

FEES PROCEDURES MANUAL FOR PUBLIC HEALTH ORGANISATIONS

AMENDMENT NO. 105

Chapter 2 – Inpatients

Chapter 6 - Diagnostics

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

Document Number	Title	PDS Issue date	Page number
PD2019_029	Brain Injury Rehabilitation Program (BIRP) - Fees Policy and Schedule of Fees	5 July 2019	2.97
PD2019_030	Health Services Act 1997 - Scale of Fees for Hospital and Other Services	8 July 2019	2.49
PD2019_031	NSW Newborn and Paediatric Emergency Transport Services (NETS) Charges	8 July 2019	2.94
PD2019_032	Lifetime Care & Support (LTCS) Scheme - Charging Policy and Rates for Designated Units	8 July 2019	2.100
PD2019_033	Ambulance Service - Charges	8 July 2019	2.90

The following content has been removed from Chapter 2:

Document Number	Title	Reason to remove	Previously on page
PD2018_022	Lifetime Care & Support (LTCS) Scheme - Charging Policy and Rates for Designated Units	Rescinded by PD2019_032	2.100
PD2018_023	Brain Injury Rehabilitation Program (BIRP) - Fees Policy and Schedule of Fees	Rescinded by PD2019_029	2.97
PD2018_024	Health Services Act 1997 - Scale of Fees for Hospital and Other Services	Rescinded by PD2019_030	2.49
PD2018_025	NSW Newborn and Paediatric Emergency Transport Services (NETS) Charges	Rescinded by PD2019_031	2.94
PD2018_026	Ambulance Service - Charges	Rescinded by PD2019_033	2.90

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).

The following content removed in error under amendment 100-102 has been reinstated in Chapter 6 and 'facility charge' terminology updated to 'infrastructure charge' as requested by Finance Branch:

Title	Page number
II. INFRASTRUCTURE (Facility) CHARGES	6.33 – 6.34
Infrastructure Charges for Staff Specialists on Level 2 to 5 arrangements	6.36 - 6.37
Salaried Medical Specialists Employed in Area Health Services, Second, Third And Fourth Schedule Hospitals And Organisations Rights of Private Practice <ul style="list-style-type: none"> • Scheme 'B' 	6.62
12.9 Expenditure from Private Practice Trust Fund	6.73 - 6.75

With this amendment the following pages have been updated on line on 25 July 2019

Existing page(s) removed	New page(s) inserted
All pages in Chapter 2 6.33 – 6.34 6.36 – 6.37 6.59 – 6.74	All pages in Chapter 2 6.33 -6 .34 6.36 – 6.37 6.59 - 6.75

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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HEALTH SERVICES ACT 1997 – SCALE OF FEES FOR HOSPITAL AND OTHER SERVICES (PD2019_030)**PD2019_030 rescinds PD2018_024****PURPOSE**

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

MANDATORY REQUIREMENTS

Hospital accommodation charges are to be raised for all chargeable patients as detailed in this Policy Directive and attached Procedures. Hospital accommodation rates from 1 July 2019 are advised in the attached Procedures.

Hospitals are to:

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

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

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

IMPLEMENTATION

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

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

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

1. BACKGROUND**1.1 About this document**

This Policy Directive updates key charging policy aspects and rates in relation to public hospital accommodation for chargeable patients. The advised rates are effective from 1 July 2019. This document replaces PD2018_024.

A case-mix charging model based on National Weighted Activity Units (NWAUs) and National Efficient Price (NEP) has recently been implemented for **Compensable Patients** in respect of Acute admitted and Emergency Department admitted and non-admitted patient services. In regard to Motor Vehicle Accident Compulsory Third Party (MVA) and Lifetime Care and Support (LTCS) patients this occurred from 1 July 2012 and for Workers Compensation and Other Compensable patients from 1 April 2014.

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

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

1.2 Legal and legislative framework

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

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

2. PRIVATE PATIENTS (Overnight Stay)

	\$ per day
Shared Room	362
Single Room	773

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

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

The **single room** rate applies for private patients where:

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

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

- Admission staff must inform eligible patients with health insurance who wish to elect to be a private patient that their health insurance policy may require a patient co-payment / excess.
- Patients from whom co-payment / excess is required or patients who elect to be private and who do not have private health insurance use normal methods of collection as appropriate for each health service to collect payment prior to or on admission where feasible.
- Where for any reason payment is not finalised on admission or upon discharge, existing procedures for the recovery of outstanding hospital accounts should be followed.

3. PRIVATE PATIENTS (Same Day Patient)

	\$ per day
Band 1	262
Band 2	294
Band 3	322
Band 4	362

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

4. INELIGIBLE PATIENTS

Excluding persons admitted to a public hospital under the Status Resolution Support Services (SRSS) previously known as the Asylum Seeker Assistance Scheme (ASAS).

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

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

4.1

Hospital Classification	Patient Classification	\$ per day
Public Hospitals	Inpatient - Critical Care	3,437
	Inpatient – Other than critical care	1,383
Public Psychiatric Hospitals	Inpatient	581
Other (eg Residential Aged Care Facilities)	Inpatient	325

Critical Care for the purpose of this document is defined as patients treated in the following units: Intensive Care Unit (ICU), Paediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), Psychiatric Intensive Care Unit, Neonatal Special Care Nurseries, Coronary Care Unit (CCU) and High Dependency Unit (HDU).

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

4.2.1 Acute Admitted Patient Services – All Hospitals

	\$ per day
Critical Care – first 21 days per episode	5,999
Critical Care – over 21 days	3,437
Other Inpatient – first 21 days per episode	2,365
Other Inpatient – over 21 days	1,383

- In counting the days in Critical Care – first 21 days per episode and Other Inpatient – first 21 days per episode, stand alone. For example if a patient is in Critical Care for 25 days and then Other Inpatient (non-critical care) for a further 30 days – charge would be 21 days at \$5,999 plus 4 days at \$3,437 plus 21 days at \$2,365 plus 9 days at \$1,383. If the same patient then returned to Critical Care for a further 2 days (same episode) the charge would be a further two days at \$3,437.

