance during the period of leave, but the charge is to commence from the date of return, provided the patient has already been entitled to free treatment for sixty (60) days. Fees are to be charged in respect of periods of leave of four continuous calendar days or less.

A record is to be maintained of each patient’s fees details (eg PH442) including pension particulars.

1.3 **Reduction of Waiver of Charges**

CE’s or delegate of Area Health Services have the authority to reduce, waive or postpone the charges in cases of hardship to the dependent family of the patient, or the patient. This authority can be delegated to Executive Officers of hospitals. See provisions incorporated in the Accounts & Audit Determination Clause 8.6.

Each case in which the authority is exercised is to be documented to indicate reasons for the reduction or waiver with a report (including write-off details) being provided to the board of the health organisation.

1.4 **Assessment in Cases of Hardship**

In cases where hardship is claimed Social Security Allowances paid to a wife or husband of an invalid pensioner (these include the wife’s allowance and allowances for children) should be taken into account when assessing the maintenance payable by the patient. Other sources of income should also be taken into account.

1.5 **Patients Under the Control of the Protective Office and Not Receiving a Pension or Only a Part Pension**

On admission (or as soon as possible thereafter or on change of patient status) it is to be ascertained if the patient’s affairs are under the control of the Protective Office.
The 60 days free treatment period applies.

Hospitals are to invoice the Protective Office on a monthly basis.

1.6 Veterans' Affairs Patients

1.6.1 Eligible DVA Patients

See pages 2.51 to 2.52 and 2.57 to 2.59 of this Manual for DVA arrangements.
1.7 Norfolk Island, Northern Territory and ACT Patients

Patients under this category are chargeable from the admission date at the ineligible rate.

1.8 Overseas and Interstate Patients

Overseas and interstate visitors are to be charged the ineligible rate from date of admission.

2. PROCEDURES FOR MAINTAINING ACCOUNTING RECORDS FOLLOWING PATIENT ADMISSION

2.1 ADMISSION

i) Admission Record

On the admission of a patient the Fees/Revenue Officer is to be advised of the patient's details and admission date.

The Fees/Revenue Officer is to check details of patients admitted against admission lists on a regular basis (at least weekly) to ensure all admissions have been recorded.

Particular attention is to be paid to the transfer of patients from other psychiatric hospitals and psychiatric units of public hospitals with the previous admission periods counting as part of the 60 days free treatment period.

33(5/00)
The Medical Records Department is to submit to the office daily a list of patients granted any leave and those patients returned from leave.

Leave in excess of four calendar days during the free treatment period is to be recorded. It should be noted the free 60 day treatment period is not extended by periods of leave.

Patient admission details are to be scanned at fortnightly or monthly (depending on local conditions) intervals and a fees record prepared where the 60 day free treatment period has expired.

Leave granted after the free treatment period is to be recorded on the patients fees record.

Patients are to be advised by means of a proforma or hospital information leaflet that charges for maintenance will be made after an initial period of free treatment.

The social workers are to notify the Fees/Revenue Officer of applications submitted for pensions or sickness benefits etc. subsequent to admission.

Patients are to be encouraged to complete authorities to enable deductions for maintenance to be made from Trust Accounts.

Fees Records are to be noted accordingly when debts are written off and retained indefinitely for follow up purposes.

ii) **Control Account and Monthly Balancing of Fees Ledger**

A control account as outlined below is to be maintained in respect of maintenance charges for patients:

A fees control account should be established and a monthly balance effected between the total of the individual accounts and the control account.

The total of fees raised is to be posted to the debit of the fees control account at the end of each month. Likewise the total of fees collected for the month is to be posted to the credit of the control account.

Adjustments in respect of overcharges, re-assessments and amounts written off, etc. should be recorded in an adjustments journal providing separate columns for debit and credit adjustments. Details
of the adjustment should be shown together with reference to any Area/District Health Service or local approval where applicable. The relevant adjusting entries should be posted to the personal accounts in the appropriate column.

The totals of the debit and credit adjusting columns should be posted to the debit and credit respectively of the control account at the end of each month.

The monthly trial balance and reconciliation with control account is to be sighted by the supervising officer who should initial and date same as evidence of such sighting.

Records are to be maintained that satisfy the Department of Health's reporting requirements eg. by programme

- leave days
- charge days
- non-charge days

At the end of each quarter a list of current patients is to be obtained from the wards by the office and checked against the patient fees records and or admission records (there has to be a record for every patient). A notation to the effect that the check has been carried out is to be indicated on the lists by the officer responsible and counter signed by the next responsible officer. The lists are to be retained for audit/inspection. Whilst checking census reports the rate of fees are re-checked and any "odd" rates checked. It is essential that any queries re the census report are followed-up.

