Northern Territory of Australia

# Government Gazette

ISSN-0157-833X

No. S83 12 August 2015

Northern Territory of Australia

*Medical Services Act*

Determination of Charges for Medical Services

I, Johan Wessel Elferink, Minister for Health:

(a) under section 6(2)(b) of the *Medical Services Act* and with reference to section 43 of the *Interpretation Act*, revoke the determination of charges for medical services dated 26 May 2015 and published in *Gazette* No. G25 on 24 June 2015; and

(b) under section 6(2)(b) of the *Medical Services Act*, determine that the charges to be made for medical services provided under the Act are as specified in the Schedule.

Dated 7 July 2015

J. W. Elferink
Minister for Health

# Schedule

## Introduction

### 34.1.1 Purpose

The NT Hospital **Fees and Charges Manual** provides a reference for NT Health staff and consumers on applicable fees and charges for patient health care services provided in Northern Territory public hospitals.

The Manual does not replace statutory law and should not be regarded as a legal document however; it does make reference to legislation.

### 34.1.2 Version Control

The Manual is a live document to which amendments will be made regularly. Notification of amendments is by Circular sent by email to relevant staff and available on the intranet. If you wish to receive Circular information contact Financial Services on 898 58008 or email healthservicescharges@nt.gov.au.

It is the responsibility of each user of the Manual to ensure that they are using the current version. The current version is:

| | |
|---|---|
| **Fees and Charges Manual** | 12 Aug 2015 |
| **Changes to latest version** | Nursing Home Type Patients – minimum statutory and default benefit |
| **Gazetted fee schedules** | 12 Aug 2015 |
| **Prostheses List** | 26 February 2015 |

### 34.1.3 Intranet/Internet

The NT Hospital **Fees and Charges Manual** is available via the Department of Health:

**Intranet** site at:
**http://internal.health.nt.gov.au/divisions/ac/feescharges/Pages/default.aspx**

**Internet** site at:
**http://health.nt.gov.au/Publications/Hospitals_Fees_and_Charges/index.aspx**

### 34.1.4 Calendar of Updates

The NT Hospital **Fees and Charges Manual** is updated regularly throughout the year.

| T34.1.4<br>**Annual Review Dates** | **Reason for update** |
|---|---|
| 1 January | Australian Government Pharmaceutical Benefit Scheme patient co-payment and safety net amount indexation |
| February | Prostheses List published |
| 20 March | Australian Government Nursing Home Type Patient fee indexation |
| 1 July | Australian Government private patient fee indexation and NT Government annual general fees indexation |
| August | Prostheses List published |
| 20 September | Australian Government Nursing Home Type Patient fee indexation |
| Miscellaneous updates may also occur throughout the year to reflect any ad-hoc fee changes, policy amendments or clarification of information in the manual. | |

### 34.1.5 Icons

For your convenience the NT Hospital **Fees and Charges Manual** have the following icons:

There is a ***form*** required.

For more *information* go to the named section.

For more detail go to ***weblink***

Table reference e.g. Table 34.3.1

### 34.1.6 Supporting Documents

***NT Government Gazette***

Pursuant to section 6(2) (b) of the *Medical Services Act* and with reference to section 43 of the *Interpretation Act*, the Minister can amend the determination of charges for medical services. These charges are set by notice in the Northern Territory Government *Gazette*.

The *Gazette* is available from:
**http://www.nt.gov.au/ntg/gazette.shtml**

Medical Services Act available from:
**http://www.austlii.edu.au/au/legis/nt/consol_act/msa153/**

***Private Health Insurance Circulars***

The Private Health Insurance Branch of the Australian Government Department of Health produces Private Health Insurance (PHI) circulars. The circulars contain important information related to Australian Commonwealth Government legislation which governs the operation of private health insurance. These circulars announce changes to private patient band rates and nursing home type patient rates.

DoH Private Health Insurance Circulars available from:
**http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars.htm**

## Contacts

**Fees and Charges Manual Enquiries**
Revenue Unit on: 898 58008 or healthservicescharges@nt.gov.au

**Re-order Patient Election Forms / other forms / brochures**
Stores on: 892 28780

**Medicare**
General Enquires: 132 011
PBS Information Line: 1800 020 613
MBS schedule interpretation: 132 150 or askMBS@humanservices.gov.au

**Motor Accidents Compensation (MAC) - Territory Insurance Office (TIO)**
1300 301 833

**NT Worksafe**
1800 250 713

**Centrelink**
132 150

## Admitted Patient Fees

### 34.3.1 Public

A public patient is an individual, eligible for Medicare, who on admission to a public hospital elects to be treated as a public patient. A public patient will be treated by doctors nominated by the hospital and cannot choose a specific doctor to provide their care. Public patients need to complete the ***Patient Election Form HR372 (a) -7/13***.

Public patients are entitled to receive care and treatment without charge (i.e. all accommodation, nursing, medical, allied health and diagnostic services are free). They may be admitted as an overnight stay or same day patient. After 35 days of continuous hospitalisation they may be reclassified as either a long stay acute or long stay nursing home type patient.

Charges may be raised for public patients classified as a long stay nursing home type patient. For more information go to ***34.14.1 Nursing Home Type Patients (NHTP)*.**

| T34.3.1<br>**Public Patient** | **Fee per day** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Nursing Home Type Patient | $56.90 | 20 March 2015 | S25 2015 | 20 September 2015 |

Residents of countries with which Australia has a Reciprocal Healthcare Agreement (RHCA) may be eligible for free treatment as a public patient under an Agreement. For more information go to ***34.12.2 Reciprocal Health Care Agreements (RHCA).***

### 34.3.2 Private

A private patient is a person who is eligible for Medicare, who on admission to a public hospital, or as soon as possible thereafter, elects to be treated as a private patient. Private patients are entitled to be treated by a doctor of their choice (provided that doctor has rights of private practice at that hospital). **Patients should be advised that this choice will remain for the patient's total hospital stay unless there are unforeseen circumstances**. (Refer to ***34.14.8 Change of Election*** for further information). Private patients need to complete the ***Patient Election Form HR372 (a) -7/13*** and the ***National Private Patient Hospital Claim Form***.

The hospital will raise an account for accommodation, doctors' fees for all medical services including diagnostic services and surgically implanted prostheses, directly to the patients' insurer and Medicare for settlement. The hospital will accept the health fund payment as full payment with no additional costs to the patient, such as gap expenses, excess or co-payments. A patient who elects to be private, but is not covered by insurance is responsible for the payment of all fees.

Hospitals should be aware of the application of a 'pre-existing ailment' condition by registered health funds. This rule applies to fund members of twelve months standing, who joined basic tables after 1 February 1984.

Accordingly, where persons indicate a wish to be admitted as a private patient and have less twelve months membership with a fund, they should be advised to check immediately with their fund, before completing an election form, about their entitlement to benefits for any pre-existing ailment in evidence at the time of joining the fund.