- Critical Care Critical Care for the purpose of this document is defined as patients treated in the following units: Intensive Care Unit (ICU), Paediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), Psychiatric Intensive Care Unit, Neonatal Special Care Nurseries, Coronary Care Unit (CCU) and High Dependency Unit (HDU).

4.2.2 Sub-Acute and Non-Acute Admitted Patient Services

Hospital Classification	Patient Classification	\$ per day
Public Hospitals	Inpatient	1,383
Public Psychiatric Hospitals	Inpatient	581
Other (eg Residential Aged Care Facilities)	Inpatient	325

4.3 Non-Inpatient Services

Hospital Classification	Patient Classification	\$ charge
Public Hospitals	Non-Inpatient	147
Public Psychiatric Hospitals	Non-Inpatient	103
Other (eg Residential Aged Care Facilities)	Non-Inpatient	103

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

4.4 Ineligible Inpatient Treatment Fee

	\$ per day
Public Hospitals	363

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

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

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

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

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

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

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

Where a VMO / HMO has chosen not to participate in the TMF Contract of Liability Coverage arrangements, they cannot be provided with PPI cover to treat an ineligible inpatient as part of the VMO contract. These VMO's can only treat ineligible inpatients as private and are to hold appropriate insurance cover for all patients treated in a public hospital.

4.5 Ineligible Patient - Hospital In The Home (HITH)

\$ per day
267

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

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

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

4.6 Ineligible Patient Dialysis – All Hospitals

\$ per session
759

4.7 Ineligible Patients – Policy aspects

- Ineligible patients are "private", that is they must elect a doctor except in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.
- Ineligible patients are to be billed for all clinical/diagnostic services provided by VMOs / HMOs and salaried staff specialists exercising their right of private practice or by the hospital (treatment fee-section 4.4 above) in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.
- Accommodation charges are not to be raised in respect of ineligible unqualified babies.
- Charges are to be raised for surgically implanted prostheses.
- Charges are to be raised for the direct cost (plus relevant on-cost) of drugs.
- Charges are to be raised at cost recovery for all other services provided in relation to a patient’s episode of care
- The dates of admission and discharge are to be counted as one day, with the date of admission being counted as that day (i.e. the 24 hour counting for compensable patients, does not apply to ineligible patients).
- In relation to section 4.2 (other than Worker Visa holders and Student Visa holders with visa condition 8501) hospitals are to obtain an assurance of payment from this category of ineligible patients before treatment is provided. This assurance may take the form of:
 - Credit card imprint (credit limits to be verified) or credit card payment to cover estimated cost
 - Cash to cover estimated cost
 - Bank cheque to cover estimated cost
 - Personal guarantee from Australian citizen whose bona fides are verified
 - Other initiatives to ensure that payment for the services is not lost to the hospital.

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

5. NORFOLK ISLAND RESIDENTS

5.1 Medicare Eligible Norfolk Island residents

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

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

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

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

5.2 Medicare Ineligible Norfolk Island residents

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

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

5.3 Norfolk Island resident - Compensable patients

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

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

6. PATIENTS ADMITTED TO A PUBLIC HOSPITAL UNDER THE STATUS RESOLUTION SUPPORT SERVICE (SRSS)

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

	\$ per day
Shared Room	639
Single Room	966
One Day Admission (Bands 1, 2, 3 or 4)	545
Critical Care	1944

7. COMPENSABLE PATIENTS ACCOMMODATION CHARGES

7.1 Acute Admitted Patient Services – All Hospitals

The patient episode reflecting the applicable *AR-DRG version 9.0* grouping aligned to the National Weighted Activity Unit (*NWAU(19)*) with adjustments applied as applicable in accordance with the Independent Hospital Pricing Authority (IHPA) publication *National Efficient Price Determination 2019-2020*. The *NWAU(19)* is adjusted to reflect that Visiting Medical Officers (VMOs) and Staff Specialists bill separately for compensable admitted patients. The removal of assessed VMO and Staff Specialist costs reduces each *NWAU* by 11% creating an *adjusted NWAU (19)* for the purposes of charging this category of compensable patients. The *NWAU* is rounded to the nearest 3 decimal places

multiplied by

The National Efficient Price (*NEP*) of \$5,134 as determined by the Independent Hospital Pricing Authority (IHPA).

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

The ED episode reflecting the applicable *URG version 1.4* or *UDG version 1.3* grouping aligned to the National Weighted Activity Unit (*NWAU(18)*) with adjustments applied as applicable in accordance with the IHPA publication *National Efficient Price Determination 2019-2020*.

The *NWAU (19)* is adjusted to reflect that Visiting Medical Officers (VMOs) and Staff Specialists bill separately for compensable admitted patients. The removal of assessed VMO and Staff Specialist costs reduces each *NWAU* by 11% creating an *adjusted NWAU (19)*, which is applicable for the purposes of charging ED admitted compensable patients. The *NWAU* is rounded to the nearest 3 decimal places multiplied by

The National Efficient Price (*NEP*) of \$5,134 as determined by the Independent Hospital Pricing Authority (IHPA).

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

The ED presentation reflecting the applicable *URG version 1.4* or *UDG version 1.3* grouping aligned to the National Weighted Activity Unit (*NWAU (19)*) with adjustments applied as applicable in accordance with the IHPA publication *National Efficient Price Determination 2019-2020*. The *NWAU* is rounded to the nearest 3 decimal places.

multiplied by

The National Efficient Price (*NEP*) of \$5,134 as determined by the Independent Hospital Pricing Authority (IHPA).

