Visiting Medical Officer (VMO) Claims Management

Summary NSW Health is committed to ensuring the sustainability of the health system. This includes the management of finances and that of service delivery. All contractors engaged by NSW Health are entitled to receive payment for services rendered. This includes Visiting Medical Officers (VMOs). Claims submitted for payment by VMOs must be checked and approved to ensure prompt payment.

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Policy Directive

Visiting Medical Officer (VMO) Claims Management

Policy Statement

NSW Health is committed to ensuring the sustainability of the health system. This includes the management of finances and that of service delivery. All contractors engaged by NSW Health are entitled to receive payment for services rendered. This includes Visiting Medical Officers (VMOs). Claims submitted for payment by VMOs must be checked and approved to ensure prompt payment.

Summary of Policy Requirements

This Policy Directive requires VMOs to submit claims that are accurate and appropriate. Claim checkers and approvers have a responsibility to ensure that claims submitted are checked and paid. Both VMOs and checkers/approvers need to validate the claims.

This Policy Directive provides information on what documentation is needed to support a clam for payment, why it is needed, and how it will assist the payment process. The information expected to be submitted should be in accordance with the *Record of Services* and *Contract of Services* Clauses described in the relevant VMO Determinations.

VMOs can submit claims for public work using the VMoney Web Portal (VMoney). Evidence must be provided to support the claim. In certain instances, VMoney requires additional information to validate the claim. The VMO should consider providing more, not less information. The quality of the information provided will assist checkers to assess the claims quickly without having recourse to the VMO for additional material.

Where a financial classification changes, it must be communicated to the VMO/delegate and the VMO needs to agree. This is important if the change occurs post procedure.

VMOs need to validate and submit their own claims in VMoney. Validation rules exist to assist the clinician and the checkers. If there is a red flag, this means that the claim is not ready for submission. The error is significant enough to impede progress. Lesser issues will have an amber flag and can still be submitted.

Claim checkers are to follow the processes described in this Policy Directive. Claims should not be approved for convenience's sake. If disputes arise, these must be escalated to the appropriate person at the Health Agency. The claim checker is not required to fix a claim that has 50% or more entries that require modification or rejection.

Both VMOs and checkers should avail themselves of the information provided on HealthShare NSW's VMO Payment Processing website.

Revision History

Version	Approved By	Amendment Notes
PD2024_032 October-2024	Deputy Secretary, Financial Services and Asset Management	• Inclusion of financial classes • Inclusion of changes in financial election • VMoney information requirements • Checker/approver information requirements • Consolidation of VMO Claims Management Audit Tool Guideline 2015.

Contents

1. Background

Visiting Medical Officers (VMOs) contracted by NSW Health are paid in accordance with the *Public Hospitals Fee-for-Service Contracts Determination (2014)*, the *Public Hospitals Sessional Contracts Determination (2014)* and/or the *Rural Doctors' Settlement Package* (RDSP). Claims are submitted by the VMO using the VMoney Web Application (VMoney).

VMoney is an online time and charge entry application that enables VMOs or their delegates to log the hours, duties and procedures undertaken by VMOs in order to claim payment. There are 3 types of arrangements: fee for service, sessional payments and RDSP.

Claims submitted must be checked for their validity and accuracy before a claim for public work can be paid. Claims cannot be made for private/chargeable patients.

1.1. About this document

This Policy Directive clarifies the roles and responsibilities of VMOs and claim checkers. Information entered and submitted is the responsibility of the VMO. This is in keeping with the 'record of services' and the 'contract for services' requirements in the VMO Determinations. This Policy Directive also details the information required to be entered, submitted and checked. Only claims for public work are to be submitted for payment.

The primary audience is claim checkers/approvers and VMOs across Health Agencies.

VMOs are to refer to this Policy Directive in conjunction with the HealthShare NSW VMO Payment Processing website when submitting claims.

1.2. Key definitions

Claim Checkers	Staff at Health Agencies tasked with checking and approving VMO claims. For the purposes of this Policy Directive, claim checkers includes approvers.
Emergency after hours (medical services)	'Services initiated by or on behalf of public patients whose medical conditions requires immediate treatment and which takes place on a public holiday, on a weekend or at any time other than between 8.00am and 6.00pm on a weekday not being a public holiday' [1].
Fee for Service Contract (FFS)	'A service contract under which a medical practitioner (or the medical practitioner's practice company) is remunerated for medical services performed by the medical practitioner by reference to a scale of fees for different kinds of medical services that is contained in, or specified or otherwise identified by, the contract' [1].

Health Agency	A NSW Health local health district (LHD), specialty network or affiliated health organisation in respect of its recognised establishments or services.
Non-public patients	Are chargeable patients. This includes compensable, Department of Veteran Affairs (DVA) patients, defence force personnel, privately insured patients, residential aged care and overseas visitors. Refer to section 11 for a comprehensive list of chargeable financial classes for admitted and non-admitted patients.
Rural Doctors' Settlement Package (RDSP)	Negotiated by the Rural Doctor's Association in 1988, it sets out the fees paid by rural hospitals for public services rendered at RSDP hospitals by VMOs.
Sessional Contract	'A service contract under which the medical practitioner (or the medical practitioner's practice company) is remunerated by reference to any hourly rate or rates for services provided, but not on a fee-for-service basis' [2].
Visiting Medical Officer (VMO)	'A medical practitioner appointed under a service contract (whether the practitioner or his or her practice company is a party to the contract) to provide services as a visiting practitioner for monetary remuneration for or on behalf of the public health organisation concerned' [3].
VMoney Web Portal (VMoney)	An online system where VMOs and/or delegates can enter and submit claims for public patient work. VMoney also permits VMOs to submit claims for other work as required by Health Agencies from time to time, in accordance with the VMO *Public Hospitals Fee-for-Service Contracts Determination (2014)* and *Public Hospitals Sessional Contracts Determination (2014)*.

1.3. Legal and legislative framework

The classification of Visiting Practitioners can be found Chapter 8 (Part 1) of the *Health Services Act 1997* (NSW) [the Act]. The contracts offered can also be found in Chapter 8 (Part 2) of the Act. The payment of services is governed by the service contract offered. The fee structures can be found in the relevant Industrial Relations Commission (IRC) Determinations and NSW Health Information Bulletins as amended from time to time.

Fee for service VMOs can only claim for clinically relevant services as described in the Commonwealth Medicare Benefits Schedule (CMBS/MBS). The legislation underpinning the CMBS is the *Health Insurance Act 1973* (Commonwealth). A complete list of relevant legislation and legislative instruments is provided below.

State Legislation

Health Services Act 1997 (NSW)

VMO Determinations

- *Public Hospitals (Visiting Medical Officers Fee-For-Service Contracts) Determination 2014* (Fee-for-Service Determination)
- *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2014* (Sessional Determination)

In this Policy Directive both documents are referred to collectively as Determinations.

VMO Rural Doctors' Settlement Package Hospitals

- NSW Health Information Bulletin *Rural Doctors' Settlement Package Clarifications Reference Guide* (updated annually)
- NSW Health Information Bulletin Rural Doctors' *Settlement Package Hospitals Indexation of Fees – Visiting Medical Officers* (updated annually)

VMO Model Service Contracts

- *Model Sessional Service Contract*
- *Model Sessional Service Contract - Practice Company*
- *Model Fee-For-Service Service Contract*
- *Model Fee-For-Service Service Contract - Practice Company*
- *Fee-For-Service Contract - Rural Doctors Package Hospitals*
- *Form-of-Fee-For-Service Contract With Practice Company - Rural Doctors Package Hospitals*

****Commonwealth Legislation/Legislative Instruments/Schedules***

Health Insurance Act 1973

Health Insurance Regulations 2018 and associated tables (GMST, DIST, PST)

Commonwealth Medicare Benefits Schedule (MBS)

*In so far as they are applicable.

2. Claims Management-Submission to Payment

The VMoney Web Portal (VMoney) is where Visiting Medical Officers (VMO) submit their claims on a monthly basis, consistent with the relevant Determination or the terms of the Rural Doctors' Settlement Package (RDSP). Compliance with the applicable Determination or Package is mandatory.