### iii) Initial Interview and Means Test

A Fees Assessment is to be carried out for every patient by, depending on local circumstances, a Social Worker or Fees/Revenue Officer. The fees assessment is to require details of income, etc. and state the fee set. If due to hardship, the full fee cannot be paid the Social Worker is to assist the patient/dependent in requesting a waiver. The assessment of the rate that is payable is to be undertaken prior to the completion of the 60 day free treatment period.

Those patients determined to be in need of acute care should be placed on a schedule and approved by the Executive Officer (Medical) or Senior Medical Officer within a reasonable time, prior to completion of the sixty (60) day period.

20(12/96)
The Fees/Revenue Officer should, at least monthly, confirm the status of those patients it has listed as in need of acute care to ensure that any change in classification has been notified to the fees/revenue clerk.

The undertaking by the patient or guarantor to pay fees is to be completed in every instance where fees are payable.

iv) Re-assessment of Fees

All patients on reduced fees are to be reassessed on a 2 monthly basis.

v) Raising of Debits for Fees

Invoices are to be forwarded to the Protective Office each month and other patients are to be billed fortnightly in advance and on discharge.

In computing the number of days, the date of admission and date of discharge are to be counted as one day with the date of admission being the effective date for fees rate purposes. (For 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.)

It is particularly important to note that when a debit is raised in respect of an interim claim the terminating date of such period should be shown as the commencing date of the succeeding period, otherwise a day will be short claimed. For example, an invoice to 31 March should be succeeded by another one on that account from that date and not 1 April. It should be noted, also, that a discharge or death on day of admission is regarded as one day for the purpose of charging fees.

The total of invoices issued for each month should be debited to a Fees Control Account (see later).

Patients granted leave for periods in excess of four calendar days are not to be charged for maintenance during the period of leave, but the charge is to commence from the date of return. For the purpose of determining the number of days credit to be allowed, the day of going on leave and the returning day should be counted as one day. No adjustment of fees is to be effected in respect of periods of leave of four continuous calendar days or less. No adjustment is to be made where patients go on holidays, camps etc and are accompanied by hospital staff whilst on duty.

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Where the rendering of fortnightly accounts proves fruitless at the expiration of six weeks, the patient or guarantor should be interviewed and if necessary a re-assessment of fees made by the Social Worker.

Patients or guarantors should be interviewed by the fees officer on discharge so that satisfactory arrangements may be made for payment of any outstanding fees.

Fees officers are to be reminded that the successful collection of fees in the cases mentioned is dependant upon:

(a) initial advice to the patient that fees are payable,
(b) regular rendering of accounts,
(c) collection while a patient and
(d) if fees are owing on discharge, arrangements are made for payment thereafter.

2.2 LONG-STAY PATIENTS - GROUP PENSION SCHEDULES

An application is to be made by the Social Worker to have patients placed on the pension schedule as soon as practicable after admission. Procedures for adjustment to the Pension Schedule are as advised in documentation provided by the Department of Social Security.

Where the affairs of the pensioner are in the hands of another party the Institution's Clerk at the Department of Social Security should be notified for the re-direction of any necessary correspondence.

A permanent Maintenance Control Total of amounts due for maintenance is to be maintained for all pensioners on the schedule.

**Pension Schedule**

On receipt of fortnightly pension schedule, the full amounts due to patients are to be posted to the individual patients trust accounts and then fees are to be deducted.

At the end of each quarter (March, June, Sept. and Dec.) a list of current patients is to be obtained from wards by the office and checked against the patient fees records. A notation to the effect that the check has been carried out is to be indicated on the lists by the officer responsible and countersigned by the next responsible officer. The lists are to be retained for audit/inspection.

26(12/96)
Respective schedules are to have receipts attached as acquittance with the schedules being retained for audit/inspection purposes.

Refunds of Maintenance

As maintenance is charged in advance in respect to pension schedule patients, on discharge or death of a patient there will frequently be a refund due. Refunds are not to be made to estates of deceased patients where the patient is on a group pension schedule. Adjustments are made as part of the schedule. Refunds will be made to discharged patients and for periods of trial leave and special care leave from which the patient returns after an absence of more than 4 calender days. A refund of maintenance should be given in these cases. No adjustment is to be effected for short periods of absence of 4 calender days or less. No adjustment is to be made where patients go on holidays, camps, etc. and are accompanied by hospital staff whilst on duty. Refunds are to be checked and authorised.