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

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

7.5 Sub-Acute and Non-Acute Admitted Patient Services

Hospital Classification	Patient Classification	\$ per day
Public Hospitals	Inpatient	1,201
Public Psychiatric Hospitals	Inpatient	504
Other (eg Residential Aged Care Facilities)	Inpatient	282

- The above charges are inclusive of diagnostic costs.

7.6 Non-Inpatient Services

Hospital Classification	Patient Classification	\$ per day
Public Hospitals	Non-Inpatient	128*
Public Psychiatric Hospitals	Non-Inpatient	89*
Other (eg Residential Aged Care Facilities)	Non-Inpatient	89*

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

https://www.sira.nsw.gov.au/_data/assets/pdf_file/0008/435905/Workers-Compensation-Physiotherapy,-Chiropractor,-Osteopathy-Fees-Order-2019.pdf

https://www.sira.nsw.gov.au/_data/assets/pdf_file/0009/435906/Workers-Compensation-Psychology-and-Counselling-Fees-Order-2019.pdf

https://www.sira.nsw.gov.au/_data/assets/pdf_file/0007/435877/Workers-Compensation-Accredited-Exercise-Physiology-Fees-Order-2019.pdf

7.7 Non-Inpatient Physiotherapy, Chiropractic and Osteopathy Service Charges

<i>Normal Practice</i>	\$ charge
Item	
PTA001 Initial consultation and treatment	96.10
PTA002 Standard consultation and treatment	81.40
PTA003 Initial consultation and treatment of two distinct areas	145.00
PTA004 Standard consultation and treatment of two distinct areas	122.70
PTA005 Complex treatment	162.60
PTA006 Group/class Intervention (rate per participant)	57.70
<i>Home Visit</i>	
PTA007 Initial consultation and treatment	118.30
PTA008 Standard consultation and treatment	94.60
PTA009 Initial consultation and treatment of two distinct areas	174.60
PTA010 Standard consultation and treatment of two distinct areas	149.50
PTA011 Complex treatment	192.00
<i>Other</i>	
PTA012 Case conference, Report Writing (per 5 minutes)	16.00
PTA012 Case conference (p/hour), Report Writing (p/hour - max)	192.00
PTA013 Activity assessment, consultation & treatment	192.00
PTA014 Travel - In accordance with “use of private motor vehicle” rates as set out in Item 6 Table 1 of the Crown Employees (Public Service Conditions of Employment) Award 2009.	

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

7.8 Non-Inpatient Psychology and Counselling Service Charges

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

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

7.9 Non-Inpatient Exercise Physiology Service Charges

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

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

INPATIENTS

2.55.2

7.10 Dialysis – All Hospitals (per non-admitted session) **\$ per session**
677

8. VETERANS' AFFAIRS PATIENTS (DVA)

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

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

9. OUTREACH SERVICES PATIENTS

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

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

Accommodation Only (excluding meals)

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

Meals

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

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

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

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

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

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

12. PRISONERS – PROVISION OF MEDICAL SERVICES

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

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

12.1 Inpatient Services

Neither the prisoner, nor the Correctional Centre is to be charged for accommodation, diagnostic, medical, nursing or other services provided by:

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

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

12.2 Non-Inpatient Services

Neither the prisoner, nor the Correctional Centre is to be charged for non-inpatient services provided by:

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

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

13. BABIES – CHARGES IN RESPECT OF NEWBORNS**13.1 Qualified Babies**

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

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

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

13.2. Unqualified Babies

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

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

14. CLASSIFICATION OF VICTIMS OF CRIME PATIENTS

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

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

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

Medicare ineligible (overseas visitors) victims of crime (confirmed by police) who present at a NSW public hospital and treatment is provided by a hospital nominated doctor, no hospital / medical charges are to be raised, otherwise charging arrangements for ineligible patients apply.

AMBULANCE SERVICE – CHARGES (PD2019_033)

PD2019_033 rescinds PD2018_026

PURPOSE

This Policy Directive provides the key principles and rates for ambulance service charges, including inter-hospital charges payable by Local Health Districts (LHDs) under the Ambulance Partnership Agreement and is effective on and from **1 July 2018**.

MANDATORY REQUIREMENTS

Ambulance Services charges as described in the attached procedures are to be applied by all LHDs from 1 July 2019.

IMPLEMENTATION

LHD Chief Executives are to ensure that the requirements of this Policy Directive are communicated to all appropriate staff.

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

BACKGROUND**1.1 About this document**

This Policy Directive provides the key principles and rates for ambulance service charges, including inter-hospital charges payable by Local Health Districts (LHDs) under the Ambulance Partnership Agreement and is effective on and from **1 July 2019**.

1.2 Key definitions

In this Policy Directive:

- **“primary emergency service”** means the provision of ambulance services by road ambulance, fixed wing aircraft or helicopter or a combination of these, from the scene of an accident, illness or injury to a public hospital or other destination nominated by NSW Ambulance.
- **“primary non-emergency service”** means an ambulance road service that is booked no later than 6pm on the day prior to service delivery with the Service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the primary emergency service charge will apply. [All services provided by a dedicated Patient Transport vehicle, where available, irrespective of time of booking or time of transport, are classified as “non-emergency services”]
- **“inter-hospital emergency service”** means the provision of ambulance services by road ambulance, fixed wing aircraft or helicopter or a combination of these, from one public hospital to another public hospital
- **“inter-hospital non-emergency service”** means an ambulance road service that is booked no later than 6pm on the day prior to service delivery with the service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the inter-hospital emergency service charge will apply. [All services provided by a dedicated Patient Transport vehicle, where available, irrespective of time of booking or time of transport, are classified as “non-emergency services”]

- **“treat-not-transport service”** – means a service where a patient is provided with ambulance services at the scene of an accident, illness or injury and does not require ambulance transport to a health facility or any other destination
- **“standby services”** – means a service where an ambulance or ambulances are required to stand by at scenes such as industrial accidents for the purpose of providing services to emergency workers or others at the scene of the incident. Neither transport nor treatment may be required.