Private patients may be admitted as an overnight stay or same day patient. After 35 days of continuous hospitalisation they may be reclassified as either a long stay acute or long stay nursing home type patient.

| T34.3.2<br>**Private Patient** | **Fee per day** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Overnight Stay (includes long stay acute) | $335 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 1 | $243 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 2 | $297 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 3 | $322 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 4 | $335 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Nursing Home Type Patient Contribution (from patient) | $56.90 | 20 March 2015 | S25 2015 | 20 Sept 2015 |
| Nursing Home Type Patient Default Benefit (from Insurer) | $86.10 | 20 March 2015 | S25 2015 | 20 Sept 2015 |
| **Note: Private Long Stay Nursing Home Type patients are to be charged **both** the Patient Contribution and the Patient Default Benefits amounts for each overnight stay.* | | | | |
| Specialist Fees (including surgery) | 100% MBS | | | |
| Diagnostics (Pathology and Radiology) | 100% MBS | | | |
| Surgically Implanted Prostheses | As per Private Insurance - Prostheses List - See ***Surgically Implanted Prostheses Fees.*** | | | |

Medical procedures carried out in a public hospital on a same day patient who elects to be private will attract a fee for accommodation, maintenance and care (excluding medical fees (MBS) and surgically implanted prostheses) based on the type of procedure undertaken.

The Australian Government has four Bands within which patient treatment will fall:

- Band 1 – gastrointestinal endoscopies, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic.

- Band 2 – procedures (other than Band 1) carried out under local anaesthetic, no sedation.
- Band 3 – procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour.
- Band 4 - procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.

A definitive list of procedures for Band 1 has been issued with no flexibility for reclassification. With respect to Band 2, Bands 3 and Band 4, theatre time and anaesthetic type should be determined by the attending doctor.

In an effort to limit hospitals claiming same day benefits for procedures traditionally undertaken on a non-admitted basis, the Type C Exclusion list has been developed. However if the medical practitioner believes that a patient warrants admission the completion of the Same Day Certificate component of the ***National Private Patient Hospital Claim Form*** must be completed.

Type C exclusions list and further information is contained in the Australian Government Private Health Insurance (Benefit Requirements) Rules 2011 available from: http://www.comlaw.gov.au/Details/F2015C00141

### 34.3.3 Compensable (excluding MACA)

A compensable patient is a person receiving services from a public hospital site that is, or may be entitled under law that is or was in force in a State or Territory of the Australian Government, to the payment of damages or other benefits in respect of the injury, illness or disease for which they are receiving care and treatment. Compensable patients need to complete the ***Patient Election Form HR372 (a) -7/13***. Should their compensation claim not be successful, patients will be asked to elect if they wish to be private or public.

Under the *Health Insurance Act 1973,* patients to whom compensation has been made are not eligible for Medicare Benefits. Where there is reasonable evidence that a person would be entitled to claim for compensation or damages in respect to an injury, illness or disease e.g. Interstate Motor Vehicle, Public Liability, Workers Compensation, that person should be classified as “compensable’ and accounts raised. **A hospital must not amend charges to compensable patients on the grounds that the patient voluntarily waives any rights to compensation. This does not constitute the failure of a claim.** In this instance the financial category remains the same and the invoices are sent to the patient.

**Compensable status takes precedence over all other financial categories including Medicare Ineligible.**

Hospitals shall not raise charges for treatment of a person entitled to compensation under the *Motor Accidents (Compensation) Act 1979 (MACA)* administered by TIO. This is met under the Agreement between DoH and TIO. Refer to ***34.3.8 Motor Accident Compensation Act (MACA)*** for further information on MACA.

| T34.3.3A **Compensable Patient** | **Fee per day** | **Date Effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| ICU, SCN, & CCU | $2,722 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Overnight (RDH/ASH) | $1,586 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Same Day (RDH/ASH) | $1,049 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Overnight (KH/TCH/GDH) | $1,238 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Same Day (KH/TCH/GDH) | $817 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Hospital in the Home (HITH) | $474 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Specialist Fees | 120% MBS | | | |

| T34.3.3B **Compensable Patient** | **Fee** | | **Date Effective** |
|---|---|---|---|
| Diagnostics | 120% MBS | | |
| MRI, CT, Nuclear Medicine | 120% MBS | | |
| Surgically Implanted Prostheses | As per Private Insurance - Prostheses List. See ***Surgically Implanted Prostheses Fees*** | | |
| Medical Transport | See ***Medical Transport Fees*** | G48 2013 | 27 November 2013 |

### 34.3.4 Medicare Ineligible

Medicare ineligible patients are persons who usually live outside Australia (overseas visitors and temporary visa holders) who are not residents of any of the countries with which Australia has Reciprocal Health Care Agreements. Refer to ***34.12.2 Reciprocal Health Care Agreements (RHCA)*** for information on RHCA. These patients are not entitled to free medical treatment at public hospitals. Medicare Ineligible patients need to complete the ***Patient Election Form – Overseas Patient HR372 (b) -7/13***.

For those persons on student and work visas it is a condition of their visa that they obtain and maintain adequate insurance whilst in the country. Refer to ***34.12.3 Overseas Students*** for more information on overseas students. The Department of Immigration and Border Protection recommends

overseas visitors seeking tourist visas that it would be in their interest to take out health insurance prior to entry to Australia.

Children born in Australia to overseas visitors on or after 20 August 1986 are not eligible for Medicare unless one parent is an Australian citizen or a permanent resident at the time of the child's birth.

No charges are raised for babies born to ineligible parents until such time that they become qualified. Refer to ***34.14.2 Newborn Babies*** for information on new-born qualification status.

Immigration detainees and illegal foreign fishers are charged under agreement with the Department of Immigration and Border Protection. See ***34.3.5 Immigration Detainees (Royal Darwin Hospital ONLY)***

| T34.3.4A **Medicare Ineligible Patient** | **Fee per day** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| ICU, SCN, & CCU | $2,722 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Overnight (RDH/ASH) | $1,586 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Same Day (RDH/ASH) | $1,049 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Overnight (KH/TCH/GDH) | $1,238 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Acute Care Same Day (KH/TCH/GDH) | $817 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Hospital in the Home (HITH) | $474 | 12 Aug 2015 | S83 2015 | 1 July 2016 |

| T34.3.4B **Medicare Ineligible Patient** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Dialysis | $776 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Specialist Fees | 120% MBS | | | |
| Diagnostics | 120% MBS | | | |
| MRI, CT, Nuclear Medicine | 120% MBS | | | |
| Surgically Implanted Prostheses | As per Private Insurance - Prostheses List See ***Surgically Implanted Prostheses Fees*** | | | |
| Medical Transport | See ***Medical Transport Fees*** | 27 November 2013 | G48 2013 | |

Where possible, the hospital is to obtain an assurance of payment before treatment is provided. This assurance may take the form of credit card details, cash to cover estimated costs or other initiatives to ensure payment for the services is made to the hospital. Where such an assurance is not forthcoming, the patient is to be informed they will receive only the minimum 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.

