Health Services Act 1997 - Scale of Fees for Hospital and Other Services

Summary  This Policy Directive provides the key policy aspects and rates in relation to specific public hospital accommodation for chargeable patients to apply on and from 1 July 2016.

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Rescinded date  27 June 2017
Functional group  Corporate Administration - Fees
Distributed to  Public Health System, Ministry of Health
Audience  Administrative; Directors of Finance; Revenue Managers; Billing Staff Administration

Secretary, NSW Health
This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
HEALTH SERVICES ACT 1997 – SCALE OF FEES FOR HOSPITAL AND OTHER HEALTH SERVICES

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

MANDATORY REQUIREMENTS
Hospital accommodation charges are to be raised for all chargeable patients as detailed in this Policy Directive and attached Procedures. Hospital accommodation rates from 1 July 2016 are advised in the attached Procedures.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Version</th>
<th>Approved by</th>
<th>Amendment notes</th>
</tr>
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<tr>
<td>June 2016</td>
<td>A/Secretary, NSW</td>
<td>Rescinds PD2015_022. Advises charging policy and updates rates to apply from 1 July 2016.</td>
</tr>
<tr>
<td>(PD2016_024)</td>
<td>Health</td>
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<tr>
<td>June 2014</td>
<td>Secretary, NSW</td>
<td>Rescinded PD2014_009. Advised charging policy and updates rates to apply from 1 July 2014.</td>
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<tr>
<td>March 2014</td>
<td>Secretary, NSW</td>
<td>Rescinded PD2013_018. Advised revised charging policy for Compensable patient services from 1 April 2014 and re-stated rates from 1 July 2013.</td>
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<td>(IB2012_030)</td>
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<td>(PD2010_044)</td>
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<tr>
<td>(PD2005_606)</td>
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<tr>
<td>January 2005</td>
<td>Director-General</td>
<td>Advised public hospital charging policy and fees.</td>
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ATTACHMENTS

1. Health Services Act 1997 - Scale of Fees for Hospital and Other Health Services: Procedures.
Health Services Act 1997 - Scale of Fees for Hospital and Other Health Services

Issue date: June-2016
PD2016_024

Rescinded
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1 BACKGROUND

1.1 About this document

This Policy Directive updates key charging policy aspects and rates in relation to public hospital accommodation for chargeable patients. The advised rates are effective from 1 July 2016. This document replaces PD2015_022.

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

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

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

1.2 Legal and legislative framework

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

The advised fees in relation to Workers Compensation patients are gazetted by order under the Workers Compensation Act 1987.
2 PRIVATE PATIENTS (Overnight Stay) $ per day

Shared Room 343
Single Room 698

The shared room rate applies for private patients in single rooms where:
- The patient elects shared ward accommodation, but only single ward accommodation is available
- The patient elects shared room accommodation, but due to clinical reasons is located in single ward accommodation.

The single room rate applies for private patients where:
- The patient is accommodated at his / her request in a single room or as a sole occupant of a shared room.

Public hospitals are to undertake the following procedures in order to ensure full payment of accommodation charges:
- Admission staff must inform eligible patients with health insurance who wish to elect to be a private patient that their health insurance policy may require a patient co-payment / excess.
- To reduce administrative effort, patients from whom co-payment / excess is required or patients who elect to be private and who do not have private health insurance, payment arrangements are to be made on admission in the form of:
  - Credit card imprint (credit limits to be verified)
  - Cash to cover estimated cost
  - Bank or personal cheque to cover estimated cost.
- On discharge, credit card imprints should be completed with the due amount and adjustments made in respect of cash advances / cheques.
- Where for any reason payment is not finalised on admission or upon discharge, existing procedures for the recovery of outstanding hospital accounts should be followed.

3 PRIVATE PATIENTS (Same Day Patient) $ per day

Band 1 249
Band 2 279
Band 3 306
Band 4 343
4 INELIGIBLE PATIENTS

Excluding persons admitted to a public hospital under the Asylum Seeker Assistance Scheme.

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

4.1 Worker Visa holders 401, 403, 416, 420, 457 & 485 and Student Visa holders 570 to 576 and 580

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>- Inpatient - Critical Care</td>
<td>3,103</td>
</tr>
<tr>
<td></td>
<td>- Inpatient – Other than critical care</td>
<td>1,249</td>
</tr>
<tr>
<td>Public Psychiatric Hospitals</td>
<td>- Inpatient</td>
<td>524</td>
</tr>
<tr>
<td>Other (e.g. Residential Aged Care Facilities)</td>
<td>- Inpatient</td>
<td>294</td>
</tr>
</tbody>
</table>

Critical Care for the purpose of this document is defined as patients treated in the following units: intensive care units (ICU), paediatric intensive care units (PICU), neonatal intensive care units (NICU), psychiatric intensive care units, neonatal special care nurseries, coronary care units (CCU) and high dependency units (HDU).

