

**FEES PROCEDURES MANUAL FOR PUBLIC HEALTH ORGANISATIONS**
**AMENDMENT NO. 103**
**Chapter 1 – Non-Admitted Patients**

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

Document Number	Title	PDS Issue date	Page number
PD2016_018	Oral Health Fee for Service Scheme (OHFFSS)	7 June 2017	1.18
PD2017_027	Eligibility of Persons for Public Oral Health Care in NSW	15 August 2017	1.14
IB2018_058	Pharmaceutical Charges for Hospital Outpatients and Safety Net Thresholds	19 December 2018	1.10

*The following content has been removed from Chapter 1:*

Document Number	Title	Reason to remove	Previously on page
PD2010_014	Denture Provision	IB2016_021 notified of an obsolete policy, no longer required – 11/5/16	1.16

Where a number appears at the bottom of an amended page [e.g. 252(17/09/15) – amendment number, date] an alteration has been made or new section included. Amendment numbers are sequential, the date represents the date the source document was published on the Policy Distribution System (PDS).

**With this amendment the following pages have been updated on line on 4 March 2019**

Existing page(s) removed	New page(s) inserted
TOC Chapter 1 All pages in Chapter 1	TOC Chapter 1 All pages in Chapter 1

**The Manuals and complete amendments are available on the Internet at**

<http://www.health.nsw.gov.au/policies/manuals/Pages/default.aspx>

**If you choose to print the amendment, ensure you print it double sided.**

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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

- 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.:
  - o Blood collection or other forms of venesection
  - o Swabs
  - o Faeces, semen or sputum collection.

And one collection OOS for each area of testing:

- o Histopathology / Cytopathology
  - o Chemical pathology
  - o Genetics
  - o Haematology
  - o Immunopathology
  - o Microbiology.
- Imaging: each type of imaging is counted as a separate OOS
    - o X-ray
    - o CT scan
    - o Nuclear medical scans
    - o MRI scans
    - o 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.

**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)**

**PD2012\_068 rescinds PD2012\_025.**

**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.

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.

## 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 PRFs 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](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:

<http://www.health.nsw.gov.au/pharmaceutical/Pages/s100-copayments.aspx> and at

[http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2016\\_011](http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2016_011)

For further information, email: [NSWH-s100CoPayment@health.nsw.gov.au](mailto: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**

- 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 \$100 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**

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

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

103(19/12/18)

<sup>1</sup> HSD (\$100 HSD and \$100 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> ).



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](mailto:nswtag@stvincents.com.au)

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## **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.

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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.

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**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 directive<sup>1</sup> 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 Government<sup>2</sup> concession cards:

<sup>1</sup> [http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2017\\_023](http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2017_023)

<sup>2</sup> Includes Centrelink and the Department of Veterans Affairs.

- ⇒ Health Care Card
- ⇒ Pensioner Concession Card
- ⇒ Commonwealth Seniors Health Card.

Note that holders of the State Seniors Card are not eligible for care unless they also hold one of the other concession cards listed above.

## 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*.<sup>3</sup>

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

For more information about the CDBS visit the NSW Health website at

<http://www.health.nsw.gov.au/oralhealth/Pages/child-dental-benefits-schedule.aspx> or the Commonwealth Department of Health at <http://www.health.gov.au/internet/main/publishing.nsf/content/childdental>

## 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.

### 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<sup>4</sup>.

### 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*<sup>5</sup>

Compensable patients are to be charged at the compensable rate for an occasion of service (see Fees

<sup>4</sup> <http://www.health.nsw.gov.au/policies/manuals/Pages/fees-manual.aspx>

<sup>5</sup> [http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2016\\_055](http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2016_055)

Procedures Manual<sup>6</sup>). 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.

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#### 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.

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<sup>6</sup> <http://www.health.nsw.gov.au/policies/manuals/Pages/fees-manual.aspx>

## 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:

Episodic dental care voucher	Is the voucher type for emergency or acute course of care that is associated with a limited examination (013).
General dental care voucher	Is the voucher type for a general course of care (excludes dentures) that is associated with a full examination (011).
Denture provision voucher	Is the voucher for full or partial dentures and is associated to a limited examination (013) for dentists and consultation (014) for dental prosthetists.
Business	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.
Practitioner	Is a dental practitioner registered with the Dental Board of Australia in the appropriate division (dentist, dental therapist, dental hygienist, oral health therapist and dental prosthetist) under the Health Practitioner Regulation National Law <a href="http://www.dentalboard.gov.au/Registration.aspx">http://www.dentalboard.gov.au/Registration.aspx</a>
Clinical Director	Is an LHD/Speciality Network clinician who is employed as an Area Clinical Director Level 1 – 3, or is a LHD delegated senior clinician.