1.3 Legal and legislative framework

The advised fees are gazetted by order pursuant to section 67L of the Health Services Act 1997.

2 FEES

2.1 Primary emergency service

The fee by road ambulance and / or fixed wing ambulance and / or helicopter shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of \$768 callout, plus an additional charge of \$6.93 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,424.

2.2 Primary non-emergency service

The fee by road ambulance shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of \$309 callout, plus an additional charge of \$1.91 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,424.

2.3 Inter-hospital emergency service

The fees by ambulance shall be charged as follows:

- Road ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of \$661 callout, plus an additional charge of \$6.59 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,183
- Fixed wing ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of \$4,072 callout, plus an additional charge of \$1.90 for each kilometre or part thereof (road travel associated with fixed wing cases is charged at the \$6.95 for each kilometre or part thereof), provided that such total fee shall not exceed \$6,183.
- Helicopter - on a time basis calculated pursuant to section 4 on the scale of \$6,991 for the first thirty (30) minutes or part thereof, with any further period charged at a rate of \$153 per six (6) minutes or part thereof
- Charges for road or fixed wing transport under this sub-section shall be paid by the hospital or health service sending the person being transported. However in the case of helicopter transport under this sub-section, the transport fee shall be apportioned equally between the hospital or health service sending the person being transported and the hospital or health service receiving that person.

2.4 Inter-hospital non-emergency service

The fee by ambulance shall be charged as follows:

- Road ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of \$303 callout, plus an additional charge of \$1.87 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,183. Charges under this sub-section shall be paid by the hospital or health service sending the person being transported.

2.5 Treat-not-transport service

The fee shall be calculated in accordance with the primary emergency service fee scale (sub-section 2.1).

2.6 Standby service fee

This fee is payable by the owners of premises or vehicles involved in dangerous incidents or events where an ambulance is required to be present (for example at chemical spills or other industrial accidents), shall be calculated in accordance with:

- The primary emergency service fee scale (sub-section 2.1) for the first hour or part thereof (provided that such total fee shall not exceed \$6,424); and in addition
- \$55.36 for every 15 minutes after the first hour
- Note that a treat-not-transport service provided by an Ambulance standby service is covered in the standby service fee provided the treatment is related to the event. However, the provision of a 'primary emergency service' emanating from a standby dangerous incident or event shall be deemed as such and a fee, calculated in accordance with sub-section 2.1, applicable.

3 CALCULATION OF TRANSPORT KILOMETRES

The total number of kilometres for the provision of services by ambulance (or ambulances) shall be calculated by determining the total number of kilometres that are travelled by road or, in the case of transportation by fixed wing aircraft or helicopter, that would have been travelled by road had no fixed wing aircraft or helicopter been available, in accordance with the distance:

- From the base ambulance station nearest to the location where the person was picked up / treated by ambulance, to that pick up / treatment location; and
- From that pick up location (where transport occurs), to the place where that person disembarked from the ambulance (or, where more than one ambulance was used in the transport, disembarked from the last ambulance used in that transport); and
- From that place of disembarkation / location of treatment, to the base ambulance station referred to in the first dot point of this section.

4 CALCULATION OF TRANSPORT TIME FOR HELICOPTERS (INTER-HOSPITAL)

The number of minutes for **a service by helicopter (other than a primary response service)** shall be calculated from the time the helicopter engine or engines are turned on, or, if the engines are already on, the time at which the helicopter is dispatched by an air ambulance controller, to the time the helicopter engine or engines are turned off at the helicopter's operational base, or the time at which the helicopter is otherwise dispatched by an air ambulance controller or other authority.

5 CHARGING CRITERIA

- Where two or more persons are transported / treated concurrently by the same ambulance or ambulances, each person shall be charged a fee calculated in accordance with sub-sections 2.1, 2.2, or 2.5 as appropriate to that transport
- The dot point immediately above shall not apply when two or more persons are transferred concurrently by ambulance (or ambulances) between any public hospitals in New South Wales
- Ambulance attendances at sporting and recreational fixtures are to be on the basis of cost recovery. A treat-not-transport service provided by an Ambulance in attendance at sporting and recreational fixtures is covered in the attendance fee. However, in the case of the provision of a primary emergency service at sporting and recreational fixtures a fee shall be calculated in accordance with sub-section 2.1
- Budget supplementation is **not** available to fund any increased costs resulting from this Policy Directive with such costs to be met from within existing allocations
- The above rates are applicable in relation to NSW ambulance services provided to Residents of NSW (Primary) and Public Hospitals in NSW (Inter-hospital)
- Residents of other States or Territories shall be charged full cost recovery as follows:

Primary	Road		Fixed Wing Emergency	Helicopter Emergency
	Emergency	Non Emergency		
	\$'s	\$'s	\$'s	\$'s
Call-Out	768	309	768	768
Variable Rate	6.93	1.91	6.93	6.93
Max.Charge	N/A	N/A	N/A	N/A

6 GOODS AND SERVICES TAX (GST)

6.1 GST-free

Ambulance Services are GST-free under section 38-10 of the GST Act where the service is provided to a person as part of their treatment. Ambulance Services deemed GST-free are as follows:

- Primary emergency service
- Primary non-emergency service
- Treat-not-transport service.

6.2 Taxable supply

Ambulance Services are a taxable supply (subject to GST) and accordingly GST must be added to the rates advised in this Policy Directive in respect of:

- Inter-hospital emergency services
- Inter-hospital non-emergency services
- Standby services
- Ambulance attendances at sporting and recreational fixtures.