### 34.3.5 Immigration Detainees (Royal Darwin Hospital ONLY)

Immigration detainees are Medicare ineligible, but whose charges for care and treatment will be met by the Australian Government Department of Immigration and Border Protection under an agreement with the Northern Territory Department of Health. Immigration detainees include asylum seekers and illegal foreign fishers and need to complete the ***Patient Election Form – Overseas Patient HR372 (b) -7/13***.

Under the current agreement, effective 1 January 2013, individual invoices are raised for each patient by the hospital and directed to the relevant immigration detention centre.

### 34.3.6 Australian Defence Force (ADF)

Defence force personnel are eligible persons under Medicare but whose charges for care and treatment will be met by the ADF. Garrison Health Services, part of Medibank Health Solutions, has been appointed by the Australian Government Department of Defence to co-ordinate the provision of health services to service personnel and active reservists within the ADF. ADF patients may elect to be treated as a public or private patient. ADF patients need to complete the ***Patient Election Form HR372 (a) -7/13***. Patients will be asked to elect if they wish to be private or public should the ADF decline responsibility.

Dependants are not covered by the Department of Defence but may be covered by one of the Defence Force Health Funds, which are Private Health Funds.

| T34.3.6 **Australian Defence Force Personnel** | **Fee per day** | **Date Effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Overnight Stay (includes long stay acute) | $335 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 1 | $243 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 2 | $297 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 3 | $322 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Same Day Band 4 | $335 | 1 July 2014 | G35 2014 | 1 July 2015 |
| Specialist Fees | 100% MBS | | | |
| Diagnostics | 100% MBS | | | |
| Surgically Implanted Prostheses | *As per Private Insurance - Prostheses List See* ***Surgically Implanted Prostheses Fees*** | | | |
| Medical Transport | *See* ***Medical Transport Fees*** | 27 Nov 2013 | G48 2013 | 1 August 2015 |

### 34.3.7 Department of Veterans Affairs (DVA)

The Repatriation Commission, Military Rehabilitation and Compensation Commission, the Australian Government and the Northern Territory Government have an agreement for providing hospital services to entitled veterans (entitled persons). Under the agreement, entitled DVA patients are to be admitted to public hospitals as Veterans Affairs patients. Eligible veterans need to complete the ***Patient Election Form HR372 (a) -7/13***.

Patients entitled to treatment through DVA have been issued with a treatment entitlement card indicating their eligibility status. Occasionally a patient may only have a written authorisation from DVA. Those veterans issued with a *Repatriation Health card – for all Conditions* (a gold card) have full entitlement to treatment. Holders of a *Repatriation Health Card – For Specific Conditions* (a white card) are only eligible for treatment for specific injuries or diseases for which DVA has accepted financial responsibility.

Entitled Persons will **not** be covered under this Arrangement if they:

a) **elect to be public patients** under the National Health Reform Agreement 2011 (NHRA);

b) are **Compensable** Patients; or

c) **elect to be admitted under their private health insurance** fund arrangements.

Hospitals are not to raise charges against DVA for patient accommodation except for a patient contribution for nursing home type patients (except for ex-Prisoners of War or Victoria Cross recipients). DVA reimburses the Department of Health for the treatment of entitled veterans under the agreement.

DVA will pay medical practitioners separately to this arrangement through Medicare Australia for admitted patient's medical specialist consultation's, including diagnostic and imaging services, at MBS rates. Hospitals may raise charges on behalf of medical practitioners under their Rights of Private Practice (ROPP) agreement. For more information on ROPP see ***34.14.5 Rights of Private Practice***

Hospitals may raise charges for surgically implanted prostheses at the Australian Government Private Health Insurance – Prostheses List gazetted rate. Instances may arise where a prosthesis item is not on the Prostheses list. In such circumstances the prior approval of the DVA medical officer is to be obtained by the treating doctor.

| T34.3.7 **Department of Veterans Affairs** | **Fee per day** | **Date effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Nursing Home Type Patient Contribution | $56.90 | 20 March 2015 | G25 2015 | 20 Sept 2015 |
| Specialist Fees | 75% MBS | | | |
| Surgically Implanted Prostheses | As per Private Insurance - Prostheses List See ***Surgically Implanted Prostheses Fees*** | | | |

### 34.3.8 Motor Accident Compensation Act (MACA)

In 1979 the Northern Territory Government established a no fault motor vehicle accident compensation scheme administered by the Territory Insurance Office (TIO). From 1 July 2014, the scheme covers everyone injured or killed in a motor vehicle accident in the Territory, except where the motor vehicle is unregistered or unregister-able (though passengers and pedestrians will be covered) or used in a motorsport event or high speed time trial (includes drivers and passengers). Certain exclusions may apply.

All types of road users are protected by the scheme, including pedestrians, drivers, passengers, motor cyclists and cyclists. The Motor Accidents scheme is funded by motor vehicle owners through compulsory contributions paid when registering vehicles in the NT. MACA patients need to complete the ***Patient Election Form HR372 (a) -7/13***. Patients will be asked to elect if they wish to be private or public should their claim not be successful.

The Motor Accidents Compensation ACT is available from:

*www.austlii.edu.au/au/legis/nt/consol_act/maa298*

Hospitals may not raise charges for admitted care of person entitled to benefits under the MACA. TIO has an agreement with the Department of Health for reimbursement of the cost of hospital treatment. This is received and receipted centrally.

If however a **patient voluntarily waives any rights to compensation. This does not constitute the failure of a claim.** In this instance the financial category remains the same and the invoices are sent to the patient at the compensable rate.

In instances where MACA patients are transferred interstate, TIO is liable for the transport costs and hospitals should raise charges as outlined in *34.10.1 Medical Transport Fees*. This does not include intra-territory transfer costs.

| T34.3.8 **Motor Accident Compensation Act** | **Fee per day** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Medical Transport (interstate only) | See ***Medical Transport Fees*** | 1 Oct 2014 | G35 2014 | 1 August 2015 |

## Non-Admitted Patient Fees

### 34.4.1 Public

*Emergency Department*

Under the National Health Reform Agreement, any person who is Medicare eligible is to receive Emergency Department services free of charge.

Refer to ***34.14.6 s19 (2) Exemptions Initiative*** for variations to this arrangement that apply at Gove District Hospital and Tennant Creek Hospital.

*Outpatients*

A public outpatient is a person who receives health care from a member of public hospital staff or receives health care at a public hospital without being admitted, or after discharge. Treatment may be provided by health professionals, such as a medical practitioner, allied health professional or nurse.

Public patients are entitled to receive non-admitted patient services for free, with the following exceptions for which charges can be raised:

- Dental Services;
- Spectacles and hearing aids;
- Surgical supplies;

- Prostheses (not including artificial limbs and prostheses which are surgically implanted either permanently, or are directly related to a clinically necessary procedure). See ***34.9 Prosthetic & Orthotic Fees*** for further details.