Health Agency systems and records should be used to check the validity of claims. VMOs must have made an appropriate notation identifying services to be paid in the medical record.

Services provided but not notated in the medical record (such as, teaching/training) must be recorded and such records are to be made available to the Health Agency. It is acceptable for the notation to have been made by a member of the medical team on behalf of the VMO, but it must identify with sufficient precision the date and nature of the service provided.

Examples of systems/records that can verify VMO claims include:

- eMR (Electronic Medical Record)/Powerchart/eRIC
- PAS (Cerner Patient Administration System)/PMI (Patient Master Index)
- Cerner Scheduling, IPM Scheduling, ARIA, Mosaiq, etc
- Approved Committee lists, attendance records, minutes and action lists
- Records of Non-Standard Arrangements approved by the Ministry of Health
- Applicable Service Plans
- Call-Back Registers (or similar)
- Surginet
- Rosters (anaesthetist, intensivists, on-call, emergency physicians, theatres, etc)
- RIS/PACs
- ComCare.

2.1. On-Call

“On call” ‘means rostered to be available to attend public patients pursuant to an on-call roster prepared by the public health organisation in consultation with the relevant clinical’ [department] [2, p. 2]. When rostered it is expected that the VMO ‘shall be readily contactable at all times and prepared to attend the hospital concerned within a reasonable timeframe’ [2, p. 4]. The VMO is expected to record the particulars of the on-call period (date, start/finish times), which can be verified by the checker. The on-call allowance is not payable while on a leave of absence [2].

2.2. Call-backs/Emergency after-hours

A “call-back” ‘means called to attend a hospital, whether or not rostered on-call, at a time when the VMO would not otherwise have attended the hospital in response to a request from the relevant hospital or public health organisation to attend for the purpose of providing services’ [2, p. 2] .

Call-backs are only paid for time spent on public patients. Travel time (not exceeding 20 minutes each way) can only be claimed if the Sessional VMO has already left the hospital. In accordance with the Sessional Determination, the name and position of the staff member requesting the call-back must be recorded and entered in VMoney. Time spent with private patients is to be deducted.

For Fee for Service VMOs, an emergency after-hours medical service record must include the name and/or designation of the person requesting the service as well as information detailing the relevant attendance and/or treatment [1].

RDSP VMOs have an Emergency Fee item number, refer to section 7.1 for more information.

2.3. Miscellaneous

Miscellaneous items (dollar values) can also be claimed using VMoney. These claims are for reimbursement of items not included in the Determinations. A mandatory description of the service performed is to be included. Invoices may be required to substantiate the claim, refer to Table 2.

VMO claims can only be submitted through VMoney. Other systems (for example iExpenses) cannot be used and claims submitted outside VMoney cannot be paid. The VMO is to submit the miscellaneous claim using the VMoney Web Portal.

2.4. Other Claims

Services that can be claimed under "Other Claims" cover non-rostered work and must include a detailed description of the service provided.

2.5. Record of Services

Under both Determinations and the RDSP, a record of services is to be maintained by VMOs. These records are to include the details for each service supplied as described below, *unless the Health Agency has reached an agreement under Subclause (2) of both Determinations Record of Services.* Note, there is a separate section for cancelled theatres, see section 10.

Table 1. Record of Services information

Type of Hours/Services	Record of Services	Additional information required
Ordinary Hours (Sessional) Routine claim is for rostered shifts/work.	Date, full name and/or medical record number (MRN) of the patient being claimed; start and finish times. Nature of service provided.	Type of remuneration (options 1-3). For radiologists, RIS/PACs information is sufficient, if start/finish times are recorded.
Detail Lines MBS/RDA item numbers (Fee For Service - FFS/Rural Doctors' Settlement Package - RDSP)	Date, full name and/or MRN of the public patient. Details of service/s provided which corresponds with the MBS/RDA item number/s being claimed.	

Type of Hours/Services	Record of Services	Additional information required
On Call (Sessional)/*On Call* (RDSP) *Call backs* (Sessional/RDSP)	Particulars of on-call periods (dates/times as per roster). Details of service/s provided which correspond with the RDA item numbers being claimed. Date, full name and/or MRN of the public patient. Particulars of the relevant medical attendance and/or treatment provided.	Access to on-call roster to justify claim. In accordance with the Sessional Determination, Clause 14 (Subclause 1c), 'for call-backs, the name and/or designation of the person requesting the call-back, and appropriate entry by the visiting medical officer in the medical record of the relevant attendance and/or treatment' [2, p. 13]. For RDSP the "emergency fee" includes the term "call-back" as requested and recorded by the nurse in charge.
Emergency after hours (FFS)	Date, start/finish times, full name and/or MRN of patient and type of service being claimed.	In accordance with the Fee for Service Determination Clause 8 (Subclause 1b) 'for emergency after-hours medical services, the name and/or designation of the person requesting the service, and appropriate entry by the visiting medical officer in the medical record of the relevant attendance and/or treatment' [1, p. 10].
Other Claims Post Graduate Training (FFS & Sessional)	Start/finish times. Evidence of lecture/tutorial or convening and chairing a session.	Attendance at an activity in which teaching and training is provided is not sufficient to justify a claim. Include particulars of teaching and training work (as per the Determinations).
Other Claims Committee attendance (FFS/RDSP & Sessional)	Start/finish times. Details of committee including attendance lists to corroborate claim.	Evidence that the committee attended was an approved committee. Evidence of attendance (such as, record of attendance noted in minutes. Actual minutes not required). Include particulars of committee work (as per the Determinations).
Miscellaneous services (FFS/RDSP & Sessional)	Details of the expenditure incurred will be required.	Record of services to be maintained by VMO. Invoices/receipts will be required to verify the claim and the amount being claimed.
Other Services (FFS & Sessional) Hospital Patient Management, Departmental Administration etc.	Evidence that the request was made by hospital executive; evidence of appointment to department head etc.	Information regarding roles and responsibilities undertaken should be made available to the Health Agency to facilitate payment.

2.5.1. Maintenance of record

The record of services referred to in the above table is to be maintained for each calendar month during which services are performed by a VMO. As per the Determinations, it shall be submitted no later than the fifteenth (15) day of the next calendar month [1] [2]. Refer to section 2.6 Submission of delayed claims for more information.

2.5.2. Insufficient evidence to support a claim

Where there is insufficient evidence provided or where sufficient information ceases to be available from the medical record or the VMO's personal records to support the claim, future payments to the officer will require the provision of additional details for a specified period of time. The type of detail and the period is determined by the Health Agency [1] [2]. *Health Agencies should provide VMOs with written notification of this requirement within two (2) weeks of the decision being made. This is to prevent reoccurrence of the issue during the following billing periods.*

2.5.3. Unsupported Claims

Where no evidence is available in any system or no documentation has been supplied to justify the claim/claim lines, and this is more than just a one-off occurrence, the claim must be escalated to the approver, who must in turn escalate to the workforce team at the Health Agency for investigation. The VMO must be given the opportunity to explain – it could simply be a miscommunication or a misunderstanding of the *Records of Services* requirements in the VMO Determinations.

2.6. Submission of delayed claims

VMOs can submit 'delayed claims' as permitted by the Determinations. However, delayed claims are subject to the delayed claims discounting rules in accord with Subclauses 8(8) of the Fee for Service Determination and 14(8) of the Sessional Determination.

'After 12 months from the date a service was provided, the value of a claim can be discounted by 50%, subject to the Health Agency having provided 28 days' notice to the VMO that a discount of 50% will apply if a claim is not received.

After 24 months from the date a service was provided, no payment is owing in respect of the service, subject to the Health Agency having provided 28 days' notice to the VMO that no payment will be made if a claim is not received.

Applications to submit claims later than these time limits without any, or with a lesser discount can be made in writing to the relevant Health Agency within 4 weeks from the date of receipt of discount notice if there are exceptional circumstances (such as serious illness of the VMO). The public health organisation has the discretion on how to deal with such applications. If a VMO is dissatisfied with the decision of the public health organisation, the dispute resolution procedures of the Determinations may be invoked' [1, p. 11] [2, pp. 13-14].