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

PD2019_031 rescinds PD2018_025

PURPOSE

This Policy Directive provides the key principles and rates for NETS charges, including Inter Hospital Charges payable by Local Health Districts (LHDs) under the Ambulance / NETS Partnership Agreement and is effective on and from 1 July 2019.

MANDATORY REQUIREMENTS

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

IMPLEMENTATION

LHD Chief Executives are to ensure that the requirements of this policy directive are communicated to all appropriate staff.

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

1 BACKGROUND**1.1 About this document**

This Policy Directive provides the key principles and rates for NETS charges, including Inter Hospital Charges payable by Local Health districts (LHDs) under the Ambulance / NETS Partnership Agreement and is effective on and from 1 July 2019.

1.2 Key definitions

In this Policy Directive:-

- **“Primary emergency service”** means the provision of NETS services by road, fixed wing aircraft or helicopter or a combination of these, from a private hospital to a public hospital or other destination nominated by NETS
- **“Primary non-emergency service”** means a NETS road service that is booked no later than 6pm on the day prior to service delivery with the service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the primary emergency service charge will apply
- **“Inter-hospital emergency service”** means the provision of NETS services by road, fixed wing aircraft or helicopter or a combination of these, from a public hospital to another public hospital
- **“Inter-hospital non-emergency service”** means a NETS road service that is booked no later than 6pm on the day prior to service delivery with the service to commence and be completed between the hours of 8am and 6pm on the nominated service delivery date, otherwise the inter-hospital emergency service charge will apply.

1.3 Legal and legislative framework

The advised fees are gazetted by order pursuant to section 69 of the *Health Services Act 1997*.

2 FEES

2.1 Primary emergency service

The fee by road and / or fixed wing service and / or helicopter shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of \$768 callout, plus an additional charge of \$6.93 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,424.

2.2 Primary non-emergency service

The fee by road shall be charged on a kilometre basis calculated pursuant to section 3, on the scale of \$309 callout, plus an additional charge of \$1.91 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,424.

2.3 Inter-hospital emergency service by NETS

The fees shall be charged as follows:-

- Road service - on a kilometre basis calculated pursuant to section 3, on the scale of \$661 callout, plus an additional charge of \$6.59 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,183.
- Fixed wing service - on a kilometre basis calculated pursuant to section 3, on the scale of \$4,072 callout, plus an additional charge of \$1.90 for each kilometre or part thereof (road travel associated with fixed wing cases is charged at the \$6.59 for each kilometre or part thereof), provided that such total fee shall not exceed \$6,183.
- Helicopter service - on a time basis calculated pursuant to section 4 on the scale of \$6,991 for the first thirty (30) minutes or part thereof, with any further period charged at a rate of \$153.00 per six (6) minutes or part thereof. Charges for road or fixed wing transport under this sub-section shall be paid by the hospital or health service sending the person being transported. However in the case of helicopter transport under this sub-section, the transport fee shall be apportioned equally between the hospital or health service sending the person being transported and the hospital or health service receiving that person.

2.4 Inter-hospital non-emergency service by NETS

The fee shall be charged as follows:-

- Road ambulance - on a kilometre basis calculated pursuant to section 3, on the scale of \$303 callout, plus an additional charge of \$1.87 for each kilometre or part thereof, provided that such total fee shall not exceed \$6,183. Charges under this sub-section shall be paid by the hospital or health service sending the person being transported.

3 CALCULATION OF TRANSPORT KILOMETRES

The total number of kilometres the provision of NETS services shall be calculated by determining the total number of kilometres that are travelled by road or, in the case of transportation by fixed wing aircraft or helicopter that would have been travelled by road had no fixed wing aircraft or helicopter been available, in accordance with the distance:

- From the NETS base nearest to the location where the patient was picked up or treated by the NETS service and
- From that pick up location (where transport occurs), to the place where that patient disembarked from the NETS transport and
- From that place of disembarkation (or where no transport occurs, from the treatment location), back to the NETS base referred to in the first dot point of this section.

4 CALCULATION OF TRANSPORT TIME FOR HELECOPTERS (INTER-HOSPITAL ONLY)

The number of minutes for a NETS service by helicopter (other than a primary response service) shall be calculated from the time the helicopter engine or engines are turned on, or, if the engines are already on, the time at which the helicopter is dispatched by an air ambulance controller, to the time the helicopter engine or engines are turned off at the helicopter’s operational base, or the time at which the helicopter is otherwise dispatched by an air ambulance controller or other authority

5 CHARGING CRITERIA

- Where two or more persons are transported / treated concurrently by the same NETS service, each person shall be charged a fee calculated in accordance with sub-sections 2.1 and 2.2 as appropriate to that transport
- The dot point immediately above shall not apply when two or more patients are transferred concurrently by a NETS service between any public hospital in New South Wales
- Budget supplementation is not available to fund any increased costs resulting from this policy directive with such costs to be met from within existing allocations
- The above rates are applicable in relation to NETS services provided to NSW Public Hospitals (Inter-hospital) and NSW Private Hospitals (Primary)
- Residents of other States or Territories shall be charged full cost recovery as follows:-

Primary	Road		Fixed Wing	Helicopter
	Emergency	Non Emergency	Emergency	Emergency
	\$'s	\$'s	\$'s	\$'s
Call-Out	768	309	768	768
Variable Rate	6.93	1.91	6.93	6.93
Max.Charge	N/A	N/A	N/A	N/A

6 GOODS AND SERVICES TAX (GST)

NETS Services are a taxable supply (subject to GST) and accordingly GST must be added to the rates advised in this Policy Directive

BRAIN INJURY REHABILITATION PROGRAM (BIRP) – FEES POLICY AND SCHEDULE OF FEES (PD2019_029)

PD2019_029 rescinds PD2018_023

PURPOSE

This Policy Directive provides the key policy aspects and fees schedule in relation to brain injury rehabilitation services provided by the state-wide network of the Brain Injury Rehabilitation Program (BIRP) units for compensable patients.