- External breast prostheses funded by the National External Breast Prostheses Reimbursement Program;

- Aids, appliances and home modifications. See ***34.9.1 Prosthetic & Orthotic Fees*** for further details.

### 34.4.2 Private

*Emergency Department*

Under the National Health Care Agreement, any person who is eligible for Medicare is to receive Emergency Department services free of charge. This includes patients who would elect to be treated as private if admitted.

Refer to ***34.14.6 s19 (2) Exemptions Initiative*** for variations to this arrangement that apply at Gove District Hospital and Tennant Creek Hospital.

*Outpatients*

A situation exists in the Northern Territory where a Medicare eligible person who is referred to a specialist medical practitioner by name from a general practitioner or district medical officer is able to be treated as a private patient under Medicare in a public hospital. See ***34.14.15 Primary Care Referred*** for further details.

A Primary Care referred patient will be Medicare bulk-billed 85% of the MBS schedule fee (no patient contribution) for non-admitted consultations, radiology and pathology services.

Private non-admitted patients who receive medical supplies, orthotics and other items of this nature, will be charged. See ***34.9.1 Prosthetic and Orthotic Fees*** for further details.

| T34.4.2<br>**Primary Care Referred Patient (Private)** | **Fee** |
|---|---|
| Medical Consultation | 85% MBS |
| Radiology | 85% MBS |
| Pathology | 85% MBS |

*all services bulk-billed directly to Medicare

### 34.4.3 Compensable (excluding MACA)

Compensable patients, as defined in ***34.3.3 Compensable,*** will be charged the non-admitted fees below:

| T34.4.3A **Compensable Patient - Emergency Department** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Resuscitation | $1,854 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Emergency | $1,171 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Urgent | $858 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Semi-urgent | $509 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Non-urgent | $319 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Diagnostics | 120% MBS | | | |
| MRI, CT, Nuclear Medicine | 120% MBS | | | |

| T34.4.3B **Compensable Patient - Outpatients** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Medical Practitioner | $406 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Allied Health or Clinical Nurse | $320 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Hyperbaric Unit | $645 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Minor operations | $596 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Chemotherapy | $898 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Diagnostic Services | 120% MBS | | | |

*fees for diagnostic services undertaken on private facilities will be determined by the service provider.

### 34.4.4 Medicare Ineligible

Medicare Ineligible patients, as defined in ***34.3.4 Medicare Ineligible***, will be charged the non-admitted fees below:

| T34.4.4A **Ineligible Patient - Emergency Department** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Resuscitation | $1,854 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Emergency | $1,171 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Urgent | $858 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Semi-urgent | $509 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Non urgent | $319 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Diagnostics | 120% MBS | | | |
| MRI, CT, Nuclear Medicine | 120% MBS | | | |

| T34.4.4B **Ineligible Patient - Outpatients** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Medical Practitioner | $406 | 12 Aug 2015 | S83 2015 | 1 July 2015 |
| Allied Health or Clinical Nurse | $320 | 12 Aug 2015 | S83 2015 | 1 July 2015 |
| Hyperbaric unit | $645 | 12 Aug 2015 | S83 2015 | 1 July 2015 |
| Minor operations | $596 | 12 Aug 2015 | S83 2015 | 1 July 2015 |
| Chemotherapy | $898 | 12 Aug 2015 | S83 2015 | 1 July 2015 |
| Diagnostic Services | 120% MBS | | | |

### 34.4.5 Immigration Detainees (Royal Darwin Hospital Only)

Schedule 7 of the Agreement with the Department of Immigration and Border Protection sets out the non-admitted fees and rates applicable.

### 34.4.6 Australia Defense Force Personnel (ADF)

Garrison Health Services have agreed to the following rates for non-admitted services until such time as NT Hospitals having the capacity to bill all services based on MBS item numbers.

| T34.4.6A **Australian Defence Force Personnel - Emergency Department** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Resuscitation | $1,854 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Emergency | $1,171 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Urgent | $858 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Semi-urgent | $509 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Non urgent | $319 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Diagnostics | 120% MBS | | | |
| MRI, CT, Nuclear Medicine | 120% MBS | | | |

| T34.4.6B **Australian Defence Force Personnel - Outpatients** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review date** |
|---|---|---|---|---|
| Medical Practitioner | $406 | 1 Oct 2014 | S83 2015 | 1 July 2016 |
| Allied Health or Clinical Nurse | $320 | 1 Oct 2014 | S83 2015 | 1 July 2016 |
| Hyperbaric unit | $645 | 1 Oct 2014 | S83 2015 | 1 July 2016 |
| Minor operations | $596 | 1 Oct 2014 | S83 2015 | 1 July 2016 |
| Chemotherapy | $898 | 1 Oct 2014 | S83 2015 | 1 July 2016 |
| Diagnostic Services | 120% MBS | | | |

*fees for diagnostic services undertaken on private facilities will be determined by the Service provider.

### 34.4.7 Department of Veterans Affairs (DVA)

The Agreement between the Repatriation Commission, Military Rehabilitation and Compensation Commission, the Australian Government and the Northern Territory Government provides eligible Veterans and war widows' (entitled persons) access to the full range of outpatient services at public hospitals.

Entitled Persons will **not** be covered under this Arrangement if they:

a) **elect to be public patients** under the National Health Reform Agreement 2011 (NHRA);

b) are **Compensable Patients**; or

c) **elect to be admitted under their private health insurance** fund arrangements.

### 34.4.8 Motor Accident Compensation Act (MACA)

No accounts for outpatient treatment should be raised for MACA patients except for Prosthetics and Orthotics. See ***34.9.1 Prosthetic & Orthotic Fees*** for further information**.**

## Pharmaceutical Fees

### 34.5.1 (under development)

## Rehabilitation Fees (Non-admitted)

### 34.6.1 Rehabilitation Services

Rehabilitation services have a separate schedule of fees for outpatient services.

| T34.6.1 **Ineligible & Compensable - Outpatient Services** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Aboriginal Health Worker | $172 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Occupational Therapy | $148 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Speech Pathology | $232 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Social Work | $194 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Physiotherapy | $111 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Classes (including hydrotherapy) | $51 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Medical Consultation | 120% MBS | | | |
| Case Management | $172 | 12 Aug 2015 | S83 2015 | 1 July 2016 |
| Checklists | $48 | 28 July 2015 | S83 2015 | 1 July 2016 |

## Dialysis Fees

### 34.7.1 Dialysis

Currently there are reciprocal renal dialysis arrangements with the United Kingdom, New Zealand and the Netherlands which provide access to renal dialysis free of charge to eligible oversees visitors as a public patient. There are however no dialysis agreements with the other RHCA countries.