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

4.2.1 Acute Admitted Patient Services – All Hospitals

<table>
<thead>
<tr>
<th>$ per day</th>
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<tbody>
<tr>
<td>Critical Care – first 21 days per episode</td>
</tr>
<tr>
<td>Critical Care – over 21 days</td>
</tr>
<tr>
<td>Other Inpatient – first 21 days per episode</td>
</tr>
<tr>
<td>Other Inpatient – over 21 days</td>
</tr>
</tbody>
</table>

- In counting days Critical Care – first 21 days per episode and Other Inpatient – first 21 days per episode stand alone. For example if a patient is Critical Care for 25 days and then Other Inpatient (non-critical care) for further 30 days – charge would be 21 days at $5,416 plus 4 days at $3,103 plus 21 days at $2,135 plus 9 days at $1,249. If the same patient then returned to Critical Care for a further 2 days (same episode) the charge would be a further two days at $3,103.
### Critical Care

Critical Care for the purpose of this document is defined as patients treated in the following units: intensive care units (ICU), paediatric intensive care units (PICU), neonatal intensive care units (NICU), psychiatric intensive care units, neonatal special care nurseries, coronary care units (CCU) and high dependency units (HDU).

### 4.2.2 Sub-Acute and Non-Acute Admitted Patient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>- Inpatient</td>
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<tr>
<td>Public Psychiatric Hospitals</td>
<td>- Inpatient</td>
<td>524</td>
</tr>
<tr>
<td>Other (e.g. Residential Aged Care Facilities)</td>
<td>- Inpatient</td>
<td>294</td>
</tr>
</tbody>
</table>

### 4.3 Non-Inpatient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>- Non-Inpatient</td>
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</tr>
<tr>
<td>Public Psychiatric Hospital</td>
<td>- Non-Inpatient</td>
<td>93</td>
</tr>
<tr>
<td>Other (e.g. Residential Aged Care Facilities)</td>
<td>- Non-Inpatient</td>
<td>93</td>
</tr>
</tbody>
</table>

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

### 4.4 Ineligible Inpatient Treatment Fee

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>$ per day</th>
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</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>328</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

4.5 Ineligible Patient – Hospital in the Home (HITH)

$ per day

241

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

- **Substitution** - The defining feature is that if not receiving the HITH service, the patient would require hospitalisation or a longer stay in hospital.

- **Prevention** – Care that does not immediately substitute inpatient care, however it is provided as preventative option to avoid an imminent hospital admission or readmission.

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

4.6 Ineligible Patient Dialysis – All Hospitals

$ per session

685
4.7 Ineligible Patients – Policy aspects

- Ineligible patients are "private", that is they must elect a doctor except in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.

- Ineligible patients are to be billed for all clinical/diagnostic services provided by VMOs / HMOs and salaried staff specialists exercising their right of private practice or by the hospital (treatment fee-section 4.4 above) in situations where the ineligible inpatient receives medical treatment under arrangement with a public hospital rather than an individual practitioner.

- Accommodation charges are not to be raised in respect of ineligible unqualified babies.

- Charges are to be raised for surgically implanted prostheses.

- Charges are to be raised for the direct cost (plus relevant on-cost) of drugs.

- Charges are to be raised at cost recovery for all other services provided in relation to a patient's episode of care.

- The dates of admission and discharge are to be counted as one day, with the date of admission being counted as that day (i.e. the 24 hour counting for compensable patients, does not apply to ineligible patients).

- In relation to section 4.2 (other than Worker Visa holders 457 and 485 and Student Visa holders 570 to 576) hospitals are to obtain an assurance of payment from this category of ineligible patients before treatment is provided. This assurance may take the form of:
  - Credit card imprint (credit limits to be verified)
  - Cash to cover estimated cost
  - Bank cheque to cover estimated cost
  - Personal guarantee from Australian citizen whose bona fides are verified
  - Other initiatives to ensure that payment for the services is not lost to the hospital.