## 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](mailto: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](http://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](http://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:
  - Be compliant with current infection control standards (<http://www.nhmrc.gov.au/guidelines-publications/cd33>)
  - 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

- 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:
  - Payment for one (1) diagnostic service per authorised voucher (episodic, general and denture) as per the Schedule of Fees
  - Issue of the appropriate voucher type for the service type required
  - The voucher was submitted for payment by an approved business or practitioner, and
  - 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:
  - The business and practitioner has not complied with the policy's roles and responsibilities (refer to Point 5)
  - Vouchers received more than 30 days after the treatment has been completed
  - Vouchers with treatment items that were provided after the voucher expiry date (unless prior authorisation has been obtained from the LHD)
  - Services provided by a business or practitioner that is not currently approved to participate in the OHFFSS
  - Treatment over and above recommendation
  - Treatment not to a required standard, or
  - Treatment items not included in Schedule of Fees.
- Once the above procedures have been followed, the LHD are required to:
  - Return any radiograph(s) supplied by the business or practitioner unless double radiographic films have been used, and
  - 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](mailto: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](mailto: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/pd/2015/pdf/PD2015\\_049.pdf](http://www0.health.nsw.gov.au/policies/pd/2015/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**

<p><b>Agreement of local primary health care practitioners</b></p>	<p>Agreement should be defined or measured as follows:</p> <ul style="list-style-type: none"> <li>• agreement obtained by the states and then demonstrated to the Commonwealth</li> <li>• 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</li> <li>• primary health care practitioners may choose to be represented by a representative in negotiations.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• Monitor and evaluate the initiative’s ongoing effectiveness and discuss proposals for changes to its operation.</li> </ul>
<p><b>Eligible health</b></p>	<p>Means an employee of a participating Local Health District who is a:</p>

<b>professional</b>	<ul style="list-style-type: none"> <li>• Nurse practitioner, or</li> <li>• Medical officer or staff specialist, or</li> <li>• Midwife, or</li> <li>• Allied health professional, or</li> <li>• Dental professional and who is eligible for a Medicare provider number.</li> <li>•</li> </ul>
<b>Eligible Services</b>	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.
<b>Eligible Site</b>	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.
<b>Medicare Benefits Provider Eligibility</b>	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 <i>Health Insurance Act 1973</i> . Information about such eligibility is available on the Department of Human Services website at: <a href="http://www.humanservices.gov.au">www.humanservices.gov.au</a> . 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.
<b>Modified Monash Model (MMM)</b>	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.
<b>MoU</b>	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).
<b>Non-Admitted Patients</b>	A <i>non-admitted</i> patient is a patient who does not undergo a hospital's formal admission process. There are three categories of <i>non-admitted</i> patient: <ul style="list-style-type: none"> <li>• Emergency department patient</li> <li>• Outpatient</li> <li>• A patient treated by hospital employees off the hospital site – includes community/outreach services.</li> <li>•</li> </ul>
<b>Operational Plan</b>	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.
9. Notify NSW Ministry of Health of the new site.

### 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

applicable). 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.

- 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



**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.....

**6.3 Attachment 3 - End of Financial Year - Medicare Information Letter**

[Local Health District Letterhead]

[Participating eligible health professional or VMO details]

[Address]

Medicare provider No. : [insert]

Dear [Title] [Name]

**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**

Name of Facility:		
Physical Address:		
Mailing Address:		
Phone number:		
Fax Number:		
Site Contact Person:		Tel:  Mob:  Email:
Medical Director:		Tel:  Mob:  Email:
Finance Contact		Tel:  Mob:  Email:
Operational or Health Service Manager:		Tel:  Mob:  Email:

**Other Key Contacts**

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

Name: Position: Organisation: Tel:  Mob:  Email:
---

**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](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.

<b>Categories of Practitioner Consulted:</b>	Yes	No	N/A
All Local General Practitioners			
Salaried Hospital Doctors			
Contracted/Visiting Medical Practitioners			
Any Aboriginal Medical Service in the Area			
Royal Flying Doctor Service			
Other: (please list all)			
❖			
❖			

**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.

<b>Stakeholder Groups Consulted:</b>	Yes	No	N/A
Primary Health Network			
Local Community Representative eg: Consumer Health Council, Health Community Councils			
Local Council representative			
Other private primary health care providers, including allied health			
Other: (please list all)			
❖			
❖			

**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*

Name: Role: Organisation: Signature: Date:	Name: Role: Organisation: Signature: Date:
Name: Role: Organisation: Signature: Date:	Name: Role: Organisation: Signature: Date:
Name: Role: Organisation: Signature: Date:	Name: Role: Organisation: Signature: Date:



**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.

I understand the context and policy objectives of the COAG s19(2) Exemptions Initiative	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand the legislative basis of a section 19(2) exemption and the effects intended by the granting of an exemption under this initiative.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.