3. RECOVERY OF OUTSTANDING FEES

i) General

Procedures for the recovery of outstanding fees are the same for psychiatric hospitals as applied to public hospitals, see pages 2.77 and 2.78 of the Fees Procedures Manual for Area Health Services and Public Hospitals. Psychiatric hospitals are to consider the matter carefully prior to using debt collecting agencies to pursue bad debts of psychiatric patients.

ii) Writing-off of Outstanding Fees (See Accounts & Audit Determination Clause 8.6)

Area/District Health Services and Independent Second and Third Schedule Hospital Boards have the authority to write-off fees and if considered warranted will delegate the authority to the executive officer or equivalent at the psychiatric hospitals.

Where amounts are written-off with the authority of the Executive Officer delegate, or Area/District Health Service, such approval should be noted on the relevant Patients Fees Record Card.

Debts written off are not abandoned but merely deleted from the books. Action must be taken to recover the whole or part of the debt in the event of it becoming known that the debtor has become possessed of assets.
iii) Deceased Estates and Fees

Should an account for maintenance fees be outstanding in respect of a deceased patient the account for same should be presented to the executor of the estate at the time of handing over any assets of the deceased which may be in the possession of the hospital. Under no circumstances should an off-set be made against any moneys which may be held in trust.

iv) Application of Balances on Hand in Trust Accounts Towards Outstanding Fees

Trust moneys cannot be applied towards outstanding maintenance which might be due unless authorities completed by the patients concerned have been obtained.

4. RECOVERY OF HOSPITAL FEES FROM THIRD PARTIES

i) General

Persons covered by workers compensation, Navigation Act or any patient entitled to other benefits are to be charged for inpatient and non-inpatient care at the appropriate full actual daily cost rate as varied from time to time in the Government Gazette.

Persons included in the abovementioned provisions would include:

(a) those entitled under the Workers' Compensation Act to hospital treatment at the expense of an employer or insurer.

(b) persons temporarily in this country, such as tourists, people admitted for particular employment, foreign business people and their families, foreign students and elderly persons admitted to Australia on compassionate grounds.

Foreign students require an assurance support agreement prior to admission for study and details and copies of those agreements can be obtained from the Commonwealth Department of Foreign Affairs, if required.

(c) members of crews of visiting ships and aircraft whose domicile is outside Australia.
(d) immigrants in respect of whom an assurances support agreement exists such as sponsors of migrants who are required to guarantee their maintenance. In such cases details and copies of these undertakings can be obtained from the Commonwealth Department of Immigration, if required.

On admission a person coming within the category of (a) above should be asked whether he/she has made, or intends to make, a claim for compensation.

Before permitting a member of the crew of a visiting ship to land for hospital treatment the Immigration Department requires an undertaking to be given by the employer that the crew member will not become a charge upon the State or upon any public or charitable institution in Australia.

Claims for full hospital fees in respect of any person within the abovementioned categories should be lodged with the employer, insurer or guarantor as appropriate and it will be the responsibility of hospitals to pursue these claims to finality.

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.

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.

Where there is reasonable evidence that a person would be entitled to claim for compensation or damages in respect of an injury, illness or disease, that person should be classified as "Compensable" and accounts raised at the rates gazetted in the Government Gazette from time to time.

ii) Third Party Insurance - Motor Accidents Act 1988

See section in respect of Third Party Insurance on page 2.30 of Fees Procedures Manual for Area Health Services and Public Hospital.

iii) Workers' Compensation Claims

General (New South Wales)

See section on Workers Compensation in the Fees Procedures Manual for Area Health Services and Public Hospital.
The fees specified in respect of both inpatients and outpatients 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, Physiotherapy, etc.

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.

**Workers' Compensation Patients - Insured Workers Not Covered by the NSW Workers' Compensation Legislation**

With regard to employees of the Commonwealth such workers are covered by the Compensation (Australian Government Employees) Act 1971. Section 37 provides that in respect of an injury to a worker the Commonwealth is liable to pay "compensation of such amount as is appropriate to that medical treatment having regard to the charges customarily made for similar medical treatment in the place which that treatment is obtained". As State legislation is subordinate to Commonwealth legislation where inconsistency occurs, normal accommodation charges would apply.