MANDATORY REQUIREMENTS

Applicable BIRP accommodation fees are to be raised for compensable patients as detailed in this policy and attached procedures.

The BIRP fees advised herein are effective from 1 July 2019 and apply only to compensable patients admitted to an inpatient BIRP rehabilitation unit or an inpatient Transitional Living Unit and compensable non-inpatient services.

Non-compensable patients admitted to BIRP Units will be covered under the National Health Reform Agreement.

For compensable patients with traumatic brain injury who are inpatients in a NSW public hospital, other than a designated Inpatient BIRP Rehabilitation unit or an inpatient Transitional Living Unit, the bulk billing arrangements under the Purchasing Agreement for NSW Health Services to Motor Accident Patients will apply in relation to MAA Compulsory Third Party patients and 'Compensable Patients' billing arrangements will apply in relation to other classes of compensable patients e.g. Workers' Compensation and Other Compensable patients.

IMPLEMENTATION

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

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

105(05/07/19)

1 BACKGROUND

1.1 About this document

This Policy Directive advises the key charging policy aspects and updates the fees in relation to brain injury rehabilitation services provided by the state-wide network of Brain Injury Rehabilitation Program (BIRP) units for compensable patients requiring rehabilitation services. The advised fees are effective from 1 July 2019. This document replaces PD2018_023. LHDs / hospitals / facilities are to raise invoices against insurers as appropriate.

1.2 Legal and legislative framework

The advised fees are gazetted under the Health Services Act 1997 and Workers Compensation Act 1987.

2 DESIGNATED BIRP UNITS

2.1 Designated Inpatient BIRP Rehabilitation units - the daily bed rate for compensable inpatients can only be charged by the following units:

- Westmead
- Liverpool
- Royal Rehabilitation Centre, Sydney.

2.2 Designated Inpatient Transitional Living Units and non-inpatient services - the daily bed rate / non-inpatient rate can only be charged by the following units:

- Westmead Hospital Brain Injury Rehabilitation Service
- Liverpool Hospital Brain Injury Rehabilitation Unit
- South West Brain Injury Rehabilitation Service
- Southern Area Brain Injury Service
- Hunter Brain Injury Service
- Dubbo Brain Injury Rehabilitation Program
- New England Brain Injury Rehabilitation Program
- Mid West Brain Injury Rehabilitation Program.

2.3 Designated Units for non-inpatient services - the non-inpatient rate can only be charged by the following units:

- Children's Hospital Westmead
- Sydney Children's Hospital
- Illawarra Brain Injury Service
- Mid North Coast Brain Injury Rehabilitation Service
- Northern Brain Injury Rehabilitation Service.

3 INPATIENT BIRP REHABILITATION UNITS AND INPATIENT TRANSITIONAL LIVING UNITS

There are three categories that apply to patients in Inpatient BIRP Rehabilitation Units and Inpatient Transitional Living Units. The BIRP unit will nominate the most appropriate category classification for a patient and identify the proposed classification on the rehabilitation plan submitted to the Insurer, and update the classification in the progress reports. Insurers may seek clarification of the classification if necessary in the course of reviewing the rehabilitation plans and progress reports.

Category A applies to patients who are being assessed for or receiving active rehabilitation.

Category B applies to patients who are not on an active rehabilitation program but who are resident in a BIRP facility. These patients are receiving nursing and / or personal care assistance, regular monitoring of their medical condition, medical care and case management as appropriate. This category includes but is not limited to patients who are admitted for respite care or patients who have finished their rehabilitation program and are waiting for a transfer, placement or appropriate accommodation elsewhere.

Category X is for the rare patient who requires an extremely high level of support such as two to one care. It is only to be used in very specific circumstances, for instance where the patient has severe or extreme behavioural problems and cannot be managed without constant close supervision, generally requiring temporary additional staffing.

4 FEES FOR DESIGNATED UNITS

4.1 Inpatient BIRP Rehabilitation Units

Category	Daily Bed Rate
Category A	\$1,262
Category B	\$807
Category X	\$1,795

4.2 Inpatient Transitional Living Units

Category	Daily Bed Rate
Category A	\$901
Category B	\$447

4.3 Non-Inpatient Services Including Outreach

Charged at the cumulative rate of **\$86 per half-hour**. The fee shall not be greater than the equivalent of **5 hours per day** of non-inpatient care.

4.4 Outpatient Medical Clinical Appointments

4.4.1 Medical Consultation – New - applies to a new patient referred for medical assessment by an attending medical officer and are charged at the standard rate of **\$298**.

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

4.5 Reports

The charging for reports is in accordance with the rates set out in Information Bulletin IB2017_035 (or as amended periodically), subject to the fees policy set out in PD2006_050. Reports that are part of the rehabilitation process such as rehabilitation plans, progress reports and case closures will be charged at the same half hourly rate as non-inpatient services.

4.6 Group Activities

4.6.1 Group Activities - qualified - applies to those group activities directly supervised by a qualified allied health clinician and are charged at the cumulative half hour rate of **\$55**.

4.6.2 Group Activities - unqualified - applies to those group activities not directly supervised by a qualified allied health clinician and are charged at the cumulative half hour rate of **\$39**.

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

PD2019_032 rescinds PD2018_022

PURPOSE

This Policy Directive provides the key charging policy aspects and rates for designated units in relation to patients accepted into the Lifetime Care & Support (LTCS) Scheme by the iCare Insurance & Care NSW (Lifetime Care).

iCare Insurance & Care NSW (Lifetime Care) (Level 7, 321 Kent Street, Sydney 2000), a statutory authority established under the *Motor Accidents (Lifetime Care and Support) Act 2006*, is responsible for the administration of the LTCS Scheme.