I understand the context and policy objectives of the COAG s19(2) Exemptions Initiative	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand the legislative basis of a section 19(2) exemption and the effects intended by the granting of an exemption under this initiative.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name:	
Occupation/Specialty:	
Practice Location:	
Employer:	
Telephone:	
Email:	

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](http://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](http://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.

- 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>.

**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.

**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](http://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>. 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**

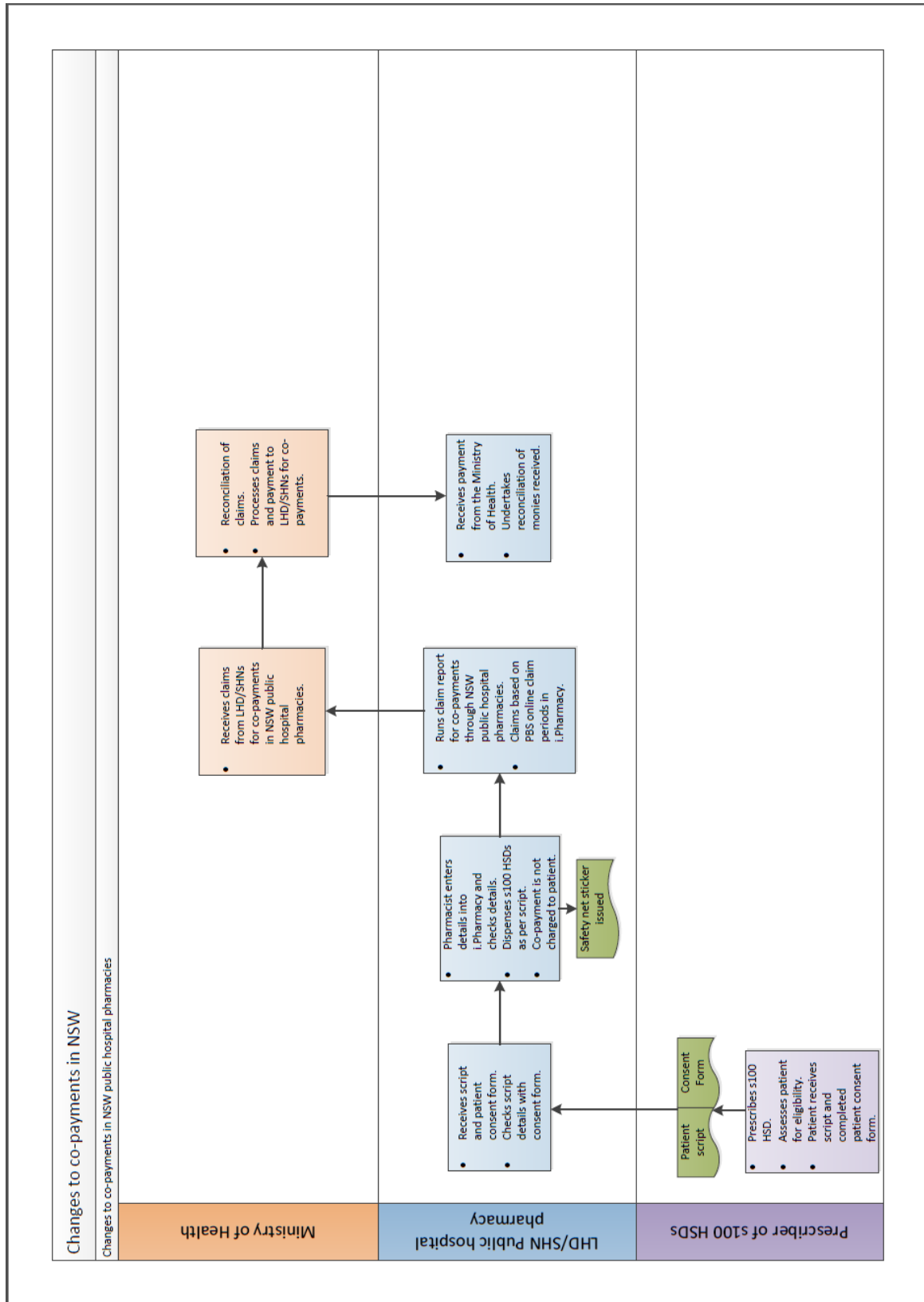
1. Claim reports for NSW public hospital pharmacies
2. Claim process in NSW public hospitals
3. Patient consent form