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

5 NORFOLK ISLAND RESIDENTS

5.1 Medicare Eligible Norfolk Island residents

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

For private patients, charges are to be raised in accordance with section 2 Private Patient (overnight stay) and 3 Private Patient (same day patient) of this Policy Directive.
It is imperative that from 1 July 2016 the “Financial Class” for these patients reflects their Medicare eligible status. Thus public patients should be coded to the appropriate “Medicare Card Holder – Hospital Doctor” (public) financial class while private patients should be coded to the appropriate “Medicare Card Holder – Elected Doctor” (private) financial class. Note that the specific “Overseas Visitor – Norfolk Island” Financial Class codes are not to be used from 1 July 2016.

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

5.2 Medicare Ineligible Norfolk Island residents

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

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

5.3 Norfolk Island resident - Compensable patients

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

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

6 PATIENTS ADMITTED TO A PUBLIC HOSPITAL UNDER THE ASYLUM SEEKERS ASSISTANCE SCHEME

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Shared Room</td>
<td>606</td>
</tr>
<tr>
<td>Single Room</td>
<td>872</td>
</tr>
<tr>
<td>One Day Admission (Bands 1,2,3 or 4)</td>
<td>517</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1,755</td>
</tr>
</tbody>
</table>

7 COMPENSABLE PATIENTS ACCOMMODATION CHARGES

7.1 Acute Admitted Patient Services – All Hospitals

The patient episode reflecting the applicable AR-DRG version 8.0 grouping aligned to the National Weighted Activity Unit (NWAU(16)) with adjustments applied as applicable in accordance with the Independent Hospital Pricing Authority (IHPA) publication National Efficient Price Determination 2016-2017. The NWAU(16) is adjusted to reflect that Visiting Medical Officers (VMOs) and Staff Specialists bill separately for compensable admitted patients. The removal of assessed VMO and Staff Specialist costs reduces each NWAU by 11% creating an adjusted NWAU (16)
for the purposes of charging this category of compensable patients. The NWAU is rounded to the nearest 3 decimal places.

multiplied by

The National Efficient Price *(NEP)* of $4,883 as determined by the Independent Hospital Pricing Authority (IHPA).

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

The ED episode reflecting the applicable *URG version 1.4* or *UDG version 1.3* grouping aligned to the National Weighted Activity Unit *(NWAU(16))* with adjustments applied as applicable in accordance with the IHPA publication *National Efficient Price Determination 2016-2017*. The *NWAU (16)* is adjusted to reflect that Visiting Medical Officers (VMOs) and Staff Specialists bill separately for compensable admitted patients. The removal of assessed VMO and Staff Specialist costs reduces each NWAU by 11% creating an *adjusted NWAU (16)*, which is applicable for the purposes of charging ED admitted compensable patients. The NWAU is rounded to the nearest 3 decimal places.

multiplied by

The National Efficient Price *(NEP)* of $4,883 as determined by the Independent Hospital Pricing Authority (IHPA).

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

The ED presentation reflecting the applicable *URG version 1.4* or *UDG version 1.3* grouping aligned to the National Weighted Activity Unit *(NWAU (16))* with adjustments applied as applicable in accordance with the IHPA publication *National Efficient Price Determination 2016-2017*. The NWAU is rounded to the nearest 3 decimal places.

multiplied by

The National Efficient Price *(NEP)* of $4,883 as determined by the Independent Hospital Pricing Authority (IHPA).

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

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

### 7.5 Sub-Acute and Non-Acute Admitted Patient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
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</thead>
<tbody>
<tr>
<td>PD2016_024</td>
<td>Issue date: June-2016</td>
<td>Page 8 of 14</td>
</tr>
</tbody>
</table>
Public Hospitals - Inpatient 1,135
Public Psychiatric Hospitals - Inpatient 476
Other (e.g. Residential Aged Care Facilities) - Inpatient 267
- The above charges are inclusive of diagnostic costs.