The Scheme provides lifelong treatment, rehabilitation and attendant care services to people who sustain a spinal cord injury, a moderate to severe brain injury, multiple amputations and severe burns or blindness from a motor accident in NSW. The Scheme commenced in relation to children under 16 years of age who are injured in a motor accident from 1 October 2006 and in relation to adults from 1 October 2007.

The Scheme is a “no-fault” scheme which means that if the injured person’s injuries are severe enough to enter the Scheme it does not matter if the injured person was at fault in the accident or not. This Scheme also covers vehicles registered in other States / Territories, provided the accident occurs in NSW. LTCS services are paid for as they are required, rather than paying the injured person a one-off lump sum to meet their lifetime needs at settlement of their CTP claim.

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

MANDATORY REQUIREMENTS

Should a person injured in a motor accident whose injuries appear to meet the eligibility requirements for the Scheme present to a public hospital / facility, the public hospital / facility should contact Lifetime Care. The Authority will appoint a LTCS co-ordinator who will assist with the completion of an application for participation in the Scheme.

Bulk billing arrangements, under the Purchasing Agreement for NSW Health Services to Motor Accident Patients, applies to all LTCS patient services except for services provided by designated Brain or Spinal Injury Rehabilitation units. The NSW Ministry of Health administers charging under the bulk billing arrangements from hospital / facility activity data recorded and conveyed via the Health Information Exchange (HIE) and disseminates this revenue to LHDs as appropriate. Hospitals / facilities / Local Health Districts (LHD) should ensure that LTCS activity is accurately identified and coded to ensure that appropriate charging occurs.

LTCS services provided by designated Brain or Spinal Injury Rehabilitation units to patients who are admitted to a designated Brain or Spinal Injury Rehabilitation Unit or are in a Transitional Living Unit and non-admitted patient services provided by designated non-admitted patient units are chargeable in accordance with the rates advised in this Policy Directive. LHD / hospital / facilities are to raise invoices against the LTCS Authority for these services.

IMPLEMENTATION

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

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

1. BACKGROUND

1.1 About this document

The bulk billing arrangements under the MAA / LTCS Purchasing Agreement applies for all LTCS patients except for LTCS patients who are in a **designated** admitted patient Brain Injury Rehabilitation Unit or in a **designated** Spinal Injury Rehabilitation Unit or in an admitted patient Transitional Living Unit and non-admitted patient services provided by **designated** non-admitted patient units.

The NSW Ministry of Health administers charging under the bulk billing arrangements from hospital / facility activity data recorded and conveyed via the Health Information Exchange (HIE) and disseminates this revenue to LHDs as appropriate. Hospitals / facilities / LHDs should ensure that LTCS activity is accurately identified and coded to ensure that appropriate charging occurs.

1.2 Legal and legislative framework

iCare Insurance & Care NSW (level 7, 321 Kent Street, Sydney 2000), a statutory authority established under the *Motor Accidents (Lifetime Care and Support) Act 2006*, is responsible for the administration of the LTCS Scheme.

2. LTCS CHARGING POLICY - OTHER THAN DESIGNATED UNITS

Bulk billing arrangements, under the Purchasing Agreement for NSW Health Services to Motor Accident Vehicle Patients, applies for all LTCS patients except those who are in a **designated** Brain or Spinal Injury Rehabilitation Unit.

The NSW Ministry of Health administers charging under the bulk billing arrangements from hospital / facility activity data recorded and conveyed via the HIE.

3. LTCS CHARGING POLICY – DESIGNATED UNITS

Accounts should be raised against the Lifetime Care at applicable rates, as advised below, for admitted patient services provided in a **designated** Brain Injury or Spinal Injury Rehabilitation Unit or a **designated** Transitional Living Unit and for non-admitted patient services provided by **designated** non-admitted patient units as per the following:-

3.1 Admitted patient Brain Injury/Spinal Injury Rehabilitation designated units.

Category	Daily Bed Rate
Category A	\$1,262
Category B	\$807
Category X	\$1,795

3.2 Admitted and Non-Admitted Patient Transitional Living Units in relation to Brain Injury/ Spinal Injury Rehabilitation designated units only.

Category	Daily Bed Rate
Category A	\$901
Category B	\$447

3.3 Non-admitted patient Rehabilitation Services, including Outreach

At the cumulative rate of **\$86 per half-hour**. The fee shall not be greater than the equivalent of **5 hours per day** of non-admitted patient care.

3.4 Non-admitted patient Medical Clinic Appointments

Medical Consultation – (New) - applies to a new patient referred for medical assessment by an attending medical officer - charged at the standard rate of **\$298**.

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

3.5 Reports

The charging for reports is in accordance with the rates set out in NSW Health Information Bulletin IB2018_035 (or as amended periodically), subject to the fees policy set out in Policy Directive PD2006_050.

Reports that are part of the rehabilitation process such as rehabilitation plans, progress reports and case closures will be charged at the same half hourly rate as non-inpatient services.

3.6 Group Activities

Group activities - qualified applies to those group activities directly supervised by a qualified allied health clinician - charged at the cumulative half hour rate of **\$55**.

Group activities - unqualified applies to those group activities not directly supervised by a qualified allied health clinician - charged at the cumulative half hour rate of **\$39**.

4. ADMITTED PATIENT FEE CATEGORIES - DESIGNATED UNITS

Category A applies to patients who are being assessed for or receiving active rehabilitation.

Category B applies to patients who are not on an active rehabilitation program. This category includes but is not limited to patients who are admitted for respite care or patients who have finished their rehabilitation program and are waiting for a transfer, placement or appropriate accommodation elsewhere.

Category X is for the rare patient who requires an extremely high level of support or monitoring. It is only to be used in very specific circumstances that cannot be managed without constant close supervision, generally requiring temporary additional staffing.