The following charges apply to overseas visitors and compensable patients requiring renal dialysis.

| T37.7.1 **Ineligible & Compensable Patients** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Dialysis | $776 | 12 Aug 2015 | S83 2015 | 1 July 2016 |

## Surgically Implanted Prostheses Fees

### 34.8.1 Prostheses

On 31 October 2005 the *National Health Amendment (Prostheses) Act 2005* came into effect, re-regulating the benefit levels health funds are required to pay for all prostheses provided to their members associated with an MBS procedure. The relevant benefit amounts are determined by the Australian Government Minister for Health. These are contained on a Prostheses List that is updated in February and August each year.

The Prostheses List ('the List') is the schedule to the *Private Health Insurance (Prostheses) Rules* and is divided in three parts: Part A (Prostheses), Part B (Human Tissue) and Part C (Other Prostheses – Cardiac Event Recorders and External Infusion Pumps).

The Prostheses List is available from:

www.health.gov.au/internet/main/publishing.nsf/content/prostheses-list-pdf.htm

**The rates contained in the Prostheses List are used for all chargeable patients.**

| **Current Prostheses List** | February 2015 |
|---|---|

Under the legislation there are two categories that can be provided to private patients – no-gap prostheses (where the health fund will meet 100% of the cost) and gap permitted prostheses (where a private patient will have a gap amount to pay in addition to the health fund rebate). For no-gap prostheses, the Prostheses List contains only a minimum amount, and for gap permitted the list contains both a minimum and maximum benefit amount.

As the Northern Territory Department of Health has a no-gap policy for private patients in its public hospitals, the minimum will be charged, for which only the private health insurers are required to pay. This is unless the relevant health fund pays a level above the minimum. Ineligible, Compensable, Immigration Detainees and ADF Personnel patients will be charged at the maximum benefit rate for gap prostheses.

Please note that if any hospital uses prostheses on a private patient and it is not on the Prostheses List, then the health fund is not compelled to pay any benefit. Under Australian Government legislation, health funds are only required to pay

benefits for items on the Prostheses List. This also applies to DVA patients, however use of prostheses not listed on the Prostheses List on an entitled DVA patient requires financial authorisation from DVA. Ineligible, Compensable, Immigration Detainees and ADF Personnel patients will be charged on a full-cost recovery basis.

Charges for Prostheses apply as follows:

| T34.8.1A **Chargeable Patient** | **No-gap prostheses** | **Gap prostheses** | **Not listed** |
|---|---|---|---|
| Private | Minimum Benefit | Minimum Benefit | No charge* |
| DVA | Minimum Benefit | Minimum Benefit | No charge* |
| Ineligible | Minimum Benefit | Maximum Benefit | Full cost recovery |
| Compensable | Minimum Benefit | Maximum Benefit | Full cost recovery |
| ADF Personnel | Minimum Benefit | Maximum Benefit | Full cost recovery |
| Immigration Detainees | Minimum Benefit | Maximum Benefit | Full cost recovery |

*prior agreement with Health Insurer or DVA is required otherwise item cannot be charged.

To reflect further arrangements negotiated between the States, Territories and Health Funds, a discount will be applicable for any Cardiothoracic or Ophthalmic item. This removes the need to provide supplier invoices to the health fund to obtain a benefit.

| T34.8.1B **Private Patients** | **Health Insurer Rebate** | **Discount** | **Details** |
|---|---|---|---|
| All items on the Prostheses List (excluding Cardiothoracic and Ophthalmic items) | Minimum Benefit | | No Invoice required |
| Cardiothoracic items | Minimum Benefit | 7.5% | No Invoice required |
| Ophthalmic items | Minimum Benefit | 20% | No Invoice required |

Benefit amounts are to be calculated using the current minimum benefit on the Prostheses List for the item and then taking off the relevant percentage discount listed above.

If the cost of purchasing a cardiothoracic or ophthalmic item is above the calculated benefit a health fund will pay, hospitals may provide supplier invoices to the health fund for these items. In this instance health funds will reimburse the cost of the prostheses up to, but not exceeding, the minimum benefit level.

## Prosthetic & Orthotic Fees

### 34.9.1 Prosthetics

An external prosthesis is an artificial device that replaces a missing body part for functional and/or cosmetic reasons. This includes artificial limbs and digits. External prosthetics can consist of components, such as feet and knee components, but do not include surgically implanted prostheses.

Charges for Prosthetic services apply to:

| T34.9.1<br>**Prosthetic Services** | **Admitted** | **Non-admitted** |
|---|---|---|
| Public | No Charge | No Charge |
| Private | Chargeable | Chargeable |
| DVA | Chargeable (except when required for discharge) | Chargeable |
| MACA | Chargeable | Chargeable |
| Ineligible | Chargeable | Chargeable |
| Compensable | Chargeable | Chargeable |
| ADF Personnel | Chargeable | Chargeable |
| Immigration Detainees | Chargeable | Chargeable |
| **Prosthetic Fee Schedule: See** Attachment A | | |

### 34.9.2 Orthotics

An orthosis is a brace or splint used to support, align, prevent or correct musculoskeletal irregularities to improve function.

Charges for Orthotic services apply to:

| T34.9.2 **Orthotic Services** | **Admitted** | **Non-admitted** |
|---|---|---|
| Public | No Charge | No Charge |
| Private | Chargeable | Chargeable |
| DVA | Chargeable (except when required for discharge) | Chargeable |
| MACA | Chargeable | Chargeable |
| Ineligible | Chargeable | Chargeable |
| Compensable | Chargeable | Chargeable |
| ADF Personnel | Chargeable | Chargeable |
| Immigration Detainees | Chargeable | Chargeable |
| **Orthotic Fee Schedule: See** Attachment B | | |

## Medical Transport Fees

### 34.10.1 Medical Transport

No charge is raised when a public or private patient is retrieved from a rural or remote area, transferred between hospitals either within the Northern Territory or interstate for medical reasons. These patients are covered by the Patient Assistance Travel Scheme (PATS).

In instances where MACA patients are transferred interstate, TIO is liable for the transport costs and hospitals should raise charges as outlined below. This does **not** include intra-territory transfer costs as these are covered under the agreement.