Health Agencies should establish the practice of sending generic letters to VMOs reminding them of the discounting rule that can be applied to late claims (where no exceptional circumstances exist).

Prior to the end of the financial year, it is good practice to remind VMOs that if they fail to submit claims with a date of service older than 12 or 24 months within 28 days of receipt of the notification, the claim may be discounted by 50% or 100% respectively. This is to encourage timely submissions.

2.7. Validating claims prior to submission – VMOs

Although delegates can enter claims on behalf of a VMO they cannot submit claims. Submission of claims is done by the VMO through their VMoney Web account. Validation rules are then applied to the submission.

Validation issues are business rules that have been built into the application to assist with the checking process. Any time there is a possible breach of a business rule, the claim line is identified in the validation panel with a description of the potential breach. The associated status and risk level will also be displayed.

If any potential issues/errors are detected, the system will alert the VMO to the number of issues found with the claim. If a claim line has a red flag, this indicates that the claim has an error which will prevent it from being submitted. The error must be rectified before proceeding.

If the issue/s identified have an orange flag, this is a system generated warning. The claim has an issue, but it can still be submitted. It is recommended that a comment be added by the VMO explaining why the claim is being submitted. This will help the checker verify the claim and expedite payment.

2.8. Changes in financial election – admitted patients

Patients can alter their financial election as described in schedule G of the *National Health Reform Agreement 2011* and NSW Heath Policy Directive *Admitted Patient Election Processes* (PD2021_046). In circumstances where a valid election has been made but subsequently changed due to 'unforeseen circumstances', the change in election is effective from the date of change onwards [4].

2.8.1. Deferred elections

Where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election or *actual* election [emphasis added], in NSW Health this is called a *deferred* election. These patients will be treated as public patients and the hospital will choose the doctor [practitioner] until such time as a valid election is made. Once a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission. Where the patient elects to be private/chargeable the consent of the treating practitioner is recommended. This is particularly relevant for smaller sites with limited administration coverage.

2.8.2. Changes in financial election post procedure

If a change in financial election occurs post procedure (and therefore a change in the financial classification), the treating practitioner must be informed. A change to a chargeable financial classification should not occur post procedure without the consent of the treating

practitioner/s. If the patient has a deferred election status at the time of the procedure, that patient is deemed to be a public patient until such time that a decision is made. If the patient elects to be a public patient, this decision does not change the financial circumstances of the patient, nor does it impact the VMO. Therefore, consent of the treating practitioner is not required. The change is retrospective.

2.8.3. Changes to financial election non-admitted

A non-admitted patient is a public patient unless the patient elects to be seen as a private patient and has a 'named' referral. If the public patient wishes to be seen in a private capacity, but does not have an appropriate referral, it is acceptable for the hospital to request a named referral. It should be made clear that the request is at the behest of the patient. This information must be communicated to the VMO.

2.8.4. Indemnity Coverage

If the Health Agency has yet to discuss/confirm the financial election with the patient or their legally authorised representative (e.g. emergency patient) and a procedure is required, that patient will be treated as a public patient, until such time that a decision is made by the patient or their representative. In this circumstance, the treating practitioner will be covered by the Treasury Managed Fund (TMF) until he/she is notified of the election or if reasonable attempts to do so have been made and documented. If the procedure takes place prior to the VMO being notified of the private election, then TMF coverage will apply for that period of time and in accordance with any Contract of Liability Coverage.

2.9. Checking submitted VMO claims – Claim checkers

VMoney's mandatory fields ensure claim details are captured in accordance with the *Record of Services* requirements in the VMO Determinations. These assist claim checkers when verifying claim lines against existing records. Claim checkers should follow the process outlined below:

- Check the named patient was a patient of the hospital on the dates claimed.
- Ensure time involved in providing services to all chargeable patients has been deducted.
- Check enough information has been provided or is otherwise available to enable the claim to be validated. If further evidence is required to substantiate the claim, the claim checker should request more information from the VMO. This request should be made prior to the expiration of the prescribed checking and approval timeframes.
- If a claim has been submitted for a chargeable patient, check if there is evidence that there was a change in the financial classification. If so, confirm that the VMO consented to the change in financial classification. This may require contact with the site. This is important if a procedure is involved. If there was no change, refer the claim back to the VMO, refer to section 2.8 for more information.
- If further information cannot be obtained, reject the line/s and state concerns in the comment field before escalating the claim to the approver.

- Where a claim has 50% or more entries that require modification or rejection, advise the VMO by email/phone before rejecting the lines and returning claim.
- Where a VMO routinely makes the same error, the claim checker should advise the VMO and/or recommend they visit the HealthShare NSW VMO Payment Processing website for more information.
- Claims entered under "Other Claims" require a mandatory description of the service/s provided. This must be substantiated by the claim checker using the Health Agency's systems and records. If necessary, further detail should be requested from the VMO.
- All claims under the Miscellaneous line type must be reviewed by the Health Agency. Miscellaneous claim lines with a value of $1000 or greater have a red flag and must be checked and approved manually.
- Where payments are made above Award rates or outside a Determination, claims should not be made paid until confirmation the non-standard arrangement has been approved by the Workplace Relations Branch at the NSW Ministry of Health. The Executive Director of Medical Services should seek this confirmation. *Where a non-standard arrangement has a Determination or is otherwise approved by an appropriate delegate at the NSW Ministry of Health, this arrangement must be kept on file and readily available if a claim dispute arises.*

Claims identified as being inconsistent with the rules are marked with an orange or red flag. Claim lines marked with red flags cannot be approved. Claim lines with an orange flag should be reviewed by the claim checker prior to being sent to the approver.

Claim checkers should ensure that the correct cost centre is provided and seek authorisation to make changes if required. The cost centre is usually the contract default cost centre.

For more information refer to HealthShare NSW's *VMoney Claims Management User Guide*.

2.10. Validating claims – Claim checkers

Validation issues are business rules that have been built into the application to assist with the checking process. Any time there is a possible breach of a business rule, the claim line is identified in the validation panel with a description of the potential breach. The associated status and risk level will also be displayed.

A risk level is considered 'High Risk' when the risk value is between 75 and 100. This risk is indicated by a red flag in the VMoney Claim Management (VCM) Claim Validation panel. It is an error that must be corrected if the claim is to proceed to payment. The VMO cannot submit the claim until this error is corrected. Claim checkers and approvers cannot proceed further unless the claim line with the red flag has been amended and revalidated.

A risk level is considered 'Medium Risk' when the risk value is between 1 and 74. This risk is indicated by an amber/orange flag in the VCM Claim Validation panel. Claim checkers and approvers should review and/or amend the claim line to proceed further. Any amended claim line will always require revalidation. **This flag should not be ignored,** doing so could lead to over/underpayment.

A risk level is considered 'No Risk' when the risk value is zero (0). This risk is indicated by a green flag in the VCM Claim Validation panel. Checkers and approvers can proceed without any issues.

VMOs need to validate their claim/s prior to submission. This will identify any issues with the claim/s that requires correction.

2.11. Payment of claims

A submission of a claim to VMoney does not imply that the account is to be paid in full at the time of submission, the claim must be verified. The Health Agency will make a payment to the VMO in respect of the account within 30 days of submission. If the Health Agency does not pay within 45 days of receipt of an account for payment, in accordance with the Determinations, interest will accrue.

Should the Health Agency fail to make payment to the RDSP VMO after 90 days of receipt of account for payment, interest will accrue. Refer to NSW Health Information Bulletin *Rural Doctors' Settlement Package Clarifications Reference Guide* (IB2024_021) or the latest version for more information.

2.12. Professional support payments – Regional VMOs

Professional support payments or expenses are permitted under both Determinations for regional VMOs (RVMO). RVMOs are entitled to receive payments for certain expenses, not to exceed $30,000 over 2 calendar years. These expenses are reimbursed through the Miscellaneous claim line in VMoney.

Professional support expenses are costs incurred by the RVMO for their own professional development. Expenses incurred by family, friends or other medical practitioners are not included.