Similarly normal accommodation charges would apply in respect of injured Australian seamen by virtue of the provisions of the Seamen's Compensation Act 1911 (Section 4[1]) which again limits payment to the hospital to that amount payable by an ordinary patient.

Except in certain circumstances the New South Wales Workers' Compensation Legislation does not apply in respect of workers injured in other States but who are treated in New South Wales hospitals, the exception being that the Act does apply where the worker is employed in this State but is outside New South Wales on the employer's behalf when the injury is sustained. Rates notified do apply in respect of workers injured and treated within New South Wales regardless as to whether or not the employer is domiciled in New South Wales.

The following schedule may be of assistance in providing a quick reference to situations which may arise.

<table>
<thead>
<tr>
<th>Injured Employee</th>
<th>Charge Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth Employee</td>
<td>Normal Accommodation Rate</td>
</tr>
<tr>
<td>Australian Seaman</td>
<td>Normal Accommodation Rate</td>
</tr>
<tr>
<td>Interstate Employee Injured in NSW</td>
<td>WCC Rate</td>
</tr>
<tr>
<td>Interstate Employee Injured Outside NSW</td>
<td>WCC Rate</td>
</tr>
<tr>
<td>NSW Employed Injured</td>
<td>WCC Rate</td>
</tr>
<tr>
<td></td>
<td>26(12/96)</td>
</tr>
</tbody>
</table>
5. RETRAINING UNITS

Pensioner patients who are accommodated in retraining units within hospital grounds and who are required to bear directly the cost of food and other domestic requirements, are to be charged maintenance at a rate representing forty (40) percent of the full pension received (standard pension plus full rent assistance) rounded off to the nearest ten cents.

Inpatients residing in cottages and working in outside employment are to be charged at the standard rate with allowance being made for the fact that the patient will be supplying his/her own food etc. Basically the rate should not be less than that charged for pensioners as mentioned above.

Patients who attend rehabilitation centres, etc. where the patient is required to pay travel costs and meals to, and whilst attending the rehab, and return to the hospitals, are to be assessed according to the cost of travel and meals, the patient has to meet out of his/her pension. The fees rate charged is not to be less than (40) percent of the pension.

6. OUTPATIENTS AND DAY PATIENTS

It will be left to the discretion of hospital managements as to whether a person is classified as a day patient or an outpatient. Basically, an outpatient is one who attends for consultation only or limited treatment and who is not provided with a meal. Patients attending night sessions are to be regarded as outpatients.

Day Patients/Outpatients

NO CHARGE FOR ATTENDANCE EXCEPT AS LISTED HEREUNDER.

i) Day Patients

Pharmaceutical Charges see page 1.5 of the Fees Procedures Manual for Area Health Services and Public Hospitals.

Meal Charge

Pensioners and their dependants - "meals on wheels" charge.

Other persons - rate as per staff meal charge.

Only in exceptional circumstances should persons be granted free meals, and in such cases there would need to be sound reasons for doing so.
These charges are not to be regarded as outpatient or daypatient fees and any receipts should be recorded in Account for "Other Receipts - Other". Also for the purpose of collecting outpatient/daypatient statistics, the provision of a meal should not be regarded as an occasion of service.

**Day patients employed in Industrial Therapy Units:**

An annual charge should be made for these meals against the Industrial Therapy Account. The charge should be based on:

a) the number of day patients on average engaged in this area who are provided with a meal each day;

b) the level of funds in the Industrial Therapy Account;

c) the annual charge is to be set by the Executive Officer.

Where the value of food provided is less than the current cost of a "meals on wheels" meals a special charge should be levied. This charge should be based on:

- the average cost of the Hospital of such meals;
- the rate should be set by the Executive Officer;
- the rate should be subject to annual review and appropriate adjustment.

**ii) Outpatients**

**Pharmaceuticals**

see page 1.5 of the Fees Procedures Manual for Area Health Services and Public Hospitals

**Meals**

Outpatients are **NOT** supplied with meals.
The Deputy Commissioner
Department of Veterans' Affairs
GPO Box 3994
SYDNEY NSW 2000

Dear Sir/Madam

Re:

Military particulars:
File No.:
Former Address:
Admitted to:
Name of Spouse:
Address of Spouse:

Copy for: General Services Section

Would you please supply details in respect to the entitlement of the abovenamed, including service related and non-service related disabilities and rights of appeal and review now open to him/her and whether he is entitled to treatment at your expense in respect of his present hospitalisation.

Yours faithfully

Medical Superintendent/Executive Officer

26(12/96)