Further information for patients about PATS is available from:

*www.health.nt.gov.au/Hospitals/Patient_Assistance_Travel_Scheme*

**Medical transport is delivered either through the aeromedical services of Careflight or the Royal Flying Doctors, with land based transport delivered through St Johns ambulance. Fees are calculated from the place of dispatch and return to the dispatch location.**

**The fee is per patient. No cost sharing is applied.**

**All other patient financial categories can be charged.**

| T34.10.1A **Aeromedical Transport (Careflight, Royal Flying Doctor Service)** | **Fee** | **Date effective** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Medical Evacuation (Doctor & Nurse) | $10.96 per aero nautical mile | 1 Oct 2014 | G35 2014 | 1 August 2015 |
| Medical Evacuation (Nurse) | $10.37 per aero nautical mile | 1 Oct 2014 | G35 2014 | 1 August 2015 |
| Repatriation and Follow up Visits | $6.40 per aero nautical mile | 1 Oct 2014 | G35 2014 | 1 August 2015 |
| Repatriation and Follow up Visits (Nurse) | $10.23 per aero nautical mile | 1 Oct 2014 | G35 2014 | 1 August 2015 |

| T34.10.1B **Commercial Transport** | **Fee** | **Date effective** | **Last Gazetted Change** |
|---|---|---|---|
| Aeroplane, Bus etc. | Full Cost Recovery* | 27 November 2013 | G48 2013 |

*Full cost recovery – as per provider's invoice

## Medical Reports, Copies of Medical Records & Imaging

### 34.11.1 When charges <u>should</u> be raised

*Circumstances under which charges **should** be raised:*

- When searching for the medical record, unless it cannot be found.
- When copies of a patient's medical record is requested by and provided directly to the patient.
- When copies of medical images to cd are requested by and provided directly to the patient.
- Replacements of medical certificates and Centrelink forms when required to be rewritten.
- Requests for medical reports or copies of medical records by solicitors, insurers and other third parties, for legal or employment purposes, subject to written consent being given by the patient (This excludes requests from TIO in relation to workers compensation claims by a DoH staff-member).

- When copies of medical images to cd are requested by an insurer, solicitor or other third party, subject to written consent being given by the patient.

- Request for information from interstate health authorities or other employers in respect to the eligibility of candidates for appointment.

- Requests for information by solicitors acting on behalf of a victim of crime.

### 34.11.2 When charges <u>should not</u> be raised

*Circumstances under which charges should **not** be raised:*

- When a copy of the discharge summary is requested by and provided directly to the patient.

- When requests are made for copies of a patient's discharge summary, operation findings and other relevant letters between health professionals, by a health professional concerned only with the patient's continued treatment or care, e.g. the patient's General Practitioner.

- When completing medical certificates and Centrelink forms at the time of consultation.

- Requests from TIO in relation to workers compensation claims by a DoH staff-member.

- Inspection of medical records by solicitors, acting for patients or other parties in court proceedings, representatives of insurers or other third parties.

- Request by a body responsible for regulating the activities of health professionals, e.g. a professional registration board investigating the conduct of a professional or a Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing.

- Requests from Family and Community Services (FACS) or the police, required in the conduct of investigating claims into suspected maltreatment of children.

- Requests from Community Corrections for reports in relation to matters of sentencing, parole and supervision of court orders.

- When a single request is made for a medical report and photocopied information from a medical record, no Search Fee is applied. This is included in the Medical Report Charge.

| T34.11.2A **Patient Request** | **Calculated** | **Fee (GST exempt)** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Search Fee | per search | $35.00 | S83 2015 | 1 July 2016 |
| Copy of Medical Records | per page | $0.23 | S83 2015 | 1 July 2016 |
| Copy of Discharge Summary | | Free | S83 2015 | 1 July 2016 |
| Replacement Medical Certificate | per certificate | $35.00 | S83 2015 | 1 July 2016 |
| Medical/Allied Health Report (max 2 pages) | per report | $290.00 | S83 2015 | 1 July 2016 |
| Medical Report (additional pages) | per page | $145.00 | S83 2015 | 1 July 2016 |
| Medical images to CD | 1 Study | $12.00 | S83 2015 | 1 July 2016 |
| | 2 Studies | $18.00 | | |
| | More than 2 studies | $28.00 | | |

| T34.11.2B **Third Party Request** | **Calculated** | **Fee (GST inclusive)** | **Last Gazetted Change** | **Review Date** |
|---|---|---|---|---|
| Search Fee | per search | $38.50 | S83 2015 | 1 July 2016 |
| Copies of Medical Records | per page | $0.89 | S83 2015 | 1 July 2016 |
| Medical/ Allied Health Report (max 2 pages) | per report | $319.00 | S83 2015 | 1 July 2016 |
| Medical Report (additional pages) | per page | $159.50 | S83 2015 | 1 July 2016 |
| Medical images to CD | 1 Study | $19.80 | S83 2015 | 1 July 2016 |
| | 2 Studies | $25.67 | | |
| | More than 2 studies | $37.22 | | |

Procedures for safeguarding the privacy of Medical Records are set out in the *Hospital Network: Patient Information Privacy Policy* available from:

*http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/16/14.pdf&siteID=1&str_title=Information%20Privacy%20Principles.pdf*

## Other Patient Categories

### 34.12.1 Prisoners

Australian prisoners are Medical eligible but Medicare benefits cannot be accessed whist incarcerated as while in custody any heath serviced provided to a prisoner are considered the responsibility of the state.

Prisoners need to complete the ***Patient Election Form HR372 (a) -7/1*.**

Under the *Health Insurance Act 1973*, the same eligibility criterion applies to prisoners and those in police custody, as for any other patient presenting for treatment. If they are an Australian citizen or eligible overseas person and no compensation case is involved, then the patient is eligible for free treatment as a public patient in a public hospital. These patients also have the right to election for private or public treatment. In the event the patient elects to be private they will not be entitled to the 75% Medicare Rebate and the patient is responsible for the payment of the resultant fees.

### 34.12.2 Reciprocal Health Care Agreements (RHCA)

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. The Agreements provide for free emergency department, outpatient and accommodation and treatment as an admitted public hospital patient. They do not cover any treatment as a private patient in any kind of hospital. Overseas visitors wishing to be admitted under a RHCA need to complete the ***Patient Election Form HR372 (a) -7/1***.

Eligibility can be confirmed by the patient holding a Reciprocal Health Care Card issued by Medicare or by showing their passport of the country with which there is a RHCA. Hospital staff should check the visa is valid.

| Country | Length of Entitlement to RHCA |
|---|---|
| United Kingdom | Duration of Stay |
| New Zealand | Duration of Stay |
| Malta | First 6 months of Visa |
| Italy | First 6 months of Visa |
| Sweden | Duration of Stay |
| Netherlands | Duration of Stay |
| Finland | Duration of Stay |
| Republic of Ireland | Duration of Stay |
| Norway | Duration of Stay |
| Belgium | Duration of Stay |
| Slovenia | Duration of Stay |

The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden, Belgium, Slovenia and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Visitors from Belgium, the Netherlands and Slovenia require their European Health Insurance card to enroll in Medicare. They are eligible for treatment in public hospitals until the expiry date indicated on the card, or to the length of their authorised stay in Australia if earlier.

People on Retiree Subclass Visa 410 issued after December 1998 are not covered by the Agreements.

Students from Norway, Finland, Malta and the Republic of Ireland aren't covered by the Agreements with those countries.

**RHCA's are not designed to replace private travel health insurance**.

**RHCAs only cover immediately necessary medical treatment as a public patient**. Immediately necessary treatment means any ill health or injury which **occurs while the person is in Australia** and requires treatment before the person leaves Australia. It does not include treatment prearranged before the person arrived in Australia or elective treatment.