To be eligible to access a professional support payment, the RVMO must:

- have held an appointment continuously for the immediately preceding 12 months, and
- reside within a 50 kilometre radius of the regional hospital where services are provided.

In addition to meeting the above criteria, eligibility for the $10,000 payment is conditional on the RVMO:

- having provided at least 450 ordinary and/or call-back hours of services over the preceding 12 months at one or more regional hospitals (sessional), or
- having provided services (including planned services and emergency after hours medical services) involving fees of at least $100,000 in total over the preceding 12 months at one or more regional hospitals (fee-for-service).

To access a further $5,000, the RVMO must:

- have participated on a 1:4 or more frequent basis in an on-call emergency after-hours medical services roster applying in at least one regional hospital over the preceding 12 months.

An RVMO may be eligible to claim up to $15,000 per calendar year. Eligibility commences on 1 January of each year. Professional support payments are **not payable** for services remunerated under the RDSP.

Eligibility for claims in the current calendar year is based on criteria met in the previous calendar year. An RVMO who has met the criteria in the previous calendar year is entitled to access the full amount of the professional support payment from 1 January in the current calendar year.

Separate professional support payments of $10,000 and/or $5,000 annually, accrue for up to two (2) years, provided the RVMO continues over that two (2) year period to satisfy the eligibility criteria. The two (2) year period is from 1 January until 31 December the following year. For example, an RVMO meets the criteria in calendar year 2023 and becomes eligible for professional support payment from 1 January 2024. The RVMO has until 31 December 2025 to take advantage of this payment before any unused funds expire and are removed from the RVMO's balance. If the RVMO ceases to meet the eligibility criteria but has an accrued balance from previous years, the RVMO can continue to access the balance until it has been fully claimed or the two (2) year accrual period has expired, whichever comes first, provided the RVMO continues to meet the first two (2) eligibility criteria outlined above in this section 2.12.

RVMOs are not eligible to receive payments from more than one local health district (district) per calendar year. The district at which the RVMO has the greatest service commitment will be responsible for payment.

Where a VMO holds appointments at both regional and RDSP hospitals, services provided under the RDSP are not included when calculating a VMO's services under the eligibility criteria above.

2.12.1. Locum expenses

The cost of locum cover is the **net cost** of engaging locum cover in private rooms while attending conferences and courses associated with continuing education. For example, if a locum costs $1,500 per day, but generates $1,000 per day as income, the net cost of $500 per day would be allowable as a professional support payment.

The locum's travel and accommodation costs (not meals) could also be claimed. These costs are only applicable for the time required for the VMO to travel to and from (and attendance) at the conference, not for any associated extra leave the VMO might take. Locum agency and/or locum fee invoices and receipts should be scanned and attached to the claim – this includes any relevant accommodation/travel costs incurred by the locum.

2.12.2. 'Other items' – Allowable expenses

'Other items' mentioned in the Determinations, these expenses cannot be claimed when associated with the business of conducting a private practice.

The following expenses are allowable:

- *Registration fee for a course/conference.
- Return travel to and from the course/conference. Travel does not need to be approved in advance by the Health Agency. There is no need to book flights through the

Government contractor. Reimbursement is limited to business class or lesser airfares. First class airfares will not be reimbursed.

- Travel insurance.
- Airport transfers, taxis, airport parking, car hire and fuel costs for the RVMO to attend a course/conference.
- Fuel/charging costs or travel claim when the RVMO drives to the course/conference.
- Accommodation expenses while attending a course/conference. Only the costs of accommodation directly related to the course/conference (that is night before, up until and including last night) can be claimed. Any additional days' in holiday accommodation is at the expense of the RVMO. Accommodation will only be paid for a single or double room, and not an apartment of 2 or more bedrooms.
- Locum expenses as per section 2.12.1.
- Laptops including hard drive/memory upgrade and warranty, iPad, or tablet up to the cost of $5,000 on the basis of one item every 2 years. Equipment remains the property of the Health Agency.
- Printer up to the cost of $500 on basis of one every 2 years.
- Medical texts (including digital and online) CDs, DVDs and subscriptions for professional journals.
- Medical education programs.
- Tertiary education course fees relevant to the specialty area.
- Registration for webinars or on-line conference participation and associated reading material.

*Payments made in advance for conference/course registrations, air fares and accommodation, and supported by original invoices and receipts, may be reimbursed prior to attendance on the understanding that if attendance at the conference/course does not proceed the amount advanced is to be repaid to the Health Agency within 14 days of the non-attendance becoming known.

Advance reimbursements are to be treated as payment of the entitlement for the year in which the entitlement falls due after having established that such entitlements have accrued in the previous calendar year/s,for example, payments reimbursed in December 2023 for a conference in January 2024 are debited against the entitlement for 2023 (which may also include the balance of entitlements left over from 2023).

2.12.3. Expenses not allowed

The following expenses are not to be claimed:

- desktop personal computer (not a portable electronic device)
- printer consumables such as ink, paper etc
- laptop carry case

- hard drive back up
- smart phone purchases and monthly mobile phone plans
- telephone and internet connection and monthly accounts
- anti-viral protection software, general software and business-related programs
- medical/clinical equipment
- DVD players/recorders etc
- payment for frequent flyer points used in travel booking
- excursion flights/trips from conference venue
- meals and beverages, such as restaurant meals, take away meals, supermarket receipts, café snacks and beverages, hotel room meals and snacks etc.
- hotel room internet connection and movie hire
- per diem meals, incidentals and accommodation allowance as per Staff Specialist entitlements
- Australian Medical Association and Specialty College/Professional Association fees
- Medical Staff Council membership
- hospital library contribution.

2.12.4. Checking professional support payments

Claims should not include costs which are reimbursed by other organisations.

Claims are to be substantiated by the submission of scanned original tax invoices and receipts attached to the claim with an appropriate description in VMoney.

Locum expenses require other appropriate evidence described in section 2.12.1.

Claims must be adjusted to exclude fares, accommodation, etc, of family members accompanying the RVMO to conferences or direct costs relating to holidays taken in conjunction with attendance at the conference. Claims will be rejected if expenses have not been adjusted to exclude family members or are without scanned original invoices/receipts. Amounts reimbursed will be included as part of Miscellaneous payments in VMoney (*Reimbursement of PSE*) and will be reflected accordingly in the annual Statement of Earnings.

Claims for conferences or courses are not to be paid if the date of the conference/course is after the RVMO has resigned.

3. Sessional Visiting Medical Officers

Under the Sessional Determination, sessional Visiting Medical Officers (VMO) shall be paid the hourly rate of remuneration for each ordinary hour specified in a sessional contract. Remuneration is for services provided to public patients.

Table 2. Claim Lines

Sessional Line Type	Information required – VMoney	Additional information for Checkers
Routine Claims	Select service type (consults, rounds, outpatient, theatre) Enter start date/time and finish times (finish date is automatically populated). Add patients Deduct hours worked for non-public (chargeable) patients.	Name/MRN of patient is required, unless the Health Agency has agreed otherwise under Subclause 14(2) of the Sessional Determination.
On Call Claims Line	Start Date/Time, Finish Date/ Time. The system will calculate hours worked.	Only one payment is to be made to a VMO who is rostered to be on-call at more than one hospital. Payment should be made by the hospital where the VMO has the greatest on-call commitment. If on-call commitments are equal, the VMO will only receive an on-call allowance from **one** hospital. On-call rosters as applicable. Add comment for claim checkers/approvers as required.
Call Back Claims Line	Complete mandatory fields. The system will calculate hours worked and the number of patients seen. Add travel time to and from hospital. Complete the *Callback Requester Details*. Deduct hours for private patients.	In accordance with the Sessional Determination, Subclause 14(1)(c), 'for call-backs, the name and/or designation of the person requesting the call-back and appropriate entry in the medical record of the relevant attendance/and or treatment' [2, p. 13]. There is no entitlement to travel unless the VMO has left the hospital and returned. Maximum travel time is 20 minutes each way. Add comment for claim checkers/approvers as required.