7.6 Non-Inpatient Services

<table>
<thead>
<tr>
<th>Hospital Classification</th>
<th>Patient Classification</th>
<th>$ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospital</td>
<td>- Non-Inpatient</td>
<td>121*</td>
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<tr>
<td>Public Psychiatric Hospitals</td>
<td>- Non-Inpatient</td>
<td>84*</td>
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<tr>
<td>Other (e.g. Residential Aged Care Facilities)</td>
<td>- Non-Inpatient</td>
<td>84*</td>
</tr>
</tbody>
</table>

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


7.7 Non-Inpatient Physiotherapy, Chiropractic and Osteopathy Service Charges

Normal Practice

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>PTA001</td>
<td>Initial consultation and treatment</td>
</tr>
<tr>
<td>PTA002</td>
<td>Standard consultation and treatment</td>
</tr>
<tr>
<td>PTA003</td>
<td>Initial consultation and treatment of two distinct areas</td>
</tr>
<tr>
<td>PTA004</td>
<td>Standard consultation and treatment of two distinct areas</td>
</tr>
<tr>
<td>PTA005</td>
<td>Complex treatment</td>
</tr>
<tr>
<td>PTA006</td>
<td>Group / class Intervention (rate per participant)</td>
</tr>
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Home Visit

<table>
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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>PTA007</td>
<td>Initial consultation and treatment</td>
</tr>
<tr>
<td>PTA008</td>
<td>Standard consultation and treatment</td>
</tr>
</tbody>
</table>
- PTA009 Initial consultation and treatment of two distinct areas 164.30
- PTA010 Standard consultation and treatment of two distinct areas 140.70
- PTA011 Complex treatment 181.00

Other
- PTA012 Case conference, Report Writing (per 5 minutes) 15.05
- PTA012 Case conference (p/hour), Report Writing (p/hour - max) 181.00
- PTA013 Activity assessment, consultation and treatment 181.00
- PTA014 Travel – In accordance with “use of private motor vehicle”
rates as set out in Item 6 Table 1 of the Crown Employees
(Public Service Conditions of Employment) Award 2009.

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

7.8 Non-Inpatient Psychology and Counselling Service Charges

<table>
<thead>
<tr>
<th>Item</th>
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| PSY005     | Travel – In accordance with “use of private motor vehicle”
rates as set out in Item 6 Table 1 of the Crown Employees
(Public Service Conditions of Employment) Award 2009.

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

7.9 Non-Inpatient Exercise Physiology Service Charges

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<tr>
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</table>
- EPA006  Case Conferencing (per hour)  144.50
- EPA007  Report Writing (per 5 minutes)  12.00
- EPA007  Report Writing (max 1 hour)  144.50
- EPA008  Travel – In accordance with “use of private motor vehicle” rates as set out in Item 6 Table 1 of the Crown Employees (Public Service Conditions of Employment) Award 2009.

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

7.10 Dialysis – All Hospitals (per non-admitted session)  
\[ \text{$ per session} \]
\[ \text{640} \]

8  VETERANS’AFFAIRS PATIENTS (DVA)  
NSW Health manages bulk billing on behalf of recognised public hospitals under Agreement with the Department of Veterans’ Affairs.  
Thus from 1 July 1993, recognised public hospitals no longer raise accounts against DVA for the cost of accommodation of DVA patients.

9  OUTREACH SERVICES PATIENTS  
The Private Health Insurance Act 2007 abolished the Outreach default benefit payable for hospital in the home type services.

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

Accommodation Only (excluding meals)  
\[ \text{$ per night} \]
- Maximum charge where accommodation is provided in a self-contained unit (including own kitchen and bathroom facilities).  
  \[ \text{46} \]
- Maximum charge per person for accommodation other than self-contained accommodation.  
  \[ \text{23} \]

Meals  
\[ \text{$ per meal} \]
- Maximum per meal per person and no greater than rates applicable to hospital employees.  
  \[ \text{8} \]

The Chief Executive has the discretion to reduce or waive these charges based on the level / standard of accommodation provided or financial hardship.
11 PATIENTS IN MEDICAL ASSESSMENT UNITS AND OTHER SHORT STAY UNITS

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

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

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

12 PRISONERS – PROVISION OF MEDICAL SERVICES

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

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

12.1 Inpatient Services

Neither the prisoner, nor the Justice and Forensic Mental Health Network is to be charged for accommodation, diagnostic, medical, nursing or other services provided by:

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

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

12.2 Non-Inpatient Services

Neither the prisoner, nor the Justice and Forensic Mental Health Network is to be charged for non-inpatient services provided by:

- The public hospital initially attended by prisoner
- The public hospital to which referred, if services not available at the initial public hospital
- A private medical practitioner (in their rooms), for services not available at a public hospital.
In these circumstances, the original hospital that the prisoner attended is responsible for meeting any costs involved.

13 BABIES – CHARGES IN RESPECT OF NEWBORNS

13.1 Qualified Babies

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

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

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

13.2 Unqualified Babies

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

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

14 CLASSIFICATION OF VICTIMS OF CRIME PATIENTS

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

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

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

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