Other services not covered under the agreements are:

- Ambulance Cover
- Dental care
- Optometry Services
- Medical evacuations intra or interstate
- Medical Evacuation to the visitor's home country
- Funerals

With the exception of New Zealand, the Agreements provide diplomats and their families with full Medicare cover for the term of their stay. This is not restricted to immediately necessary treatment.

Patients are eligible for air transfer services between public hospitals providing they meet the eligibility criteria.

Further information about each agreement is available at:

http://www.humanservices.gov.au/customer/services/medicare/reciprocal-health-care-agreements

### 34.12.3 Overseas Students

Patients on student visas from the United Kingdom, Sweden, the Netherlands, Belgium, Slovenia, Italy or New Zealand, are covered by Medicare. Students from Norway, Finland, Malta and the Republic of Ireland are not covered by the Reciprocal agreements with those countries.

With the exception of students from Belgium, New Zealand, Norway and Sweden, it is a condition of their student visa that they take out Overseas Student Health Cover (OSHC). Overseas students are charged the same rates as other Medicare Ineligible patients, see ***34.3.4 Medicare Ineligible,*** and are required to complete the ***Patient Election Form – Overseas Patient HR372 (b) -7/13***.

## Waiving of Fees

### 34.13.1 Waiving fees

Waivers extinguish the hospitals right to collect the debt at a future date. However prior to fees being waived, there should be every attempt to establish a payment plan. Please contact patient Accounts with regards to payment plan options.

In particular cases, where it is established that that a person does not have the financial capacity to pay as it would involve personal financial hardship or where it is not in the public interest, charges can be waived. Examples included;

- Ineligible patients who are hospitalised for communicable diseases;
- Financial disadvantaged pensioners
- Patients without any independent source of income, such as children of pensioners.

The Chief Executive may waiver or postpone all or part of the charge up to $1,500 under the *Medical Services Act*. Waivers over $1,500 are to be referred to the Minister for Health for Approval. Medical Services Act available from: http://www.austlii.edu.au/au/legis/nt/consol_act/msa153/

As soon as it is established that a person does not have the financial capacity to pay, a briefing showing the amounts owing and the reason why the charges should be waived shall be submitted to the Chief Executive through the Chief Finance Officer.

Debts may also be written under the *Financial Management Act.* For more information in relation to write-offs please refer to Section 21.11 of the Accounting & Property Manual, available from:http://internal.health.nt.gov.au/finance/apm/Pages/default.aspx

## Explanatory Notes

### 34.14.1 Nursing Home Type Patients (NHTP)

Public, private and DVA patients are reclassified as Nursing Home Type patients if after 35 days of continuous hospitalisation the patient is then provided with accommodation and nursing care. Charges are raised against all public, private and DVA Nursing Home Type patients (except ex Prisoner of War or Victoria Cross recipients).

The 35 day qualifying period may be accrued in a single or multiple hospitals either public or private. Transferring between hospitals does not effect on the qualifying period. The qualifying period is only broken if the patient is discharged from hospital and is not re-admitted within 7 days. In such cases a new 35 day period will commence from day one of the next admission, excluding statistical discharges. Periods of less than 7 days out of hospital do not break the qualifying period, though this period outside hospital care is not included in the count e.g. a patient who has accrued 20 days then takes three days of weekend leave will start day 21 when returning to the hospital.

The Nursing Home Type Patient rate represents 87.5% of the Australian Government adult single rate pension plus rent assistance, excluding the GST compensation component and pharmaceutical allowance. Rates are adjusted in accordance with CPI by the Australian Government in March and September every year.

Private Nursing Home Type patients are to be charged both the Patient Contribution and the Basic Benefits amounts for each overnight stay.

### 34.14.2 Newborn Babies

All newborn babies are admitted patients. They are however further classified into unqualified or acute (qualified).

*Classification Criteria*

A newborn patient day is acute (qualified) if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care (ASH & RDH only)
- is admitted to, or remains in hospital without its mother

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

If a newly born baby is classified as acute (qualified), the parent or parents must elect whether the baby is to be treated as a public patient or a private patient; admission documentation must be completed as for any other patient.

Should only the mother continue to require admitted patient care on the 10th day, the baby is classified as a boarder.

### 34.14.3 Acute Care Certificates

If after 35 days of continuous hospitalisation it is determined by the treating doctor that the patient requires continued acute care then the doctor is required to complete an Acute Care Certificate. The requirement under legislation for a section “3B certificate” to be issued for long stay acute patients no longer exists.

Despite this change it is however advised that a certificate still be completed if the patient is deemed to be acute. Certificates continue to be required by Veterans Affairs, TIO under the Motor Accident Compensation Act (MACA) agreement and workers compensation insurers. Should a dispute arise between a hospital and a third party whose is financially responsible for the patients treatment the acute care certificate will act as medical evidence.

Work is currently underway nationally to develop a nationally consistent Acute Care Certificate.

### 34.14.4 Primary Care Referred

A Medicare eligible person who is referred to a specialist medical practitioner, by name, from a general practitioner (GP) or district medical officer (DMO) following provision of a primary care level service in the community for a consultation or a procedure, including radiology and pathology services.

Under ordinary circumstances (i.e. in the context in which the MBS rules have been designed) specialist consultants would receive GP type primary care level referrals in their private rooms and would Medicare bill for these services. In the Northern Territory there is insufficient critical mass of population for most specialist consultants to establish private rooms therefore Specialist Medical Consultants see private patients on hospital premises.

The important thing is that the services, which are Medicare billed, are provided within the following conditions:

- They are primary level services (i.e. community patients) and not related to a current hospital admission;
- They are referred by a GP or DMO to a named Specialist Medical Consultant;
- The Specialist Medical Consultant has rights of private practice. See ***34.14.5 Rights of Private Practice.***
- The classification of Primary Care Referred is for non-admitted patients only.

A primary care referred patient will be Medicare bulk-billed 85% of the MBS schedule fee (no patient contribution) for non-admitted consultations, radiology and pathology services.

### 34.14.5 Rights of Private Practice

The Department may grant a Staff Specialist Clinician, who is registered and credentialed to perform clinical duties for 75% of his/her employment with the Department, the ability to engage in private practice during employment time and within public hospitals.

Under such arrangements, eligible clinicians will elect to receive either Category A or Category B Private Practice Allowance in exchange for the undertaking to exercise their rights to private practice to the fullest extent possible and paying over to the Department an agreed amount of the fees arising from such Private Practice work

### 34.14.6 s19(2) Exemptions Initiative

To improve access to primary care in rural remote areas, the Australian Government will allow Medicare benefits to be claimed in respect of bulk-billed, non-admitted, non-referred professional services provided in emergency departments and outpatient clinics at some small rural hospitals. This includes nursing and allied health services.

This situation existed prior to the National Health Reform and the Government with continue to support the two exempt sites in the Northern Territory, Gove District Hospital and Tennant Creek Hospital.

It is important to note that these are public patient services that are claimed against the MBS under a 19(2) exemption. So whilst the public hospital employed doctor providing the service requires a valid provider number for MBS benefit purposes, they do not require engagement in private practice.