Sessional Line Type	Information required – VMoney	Additional information for Checkers
Miscellaneous Claims Line Includes: Xrays, Echoes, Other, Travel, Reimbursement of professional support expenses (PSE), Special, Teaching and Pandemic Leave. Hours not required; dollar value is submitted.	Start Date Select *Miscellaneous Category* from dropdown list. Add dollar amount. Mandatory description required.	Include any supporting documentation. Scanned copies of invoices and receipts are to be attached to ensure prompt payment. When claiming for *Reimbursement of PSE*, refer to section 2.12. Add comment for checkers/approvers as required.
Other Claims Line Administration of a Dept Agreed committee meeting	Complete mandatory fields. The system will calculate hours worked. Mandatory description required. Complete mandatory fields. The system will calculate hours worked. Mandatory description required.	Evidence of departmental head position. Name of approved committee and accepted attendance sheet. Meeting claims, refer to Section 9 for a list of approved/unapproved meetings. Add comment for claim checkers/approvers as required.
Other Claims Line Cancelled Theatre	Complete mandatory fields. The system will calculate hours worked. Mandatory description required.	Evidence that the theatre session was cancelled by the Health Agency. Sessional Determination (Subclause 10(3)). Add comment for claim checkers/approvers as required.
Other Claims Line Clinical Planning, Hospital Patient Management	Complete mandatory fields. The system will calculate hours worked. Mandatory description required.	Evidence that the meeting took place including date/time attended. Evidence that planning/patient management was requested by hospital executive. Add comment for claim checkers/approvers as required.

Sessional Line Type	Information required – VMoney	Additional information for Checkers
Other Claims Line Peer Review	Complete mandatory fields. The system will calculate hours worked. Mandatory description required.	Evidence that the peer review took place. Add comment for claim checkers/approvers as required.
Post Graduate Education	Complete mandatory fields. The system will calculate hours worked. Mandatory description required.	The VMO is to personally deliver a lecture or tutorial, convene and/or chair a session to be eligible to claim for Academic Leads/Teaching. Attendance at an activity in which teaching and training is provided is not sufficient to justify a claim. Add comment for claim checkers/approvers as required.
Other Claims Line '*Unspecified' allows entry of hours that do not relate to a specific time but to an agreed amount of time.)	Complete mandatory fields. The system will calculate hours worked. Mandatory description required.	A mandatory description of the service performed is required. If claiming for mandatory training, please include certificate of completion/report from My Health Learning (MHL) to ensure payment. Add comment for claim checkers/approvers as required.

*More information can be found at HealthShare NSW VMO Processing Payments website.

4. Checking Claims Submitted by Sessional Visiting Medical Officers

The sessional payment system is based on the time taken to provide services to non-chargeable (public) patients. A sessional Visiting Medical Officer (VMO) is paid an hourly rate of remuneration for each ordinary hour (and on a proportionate basis to the nearest quarter hour) specified in a sessional contract for services provided to public patients, consistent with the clinical privileges granted to the VMO. The ordinary hours during which a VMO is to provide services will be as agreed between the VMO and the Health Agency on an annual basis. Rate increases for sessional contracts are negotiated annually. Changes are published by NSW Health on the Policy Distribution System (PDS) webpage. Where the finalisation of rates occurs after July, pay rates will be backdated.

For ordinary hours of remuneration, one of the following options apply to sessional VMOs as set out at Clause 5(3) of the Sessional Determination:

- Option 1 – Budgeted actual hours remuneration

- Option 2 – Specified procedures remuneration
- Option 3 – Agreed hours remuneration.

The number of ordinary hours may be varied at any time by written agreement between the VMO and the Health Agency.

A VMO's record of services as prescribed in the Sessional Determination is to include all services rendered under the sessional contract. The record is to indicate, in respect of each of the services rendered (unless agreed otherwise with the Health Agency under Subclause 14(2):

- date
- start and finish times
- patient's full name and/or medical record number (MRN) [MRN preferred]
- nature of service.

4.1. Routine claims

The following procedures apply to the checking of routine sessional claims:

- Ensure that times for all chargeable patients on the VMO's claim have been deducted.
- Some patients may have a 'deferred' financial classification upon admission or may change their financial election, refer to section 2.8 and section 2.9 for additional information.
- Query sessional hours greatly in excess of contracted hours and advise hospital management.
- Check that the cost centre used is correct for the service provided (for example, outpatient clinics). This is usually the 'contract default cost centre', when the VMO is setup in VMoney. If the VMO requires remuneration from a different cost centre, the claim checker has the functionality to change the cost centre.

4.2. Call-backs

Call-backs claimed can only be for non-chargeable patients and remunerated at the Determination rate. 100 percent of all call-backs must be checked against patient records. VMoney will automatically calculate the applicable rates.

Under Clause 14 of the Sessional Determination *Record of Services* the VMO must include the name and/or designation of the person requesting the call-back. An appropriate entry by the VMO in the medical record of the relevant attendance and/or treatment is also required [2].

4.2.1. Call-back hours

Call-backs for non-chargeable patients are remunerated at the Determination rate. There is no entitlement to travel unless the VMO has left the hospital and returned.

If a VMO is claiming for a chargeable (non-public) patient, the call-back claim is adjusted accordingly to reduce the hours claimed. The time claimed may be prorated according to the number of patients claimed, for example, total hours claimed is 1hr 30mins; the number of patients is three (3) but one was verified as a chargeable type, then the total hours should be only one (1) hour.

The call-back should be entered as a total time period – NOT per patient. Entries against reports must be checked to ensure dates and times match. No payment is to be made without the appropriate documentation entered. No payment can be made if the staff member requesting the call back has not been provided (mandatory field in VMoney and Clause 14 of the Sessional Determination).

Call back claims for excessive before and after times compared with actual operation time should be reviewed by the claim checker. Any excessive hours that cannot be supported with documentation should be deducted after appropriate review. *Consideration should be given to those elements outside the control of the VMO (time taken to transfer to/from ward, post operative recovery etc).*

4.3. On-call

All on-call claims must be checked and reconciled against the relevant on-call roster for each VMO at the hospital. If any discrepancies are found, the VMO is to be contacted and should provide appropriate documentation to confirm the accuracy of the date(s) and or time(s) claimed.

Where a VMO is rostered to be on-call at more than one NSW Health hospital at the same time either within the same local health district (district) or another, the VMO must advise the districts concerned that they are on-call at separate locations, to ensure maintenance of service provision. The VMO shall be entitled to receive an on-call allowance only from that hospital to which the VMO has the greatest on-call commitment, or where the on-call commitments are equal, the VMO shall receive an on-call allowance only from one hospital. In other words, only one payment is to be made to the VMO.

4.4. Other claims

Claim checkers must read the mandatory description supplied by the VMO. Where there is insufficient detail to justify the claim and there is no supporting evidence in the records or systems used or available to the Health Agency, claim checkers should contact the VMO requesting supporting documentation. If the VMO is unable or unwilling to provide the requested information, the claims must be rejected, refer to Table 2.

4.5. Miscellaneous claims

Claim checkers must read the mandatory description provided by the VMO. All miscellaneous item types require substantiation and (where applicable), scanned copies of invoices and receipts must be attached to the claim. Where insufficient detail is provided or no invoice/receipt is attached, the claim checker should contact the VMO for more information. If the VMO is unable or unwilling to supply the information, the claim is rejected.

With regard to the checking of Professional Support Payments *(Reimbursement of PSE*), claims submitted are to conform with the requirements described in section 2.12.

5. Fee for Service and Rural Doctors' Settlement Package Visiting Medical Officers

When submitting claims through VMoney, Fee-for-Service and Rural Doctors' Settlement Package (RDSP) Visiting Medical Officers (VMO) should refer to the table below. More information can be found on the HealthShare NSW VMO Payment Processing website.