PBS Postcode Report v6.2													
Under Copayments (Charge or Waive): Charge													
Period: 01 October 2015 to 31 October 2015													
Patient Name	Date dispensed	Suburb/Town	Patient Postcode	Payment Category	Hospital/Pharmacy	Cial	Payment Status code	Prescriber	dispense ID	pbs code	Product	Patient Price	UCF
<b>Not Eligible</b>													
Site/Hospital:													
Pharmacy:													
PBS Online Payment Code: Approved													
01/10/2015	31/10/2015			General Benefit	1	\$37.70		Hospital Provider Number:				\$37.70	
01/10/2015	31/10/2015			PBS Claim ID:	1	\$37.70		Pharmacy Approval Number:				\$37.70	
<b>NSW Postcode - Eligible</b>													
Site/Hospital:													
Pharmacy:													
PBS Online Payment Code: Approved													
01/10/2015	31/10/2015			Concessional	57	\$341.60		Hospital Provider Number:				\$423.10	
01/10/2015	31/10/2015			PBS Claim ID:	57	\$341.60		Pharmacy Approval Number:				\$423.10	
01/10/2015	31/10/2015			Entitled	4	\$0.00						6.10	N N
01/10/2015	31/10/2015			PBS Claim ID:	4	\$0.00						0.00	N N
												0.00	N N
												0.00	N N
01/10/2015	31/10/2015			General Benefit	3	\$75.40						37.70	N N
01/10/2015	31/10/2015			PBS Claim ID:	2	\$75.40						37.70	N N
01/10/2015	31/10/2015			PBS Claim ID:	1	\$0.00						0.00	N N
01/10/2015	31/10/2015			Repatriation	1	\$6.10						6.10	N N
01/10/2015	31/10/2015			PBS Claim ID:	1	\$6.10						6.10	N N
<b>Grand Total</b>													
<b>Not Eligible</b>													
Site/Hospital:													
Pharmacy:													
PBS Online Payment Code: Approved													
Hospital Provider Number:													
Pharmacy Approval Number:													
\$37.70													
\$37.70													
\$37.70													
\$37.70													
\$423.10													
\$423.10													
\$423.10													
\$423.10													
6.10 N N													
0.00 N N													
0.00 N N													
0.00 N N													
0.00 N N													
37.70 N N													
37.70 N N													
0.00 N N													
6.10 N N													
<b>\$460.80</b>													
<b>\$37.70</b>													
<b>\$37.70</b>													
\$37.70													
\$37.70													



01/10/2015	31/10/2015		General Benefit	1	\$37.70	
01/10/2015	31/10/2015		PBS Claim ID:	1	\$37.70	
<b>NSW Postcode - Eligible</b>						
Site/Hospital:						
Hospital Provider Number:						
Pharmacy Approval Number:						
PBS Online Payment Code: Approved						
01/10/2015	31/10/2015		Concessional	57	\$341.60	
01/10/2015	31/10/2015		PBS Claim ID:	57	\$341.60	
01/10/2015	31/10/2015		Entitled	4	\$0.00	
01/10/2015	31/10/2015		PBS Claim ID:	4	\$0.00	
01/10/2015	31/10/2015		General Benefit	3	\$75.40	
01/10/2015	31/10/2015		PBS Claim ID:	2	\$75.40	
01/10/2015	31/10/2015		PBS Claim ID:	1	\$0.00	
01/10/2015	31/10/2015		Repatriation	1	\$6.10	
01/10/2015	31/10/2015		PBS Claim ID:	1	\$6.10	
						<b>Grand Total</b>
						<b>\$460.80</b>

EXAMPLE ONLY



## 12 MONTH PATIENT CONSENT FORM

Attach this form to prescriptions for  
**s100 Highly Specialised Drugs**



Health

### 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 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 privacy legislation and the NSW Health Privacy Manual for Health Information.

### SIGNATURE OF PATIENT OR AUTHORISED REPRESENTATIVE

Printed full name:

Signature:

Date signed:

### 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 full name:

Patient's address:

#### PRESCRIBER DETAILS

Prescriber's full name:

Prescriber number:

Hospital/practice name:

Prescriber's address and phone:

#### PRESCRIBER 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/pharmaceutical/Pages/s100-copayments.aspx](http://www.health.nsw.gov.au/pharmaceutical/Pages/s100-copayments.aspx)