The unit / hospital will nominate the appropriate category classification for a patient and identify the proposed classification on the rehabilitation plan, and update the classification in the progress reports. Lifetime Care may seek clarification of the classification if necessary in the course of reviewing the rehabilitation plans and progress reports.

5. DESIGNATED UNITS**5.1 Admitted patient Brain Injury Rehabilitation designated units:**

- Westmead Hospital Brain Injury Rehabilitation Service
- Liverpool Hospital Brain Injury Rehabilitation Unit
- Royal Rehabilitation Centre Sydney Brain Injury Unit

5.2 Admitted and Non-Admitted patient Brain Injury Rehabilitation designated Transitional Living units:

- Westmead Hospital Brain Injury Rehabilitation Service
- Liverpool Hospital Brain Injury Rehabilitation Unit
- South West Brain Injury Rehabilitation Service
- Southern Area Brain Injury Service
- Hunter Brain Injury Service
- Dubbo Brain Injury Rehabilitation Program
- New England Brain Injury Rehabilitation Program
- Mid West Brain Injury Rehabilitation Program

5.3 Non-admitted Brain Injury patient Rehabilitation designated units:

- Children's Hospital Westmead
- Sydney Children's Hospital
- Illawarra Brain Injury Service
- Mid North Coast Brain Injury Rehabilitation Service
- Northern Brain Injury Rehabilitation Service

5.4 Admitted patient Spinal Injury Rehabilitation designated units:

- Prince of Wales
- Royal North Shore
- Children's Hospital at Westmead
- Sydney Children's Hospital
- Royal Rehabilitation Centre Sydney.

5.5 Admitted and Non-Admitted patient Spinal Injury Rehabilitation designated Transitional Living units:

- Prince of Wales
- Hunter Spinal Injury Service

5.6 Non-admitted Spinal Injury patient Rehabilitation designated facilities:

- Prince of Wales
- Children's Hospital Westmead
- Sydney Children's Hospital
- Illawarra Spinal Injury Service
- Royal North Shore
- Spinal Outreach Service
- Rural Spinal Injury Service

DIAGNOSTIC SERVICES

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

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

3.2 Scheme “B”

This Scheme will include the following features:

- (i) one Trust Fund for all participants within the hospital;
- (ii) subject to legal advice on the taxation and trust aspects, one or both of the alternative models proposed by the Penington Report (Recommendation No. 18) must be adopted; viz. control of management of Trust Funds should rest with the Board of Management of the hospital or its equivalent through a Committee on which either nominees of the Board form a majority or where this is not so, that all recommendations for disbursements require approval by the Board with a right to disallow or vary these recommendations. Operation of Trust Funds is to be subject to audit at least annually;
- (iii) participating specialist to have drawing rights (to be made calendar monthly) from Trust Fund in accordance with their individual or agreed group (e.g. “Departmental”) contributions to the Fund up to a maximum of **25 per cent** of salary (**excluding** any administrative allowance). (refer clause 3 for Definition of Salary)

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

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

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

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

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

12.9.1 From the fees so paid into the Private Practice Trust Fund, there shall be paid as a first charge the following Infrastructure charges to the hospital for the provision of services and facilities, which will be percentage of the gross fees received pursuant to paragraph 12.9.

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

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

(iii) fees received for pathology services:-

Histopathology (including cytopathology)	20%
Microbiology	60%
Immunology	60%
Haematology	80%
Chemical Pathology	90%

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

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

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

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

12.9.2 Infrastructure Charges for Scheme “D”

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

12.9.3 Secondly, from the Trust Fund shall be paid to each participating specialist ("C" and "B") a % of base award salary, as varied from time to time, for the period of participation in that year. (77/15) (PD2005_499)

12.9.4 Thirdly, for grants, (other than salary whilst on conference or study leave) for participating specialists. (77/15) (PD2005_499)

12.9.5 Residues remaining in the Trust Fund after payment of the amounts mentioned in 12.9.1, 12.9.3 and 12.9.4 may be used at the direction of the trustees for travel, research and equipment. (77/15) (PD2005_499)

12.9.6 . All recommendations for disbursements are to require approval by the Board of Directors which shall have a right to disallow or vary these recommendations. Operation of trust funds are to be subject to audit annually with the cost thereof being met by the trust funds. (85/4, 87/94, 90/39) PD2005_429?

D2. RIGHTS OF PRIVATE PRACTICE - SALARIED DIAGNOSTIC SPECIALISTS IN RESPECT OF COMPENSABLE PATIENTS

(C78/141 - 24/4/78 - 3313) (c.c. 1.3.2.3.)
PD2005_007

Under the present arrangements accounts can be issued in respect of clinical services to compensable inpatients, **but not in respect of diagnostic services** to such patients. Therefore staff clinicians can receive separate remuneration for such services in accordance with the appropriate arrangement under the provisions of Part D1, but staff diagnosticians cannot.

The Department has approved of the following action in respect of services to compensable inpatients by staff diagnostic specialists in accordance with the various arrangements under the provisions of Part D1 of this section.

Arrangement A	No specific action required.
Arrangement B	Hospitals should pay into the appropriate Private Practice Trust Fund(s) amounts equal to the particular scheduled benefit for each service provided (through appropriate items within subgroup 1640 - Payments for Purchases of Special Services or like items under accrual accounting arrangement). Distribution will be in accordance with section 3.2 of Part D1
Arrangement C	Same as for Arrangement B except that distribution will be in accordance with section 3.3 of Part D1

Arrangement D (Part-time arrangement)

Hospitals should pay direct to the diagnostic specialist (through Maintenance Account 1640) the appropriate scheduled fee for each particular service provided **less** a charge for the use of hospital facilities and/or staff in accordance with the percentages listed in section 12.9.1 of Part D1.

Charges cannot be made for medical services to compensable non-inpatients and no payments (other than salary) are to be made to staff specialists for services to non-inpatients.