Table 3. Fee for Service and RDSP Claim Types

VMO FFS line type	Information required – VMoney	Additional information for Checkers
Detail Lines (Fee For Service [FFS]) *Claim Lines* (RDSP)	Choose Start Date and time. Select patient type (in/out) and add patient. Add item number/s. Complete all mandatory fields. Do not include non-public patients.	Outpatient consults are confirmed via an outpatient clinic appointment list or progress notes within the electronic medical record (eMR) in Patient Administration System (PAS). If there is no evidence that the service took place, there can be no payment until this is rectified. Refer back to the VMO.
Emergency (FFS)	Select *Special Use* field and choose *After Hours Emergency* from the dropdown list. Do not include non-public patients.	After hours emergency is selected only if services are initiated by or on behalf of patients whose medical condition requires immediate treatment, and where those services take place on a weekend, public holiday or other than between the hours of 0800 and 1800 on weekday not being a public holiday. VMOs are to provide the name and position of the staff member requesting the after-hours medical service (Fee for Service Determination Subclause 8(1)(b)).
Emergency (RDSP)	Add RDA item number/s and complete all mandatory fields.	Date and time of attendance must be recorded. Evidence that hospital executive/nurse in charge, requested emergency attendance must also be recorded.
Assistance at operations (FFS/RDSP)	If assisted at operations, tick the Assistance box [only permissible	

VMO FFS line type	Information required – VMoney	Additional information for Checkers
	if the item descriptor includes the text *(assist)*].	Ensure operation report is completed in Surginet (or equivalent system).
Multiple Operation/Derived Fee, (FFS/RDSP)	Choose the correct item number. For a full list of MBS item numbers and descriptors refer to MBS online. If the item number is eligible for a multiple operation grouping the system allows the VMO to add multiple items for the patient for same date/time. If the fee is derived the 'D Fee' indicator is changed to Y.	Ensure operation report is completed in Surginet (or equivalent system).
Multi Anaesthetic/Derived Fee (RDSP)	Use the RDA/MBS item number. Ensure you do not add non-public (chargeable) patients.	Anaesthetic time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia [5, p. 15]. Add comment for claim checkers/approvers as required.
Other Claims Line (FFS) Use the *Service* drop down list to select the service for payment (such as, Agreed Committee Meeting, Cancelled Theatre, Post Graduate Education).	Complete mandatory fields. The system will calculate hours worked. Mandatory description required. Refer to Sessional 'Claim Lines' see Table 2. Choose appropriate RDA item number.	Refer to Sessional 'Claim Lines' see Table 2. Add comment for claim checkers/approvers as required.
Claim Lines (RDSP) *On-call, visits in/out of hours, prolonged professional attendances, mandatory training meetings, supervision etc.*	Add the relevant RDA item numbers for service performed. Patient details are not required when using an RDA item numbers for on-call and meetings.	Ensure documentation verifying service is available for review. Add comment for claim checkers/approvers as required.
Other Claims Line –Unspecified (FFS) *Unspecified* allows entry of hours that do not relate to a specific time but to an agreed amount of time.	Enter hours worked (start and finish times). The system will calculate the hours worked. Mandatory description required.	If claiming for mandatory training, please include certificate of completion/report from My Health Learning (MHL) to ensure payment. Add comment for claim checkers/approvers as required.

VMO FFS line type	Information required – VMoney	Additional information for Checkers
Miscellaneous Claims Line (FFS & RDSP) Includes: Xrays, Echoes, Other, Travel, Reimbursement of Professional Expenses, Special, Teaching and Pandemic Leave. Hours not required; dollar value is submitted.	Select miscellaneous category from dropdown list. Add dollar amount. A mandatory description of the claim is required.	Include any supporting documentation. Add comments for claim checkers/approvers. Scanned copies of invoices and receipts are to be attached to ensure prompt payment. When claiming for *Reimbursement of PSE*, refer to section 2.12. Add comment for claim checkers/approvers as required.

6. Checking Claims Submitted by Fee for Service Visiting Medical Officers

The fee for service payment system is based on the Commonwealth Medicare Benefits Schedule (CMBS), commonly known as the Medicare Benefits Schedule (MBS). Health Agencies are to ensure that all claims submitted by Fee for Service Visiting Medical Officers (VMO) are checked. Where it is not possible for all claims to be checked, a rotation system of VMO claims should be applied which will ensure each VMO will have at least one monthly claim submission thoroughly checked every 3 months.

If the VMO wants to use multiple MBS item numbers for a procedure, they need to select *Add Multi-Operation Item*. An MBS item number cannot be added if the first item number is not subject to the multiple operations rule, for example a consult.

6.1. Fee for Service claims

Claim checkers need to verify all fee for service (FFS) line items to confirm that the correct MBS item number has been used by the VMO.

Things to consider when checking attendance item numbers include the duration, frequency and age of the patient. For example, both 132/133 are time-based attendance item numbers and have annual limits for complex patients. Items 141/142 are for patients 65 and over, are time based and can only be used by qualified geriatricians.

6.1.1. Initial consultations

There should only be one initial attendance per doctor per patient upon admission or attendance at an outpatient clinic. This signifies the commencement of a single course of treatment.

Outpatient consults are checked using an outpatient clinic appointment list or progress notes within eMR (electronic medical record such as Powerchart or similar). A claim cannot be made for an outpatient attendance if the patient is a current inpatient.

6.2. Emergency after-hours

Any emergency after-hours claims must be checked against the after-hours roster and the name and position of the staff member requesting the emergency after-hours medical services must be provided as per Clause 8 *Record of Services* of the (Fee for Service Determination).

Emergency after-hours medical services do not include normal ward rounds being performed either during the morning or evening on any day Monday through to Sunday, nor does it apply to *twilight* surgery lists.

6.3. Other and Miscellaneous claims

'Other claims' must include a description and evidence that the service was undertaken by the VMO in accordance with Clause 8 *Record of Services* of the Fee for Service Determination. Always check the appropriate cost centre has been chosen (this is usually the *contract default* cost centre).

Miscellaneous claims must also include a description and scanned copies of the invoices and receipts must be uploaded to VMoney (where required). Always check the appropriate cost centre has been used as described above.

7. Checking Claims Submitted by Rural Doctors' Settlement Package Visiting Medical Officers

The Rural Doctors' Settlement Package (RDSP) fees are applicable to Visiting Medical Officer (VMO) general practitioners (GP), locally resident VMO non-GP specialists who have elected to be remunerated under the RDSP and non-resident VMO non-GP specialists with the agreement of the relevant local health district (district), who provide services at facilities to which the RDSP applies.

Non-resident non-GP specialist VMOs, and those who provide services at an RDSP facility as part of an outreach service from a tertiary, regional or base hospital, do not have an automatic right to elect to be remunerated under the RDSP, but can only do so with the agreement of the relevant district that RDSP arrangements will apply.

A non-GP specialist VMO is locally resident for this purpose, if their usual place of residence is within a 50 kilometre radius of the RDSP facility and the RDSP facility is the closest public hospital to that place of residence.

RDSP VMOs are remunerated in accordance with the August 1987 Medicare Benefits Schedule (MBS). Fees under the RDSP are indexed from 1 August each year according to an agreed formula. Refer to the NSW Health Information Bulletins *Rural Doctors' Settlement Package Clarifications Reference Guide* (IB2024_021) and *Rural Doctors' Settlement Package Hospitals Indexation of Fees – Visiting Medical Officers* (IB2024_046) or latest versions.

Any items not listed in the schedule are to be paid at the rate of 140% of the current MBS fee.

GP Registrars are appointed as VMOs at a rural district in accordance with NSW Health Policy Directive *Visiting Medical Officer Appointments for General Practitioner Vocational Trainees* (PD2011_074). They are provided with Rural Doctors' Association (RDA) VMO contracts and are entitled under PD2011_074 to bill under the RDSP schedule. GP Registrars and GP VMOs should not claim for an attendance for the same patient on the same day unless it is clinically appropriate.

In circumstances where GP registrars who hold VMO appointments call in their supervisor to assist payment can be made to both doctors. The services performed by the GP Registrar should not be inconsistent with their skills and capabilities.

7.1. Emergency fee

The emergency fee includes the term, *call-back fee* and *emergency consultative fee*. The fee is paid to the on-call practitioner or a practitioner who is called to assist an on-call practitioner or is called by the hospital. This fee is payable whether or not the VMO is at the hospital at the time of the call.