### 34.14.7 Multiple Visits on the Same day/ Attendances During The same Episode

The possibility exists that a person may attend, or be admitted to, and discharged from a hospital more than once in the same day.

Hospitals may charge for every outpatient attendance for chargeable patients. This means hospitals can charge for the following:

- Multiple same-day outpatient hospital attendance;
- Outpatient attendances when the patient is subsequently admitted.

Hospitals may also charge for an Emergency Department and an Outpatient attendance on the same day.

When a chargeable day stay patient is admitted and discharged, and then subsequently readmitted and discharged within the period of one day (midnight to midnight) at the same hospital, only one day stay account is to be raised.

When a day stay patient is subsequently retained by the hospital (or if discharged and readmitted on the same day) beyond midnight on the day of admission, the patient is reclassified as an overnight stay and only charged the overnight fee.

### 34.14.8 Change of Election

Patients should make an informed decision to be private or private at the time of admission, or as soon as possible after admission. The patient should be advised that this choice will remain for the total hospital stay unless there are unforeseen circumstances.

Unforeseen circumstances include but are not limited to:

- A change in medical circumstances, for example where the patient is admitted for a particular procedure but found to have complications requiring additional procedures.
- The length of stay is extended beyond that originally and reasonably planned by an appropriate health care professional.
- A change in social or financial circumstances while in hospital (e.g. loss of job)

**Inadequate private health insurance cover is not sufficient reason to change an election**.

To make a change of election the patient must complete a new election form. The change is effective for the remainder of the admission and is not retrospective.

## Glossary

**Admission**

The formal administrative process by which a patient commences a period of treatment, care and accommodation in a hospital.

**Admitted Patient**

A patient who has undergone the formal admission process.

**Australian Government**

Commonwealth Government

**Boarder**

A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. A boarder is thus defined as not admitted to the hospital. A hospital however may register a boarder.

METeOR (Metadata Online Registry)

**Compensable Patient**

A patient receiving hospital services who, is or may be, entitled to payment, or has received payment, by way of compensation in respect to the injury, illness or disease for which the patient is receiving those services.

**Coronary Care Unit (CCU)**

A specialised ward dedicated to acute care services for patients with cardiac diseases.

METeOR (Metadata Online Registry)

**Day Only or Same Day Patient**

A patient who is admitted and separated on the same day

**Department of Veterans Affairs**

The Australian Government Department which arranges and/or pays for the health care of veterans and war widows according to their entitlement for certain services and their clinical need for those services.

**Discharge or Separation**

The formal administrative process by which an admitted patient ceases a period of treatment, care and accommodation in a hospital.

**Eligible Person**

A person who is eligible for Medicare as defined in the *Health Insurance Act 1973* as an Australian resident or eligible overseas representative. A person covered by a Reciprocal Health care Agreement is eligible for Medicare for immediately necessary medical treatment, if they elect to be a public patient. The *Health Insurance Act 1973* gives the Minister discretionary powers to either include or exclude certain persons or categories of persons for eligibility for Medicare. Eligible persons must enroll in Medicare before benefits can be paid.

**Emergency Department (ED)**

A purposely designed and equipped area with designated assessment, treatment and resuscitation areas. It has the ability to provide resuscitation, stabilisation and initial management of all emergencies. It utilises skills of medical staff, designated emergency department nursing staff and nursing unit manager, 24 hours per day, 7 days per week.

METeOR (Metadata Online Registry)

**Hospital**

A health care institution that has an organised medical and other professional staff, inpatient facilities and delivers medical, nursing and related services 24 hours per day, 7 days per week.

WHO (World Health Organisation)

**Hospital-in-the-home (HITH)**

Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

METeOR (Metadata Online Registry)

**Inpatient**

See “overnight stay patient”

**Intensive Care Unit (ICU)**

A designated ward of a hospital, which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises skills of medical, nursing and other staff trained and experienced in the management of these problems.

METeOR (Metadata Online Registry)

**Medicare Benefits Schedule (MBS)**

The schedule of fees set by the Government for standard medical services, based on a fair price and how much Australia can afford to pay for the total health system. Whether you have private health insurance or you are a private patient paying for all your own costs, the Government provides a rebate on nearly all medical fees. This rebate is currently 75% of the MBS fee for in-hospital medical fees and 85% of the MBS fee for specialist medical fees incurred out of hospital. You can purchase health insurance to cover the remaining 25% of the MBS fee and gap cover for any potential additional fees.

**Neonate**

A live birth that is less than 28 days old.

METeOR (Metadata Online Registry)

**Newborn Qualification Status**

Qualification status indicates whether a patient day within a newborn episode is either acute (qualified) or unqualified.

METeOR (Metadata Online Registry)

**Non-Admitted Patient**

A patient who does not undergo a hospitals formal admission process. There are three categories of non-admitted patient:

- Emergency Department patient
- Outpatient
- Other non-admitted patient (treated by hospital employees off the hospital site – community/outreach services.

METeOR (Metadata Online Registry)

**Nursing Home Type Patient (NHTP)**

The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

**Outpatient**

See “Non-Admitted Patient”

**Overnight Stay**

An admitted patient of a hospital who remains an admitted patient of the same hospital until a calendar day subsequent to the calendar day of their admission.

**Patient**

A person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patients, admitted and non-admitted. Boarders are not patients.

METeOR (Metadata Online Registry)

**Primary Care Referred Patient**

A Medicare eligible person who is referred to a specialist medical practitioner by name from a general practitioner or district medical officer following provision of a primary care level service in the community for a consultation or a procedure, including radiology and pathology services.

**Private Patient**

A private patient is a person who is eligible for Medicare, who on admission elects to be treated as a private patient. The patient receives medical or diagnostic services from a medical practitioner chosen by the patient.

**Prostheses (surgically implanted)**

Surgically implanted prostheses, includes such things as hip replacements, artificial lenses and heart valves.

**The Prostheses List**

Under the *Private Health Insurance Act 2007*, private health insurers are required to pay mandatory benefits for a range of prostheses that are provided as part of an episode of hospital treatment (or hospital substitute treatment) where a Medicare benefit is payable for the associated professional service(surgery).

There are more than 9,000 products on the Prostheses List, including cardiac pacemakers and defibrillators, cardiac stents, hip and knee replacements and intraocular lenses, human tissues such as human heart valves, corneas, bones (part and whole) and muscle tissue. The List does not include; external legs, external breast prostheses, wigs and other such devices, only surgically implanted prostheses.

**Public Hospital**

A hospital funded by the Government. 'Recognised' public hospitals have access to the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and private health insurance arrangements.

**Public patient**

A public patient elects to be treated in a public hospital under Medicare, by a doctor appointed by the hospital.

**Rights to Private Practice**

The Department may grant a Staff Specialist Clinician the ability to engage in private practice during employment time within public hospitals.

**Special Care Nursery (SCN)**

A hospital ward staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

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