7.2. GP VMO sessional arrangements in emergency departments at RDSP facilities

It is possible with the agreement of both the relevant district and a GP VMO, that where a GP VMO is required to provide a continuous on-site presence at a facility covered by the RDSP, sessional remuneration arrangements can apply.

A GP VMO can be provided with both RDSP fee-for-service rates and also receive sessional rates for shift work at the applicable sessional VMO remuneration rate including background practice costs as applicable from time to time. Two contracts, RDSP and sessional, must be in place.

For sessional rates to apply, it is a requirement that a GP VMO be present at the hospital during the entire duration of a shift, and all work conducted during that shift (including inpatient rounds) will be covered by the sessional payments. Where the shift is of 4 hours or more, inpatient rounds are to be completed.

7.3. RDSP FFS claims checking

The checking of RDSP claims should include, (but not limited to) the following:

- Verifying that on-call claims against the roster and corresponding days/hours are correct.
- Confirming the VMO has documented the attendance or procedure in the patient's medical record.
- For after-hours item numbers, times of attendance must be recorded on the claim.
- The number of attendances for Nursing Home Type patients complies with the RDSP.
- Any claims for attendances at outpatients and a subsequent admission comply with the RDSP. If the VMO has seen the patient in the outpatient clinic and a subsequent admission occurs the VMO should not claim a second fee unless it is clinically relevant

for the additional service. The non-inpatient fee is to be regarded as a consultation for these purposes.

- Ward rounds occur once per day at any reasonable hour where a VMO will see most or all inpatients under their care. A VMO is entitled to claim one ward round visit per day per acute patient.
- ECGs: generally, item 1908 would apply where the complete procedure was provided by the one VMO. Item 1909 applies where the tracing and report are provided by different VMOs.
- All assistant at operation numbers.

For emergency item numbers, the term “emergency” includes the term ‘call-back’ and ‘emergency consultative’ fee.

Items not listed in the schedule are to be paid at the rate of 140% of the current Medicare Benefits Schedule fee.

With regard to the multiple operations rule, the VMO can add both multi-anaesthetic, multi-operation item numbers.

7.4. Emergency and Out of Hours claims

The definition for an emergency attendance as per the Rural Doctors’ Settlement Package is as follows: ‘An emergency attendance occurs where the hospital requires the visiting medical practitioner’s immediate and urgent attendance’ [5, p. 10].

An emergency must be requested by the hospital, and the medical records for all emergency claims for inpatients should be examined to verify that the emergency was initiated by the hospital. Emergency consultations for non-inpatients should also be recorded on the system (FirstNet/Eric).

7.5. Consultations

Claims pursuant to Item 1002 of the 1987 MBS (referred to as an RDA item), apply only where one inpatient has been seen on the one occasion. If more than one inpatient has been seen (on the one occasion), the rate for Item 1004 should apply.

Attendance times are to be recorded on the VMO’s claims for out of hours items. The claim checker is to ensure these agree with times recorded on the inpatient (admitted patient) records and in the scheduling system (outpatient clinic appointment list/or progress notes [Powerchart]). VMoney will only verify inpatient classification and hospitalisation dates.

Claim checkers should check that the correct items are claimed, and that the frequency of attendances for Nursing Home Type patients and the rate of payment conforms with NSW Health Information Bulletins *Rural Doctors’ Settlement Package Clarifications Reference Guide* (IB2024_021) and the *Rural Doctor’s Settlement Package Hospitals Indexation of Fees – Visiting Medical Officers* (IB2024_046) or latest versions.

Any attendances that result in an admission can be claimed at RSDP rates.

8. Teaching and Training of Post Graduate Medical Officers – All Visiting Medical Officers

Visiting Medical Officers (VMO) may participate in the teaching and training of postgraduate medical officers where reasonably required and remunerated by the local health district/specialty network in accordance with the hourly rate determined by the NSW Ministry of Health.

VMOs who personally delivered teaching and training to postgraduate and prevocational medical officers shall be remunerated for their time. Attendance at an activity in which teaching and training is provided is not sufficient to justify a claim. The VMO is to deliver a lecture or tutorial, convene and chair a session etc. The contractual context for payment of Sessional/Fee-for-Service VMOs for teaching and training can be found at Subclause 4(6) – Sessional Determination and Subclauses 4(6) and 5(5) – Fee for Service Determination respectively.

The Rural Doctors' Settlement Package (RDSP) VMO may participate in the teaching and training of postgraduate medical officers where reasonably required and remunerated by the Health Agency in accordance with the hourly rate determined by the NSW Ministry of Health.

Health Agencies must ensure that a list of approved teaching and training activities is maintained and the names of all attendees are recorded, to substantiate the claim.

9. Meetings – All Visiting Medical Officers

Visiting Medical Officers (VMO) are entitled to claim payment for attendance at approved meetings under the terms and conditions of the Determinations and the Rural Doctors' Settlement Package (RDSP).

VMOs 'shall participate in committees expressly established and authorised by the Health Agency to which the officer is appointed where reasonably required by the Health Agency for the proper and efficient functioning of the hospital or hospitals concerned' [1, p. 4], [2, p. 4].

The VMO can claim for attendance at most, but not all meetings. Examples of types of meetings/committees payable are:

- Health Agency based administrative meetings where VMO assistance is required or requested. For example:
    - Medical and Dental Appointments Advisory Committee (MDAAC/MADAAC)
    - Credentials Committee
    - "Clinical Stream" Meeting
    - Clinical Council
    - Chronic and Complex Care
    - Aged Care etc.

- Hospital administrative meetings where VMO assistance is required or requested. For example:
    - Infection Control Meetings
    - Operating theatre management committees
    - Morbidity and Mortality committees
    - Patient Care Committees
    - Multi-disciplinary Team Meetings
    - Perinatal Committees etc.
- Ad hoc meetings where a VMO presence is requested by a hospital manager (General Manager) or local health district (district) Executive:
    - Planning meetings
    - Meetings with consultants etc.

Hospital General Managers/district Executive may submit to the Chief Executive for authorisation, committees for which a VMO payment is to be made.

9.1. Meetings that do not attract a payment

Examples of meetings not payable include:

- Medical Staff Council Meetings
- Education meetings for the benefit of the Medical Officer
- Public relations type meetings where the VMO may be invited and attends by their own choice (for example, opening ceremonies and meetings with dignitaries)
- Any unapproved meetings.

Where claims are submitted for attendance at meetings, claim checkers should make sure that the meeting for which reimbursement is being sought has been approved by checking with the relevant Director, Medical Services/Health Service Manager. Meeting minutes (attendance sheet) can also be checked before payment is made.

10. Cancelled Theatre Sessions (Sessional/Fee for Service)

Cancelled theatres – the Visiting Medical Officer (VMO) is entitled to be paid for the portion of the cancelled time that is reasonably estimated would have involved the treatment of non-chargeable patients at the hourly rates, on the condition that the VMO attends the Health Agency to provide services for the relevant period in lieu of the cancelled theatre session, unless excused from such attendance by the Health Agency. The payment should only apply where a VMO has a prearranged operating theatre session cancelled by the Health Agency with:

- less than 28 days' notice of such cancellation was provided to the anaesthetists

- less than 14 days' notice of such cancellation was provided to a regional VMO who is not an anaesthetist
- less than 7 days' notice of such cancellation was provided to other VMOs.

For payment to be made, the following activities should be undertaken as requested by the Health Agency:

- undertaking training and education activities specified by the Health Agency
- undertaking clinics or procedures within the scope of the VMO's clinical privileges
- undertaking quality assurance or review activities specified by the Health Agency.

Where a VMO cancels a pre-arranged operating theatre session, and the cancellation is not due to illness, the VMO is required to make up the cancelled time over the ensuing 14 day period at time/s of mutual convenience to the VMO and the Health Agency. If such mutually convenient time is unavailable, the VMO will cooperate with the Health Agency in examining the feasibility of alternative arrangements with another medical practitioner for the performance of operations or procedures upon non-chargeable patients affected by such cancellation [2] [1].

11. Financial Classifications – Deducting Chargeable Patient Claims – All Visiting Medical Officers

Visiting Medical Officers (VMO) are to only make claims for public patients. Deductions for private patients must be made. In circumstances where there are no time records within the patient record, NSW Health permits claim checkers to endorse a claim based on the proportion of public or private patients within a session or period of engagement (including call-backs). Where this is unsuitable, claim checkers should seek particulars from the VMO as to the services provided to public patients within a session or period of engagement before verification. For example, total hours claimed is 1.5, the number of patients is three (3) but one was verified as chargeable, therefore the total hours should be reduced to one (1) hour.

Changes in financial elections can occur during an episode of admitted patient care. For example, a patient is compensable, Department of Veteran Affairs (DVA) patients or elects to be private. When this occurs, refer to section 2.8 in this Policy Directive.

Where a Fee for Service VMO/RDA doctor does not deduct a private patient, the claim checker must refer the claim back to the doctor. The claim cannot be progressed.

VMOs and claim checkers should be aware that emergency department (ED) patients are not assigned an inpatient financial classification until they are admitted. Once admitted with a chargeable financial classification, no further payment to the VMO for public work should be made by the Health Agency. [6]

Where a patient is an overseas visitor, charges are raised by the Health Agency and/or the VMO upon presentation to the emergency department/service.

VMoney claim checkers should deduct any patients with a chargeable financial classification (inpatient and outpatient – excludes ED).

The following chargeable inpatient financial classes require a deduction (with 7 exceptions).

Table 4. Private Patients (with/without Private Health Insurance)

Inpatient Financial Class	Description	Deduction Required
EW	Privately Insured/Shared Room/ Overnight	Y
ES	Privately Insured/Single Room/ Overnight	Y
E1, E2, E3, E4	Privately Insured/Day Only/Bands 1-4	Y
EUW	Self Funded (no PHI)/Shared Room/Overnight	Y
EUS	Self Funded (no PHI)/Single Room/Overnight	Y
EU1, EU2, EU3, U4	Self Funded (no PHI)/Day Only/Bands 1-4	Y

Table 5. Compensable Patients – Motor Accident

Inpatient Financial Class	Description	Deduction Required
VNW	NSW Motor Accident – NWAU Claim	Y
V10	NSW Motor Accident – *No Claim Public	**N**
V12	NSW Motor Accident – No Claim PHI	Y
V14	NSW Motor Accident – No Claim DVA	Y
V16	NSW Motor Accident – No Claim Overseas Visitor	Y
Y1	Non NSW Motor Accident – NWAU	Y
Y2	Non-NSW Motor Accident – Sub acute/Non-acute	Y
LNW	Lifetime Care & Support – NWAU	Y
LSA	Lifetime Care & Support – Sub acute/Non-acute	Y
LA, LB, LX	Lifetime Care & Support – Rehab Cat A, Cat B, Cat X	Y
LTA	Lifetime Care & Support – Transitional Living Units	Y

Inpatient Financial Class	Description	Deduction Required
LTB	Lifetime Care & Support – Transitional Living Units	**N**

**No claim* means that, under the *Motor Accident Injuries Act 2017* (NSW), a patient may choose not to submit a claim. However, NSW Health will still be paid for services rendered to these motor accident patients by the State Insurance Regulatory Authority (SIRA). VMOs can submit a claim when the patient elects to be "public" – V10.

Table 6. Compensable Patients – Workers Compensation/Other Compensable

Inpatient Financial Class	Description	Deduction Required
WNW	Workers Comp – NWAU	Y
WSA	Workers Comp – Subacute/Non-acute	Y
WCP	Workers Comp – Psychiatric Hospital	Y
WCD	Workers Comp – Dialysis	Y
CNW	Other Comp – NWAU	Y
CSA	Other Comp – Subacute/Non-acute	Y
CDS	Other Comp – Dialysis	Y
CPO	Other Comp – Psych Hospital	Y
DVN	Dept of Veterans' Affairs – NWAU	Y

Table 7. Medicare Ineligible

Inpatient Financial Class	Description	Deduction Required
OCC	Overseas – Critical Care	Y
ONC	Overseas – Non Critical	Y
OVC	Overseas – Critical – Visa Holder	Y
OVN	Overseas – Non Critical – Visa Holder	Y
OVD	Overseas – Dialysis	Y
OVH	Overseas – Hospital in the Home	Y
OPY	Overseas – Psychiatric Hospital	Y
OIM	Overseas – Involuntary Mental Health	**N**
OHP	Overseas – High Risk Pregnancy	**N**
OCV	Overseas – Victim of Crime	**N**
OID	Overseas – Infectious Diseases – Public Health Risk	**N**

Inpatient Financial Class	Description	Deduction Required
OVK	Overseas – Kidney Donor	**N**

Table 8. Miscellaneous

Inpatient Financial Class	Description	*Deduction Required
DFS	Australian Defence Force – Same Day	Y
DFO	Australian Defence Force – Overnight	Y
*ARW	Asylum Seeker/ROMAC – Shared Room/Overnight	Y
*ARS	Asylum Seeker/ROMAC -Single Room/Overnight	Y
*ARD	Asylum Seeker/ROMAC/ Same Day Bands 1-4	Y

*Note: If the patient is classed as an asylum seeker through the NSW Refugee Service, the fees are waived and the VMO would not deduct any hours. Please liaise with the site/local health district revenue manager to confirm.

11.1. Non-Admitted Chargeable Financial Classifications

Table 9. Non-Admitted Financial Classifications

Non-Admitted Patient Financial Class	Description	Deduction Required
NAC.01	Non-admitted: MBS/PBS Claim – Privately referred	Y
NAC.02	Non-admitted: Charge – Overseas student health insurance claim	Y
NAC.05	Non-admitted: MBS/PBS Claim – DVA Privately Referred	Y
NAC.06	Non-admitted: Charge – Department of Defence	Y
NAD	Non-admitted: Charge NDIS Plan Manager	Y
NAI.01	Non-admitted: Charge – Medicare ineligible – self funded	Y
NAI.02	Non-admitted: Charge – Medicare ineligible – travel insurance	Y
NAN.02	Non-admitted: MBS/PBS Claim – Public Patient S19 (2)	Y

Non-Admitted Patient Financial Class	Description	Deduction Required
NAN.16	Non-admitted: MBS/PBS Claim – DVA Public Patient	Y
NAO	Non-admitted: Compensable – Public liability – Other	Y
NAS	Non-admitted: Compensable – Interstate 3rd party motor vehicle accident compensation	Y
NAW	Non-admitted: Compensable – NSW Workers Comp	Y

For completeness, the chargeable emergency financial classes for presentations have been included.

Table 10. Emergency Department

Emergency Dept Financial Class	Description	Deduction Required
EDC.08	Emergency Department: Charge – S19(2)	**N**
EDC.09	Emergency Department: Charge – Overseas Visitor	Y

12. References

[1] NSW Industrial Relations Commission, "NSW Health Careers/Conditions/Awards feeforservicedetermination," 19 November 2014. [Online]. Available: https://www.health.nsw.gov.au/careers/conditions/Awards/feeforservicedetermination.pdf. [Accessed 23 January 2024].

[2] NSW Industrial Relations Commission, "NSW Heatlh Careers/Conditions/Awards sessionaldetermination," 19 November 2014. [Online]. Available: https://www.health.nsw.gov.au/careers/conditions/Awards/sessionaldetermination.pdf. [Accessed 23 January 2024].

[3] NSW Government Legislation, "Health Services Act 1997 No. 154," 8 November 2023. [Online]. Available: https://legislation.nsw.gov.au/view/html/inforce/current/act-1997-154#sec.78. [Accessed 30 November 2023].

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[6] NSW Government - Health, "NSW Health - Remuneration and Conditions," November 2015. [Online]. Available: https://www.health.nsw.gov.au/careers/conditions/Documents/vmo-claims-audit-tool-guide.pdf. [Accessed 24 January 2024].

[7] NSW Government, "Rural Doctors' Settlement Package Clarifications Reference Guide," 21 June 2023. [Online]. Available: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2023_017.pdf. [Accessed 12 March 2024].