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<th>Meaning</th>
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<tr>
<td>ACS</td>
<td>Australian Coding Standards</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>CAEP</td>
<td>Community Aids and Equipment Program</td>
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<td>CAHS</td>
<td>Child and Adolescent Health Service</td>
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<tr>
<td>CFO</td>
<td>Chief Finance Officer</td>
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<td>CMBS</td>
<td>Commonwealth Medicare Benefits Schedule</td>
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<td>CTG</td>
<td>Cardiotocograph</td>
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<tr>
<td>Home Affairs</td>
<td>Department of Home Affairs</td>
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<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
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<td>EAF</td>
<td>Elective Admission Form</td>
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<td>EMHS</td>
<td>East Metropolitan Health Service</td>
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<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<tr>
<td>EP</td>
<td>Entitled Persons</td>
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<td>FMA</td>
<td>Financial Management Act 2006</td>
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<tr>
<td>FMM</td>
<td>Financial Management Manual</td>
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<td>FMR</td>
<td>Financial Management Regulations 2007</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<td>Hospital Morbidity Data System</td>
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<td>HSD</td>
<td>Highly Specialised Drugs</td>
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<td>HSA</td>
<td>Health Services Act 2016</td>
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<td>Health Support Services</td>
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<td>ICWA</td>
<td>Insurance Commission of Western Australia</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>IVF</td>
<td>In-Vitro Fertilisation</td>
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<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
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<td>Meaning</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td>MVA</td>
<td>Motor Vehicle Accident</td>
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<tr>
<td>MVTP</td>
<td>Motor Vehicle Third Party Insurance</td>
</tr>
<tr>
<td>NHDD</td>
<td>National Hospital Data Directory</td>
</tr>
<tr>
<td>NHRA</td>
<td>National Health Reform Agreement</td>
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<td>NHTP</td>
<td>Nursing Home Type Patient</td>
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<td>NMHS</td>
<td>North Metropolitan Health Service</td>
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<tr>
<td>OHCWA</td>
<td>Oral Health Centre of Western Australia</td>
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<td>OSHC</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PCH</td>
<td>Perth Children’s Hospital</td>
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<tr>
<td>POW</td>
<td>Ex-Prisoner of War</td>
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<tr>
<td>PPLO</td>
<td>Private Patient Liaison Officer</td>
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<tr>
<td>PRNI</td>
<td>Privately Referred Non-Inpatient</td>
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<td>RHCA</td>
<td>Reciprocal Health Care Agreement</td>
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<tr>
<td>RSS</td>
<td>Revenue Strategy and Support</td>
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<td>SHQ</td>
<td>State Headquarters</td>
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<td>SIP</td>
<td>Surgically Implanted Prostheses</td>
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<tr>
<td>SMHS</td>
<td>South Metropolitan Health Service</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>VC</td>
<td>Victoria Cross</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
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<td>WACHS</td>
<td>WA Country Health Service</td>
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Introduction

The WA Health Fees and Charges Manual sets out the rules in relation to fees and charges that Health Service Providers may apply for ‘health services’ and ‘other goods and services’.

For the purposes of this Manual:

- a **health service** is a service provided for maintaining, restoring, or managing a person’s physical and mental health and wellbeing (including goods and facilities related thereto).
- **other goods and services** are services provided that are not ‘health services’ (including goods and facilities related thereto). These services are sometimes called ‘commercial activity’.

The Manual includes much of the information that was previously in the WA Health Patient Fees and Charges Manual, with appropriate changes and additional information that reflect the new fees and charges regime applicable to Health Service Providers from 1 July 2016, as a result of the introduction of the Health Services Act 2016 (HSA).

**New Fees and Charges Regime under the Health Services Act 2016**

The HSA offers Health Service Providers greater clarity and flexibility on what services they can apply fees and charges to, than under the previous Hospitals and Health Services Act 1927.

The new fees and charges regime under the HSA is as follows:

- **Certain health services must be provided free of charge.**
  Health Service Providers are not permitted to apply fees or charges for non-chargeable health services (see s55(5) HSA); these are health services that are to be provided free of charge under the National Health Reform Agreement (NHRA), or that the Minister for Health has specified are to be provided free of charge by Ministerial Order.

- **The Minister for Health can set an upper limit on any applicable fees and charges.**
  The Minister for Health may fix the fees or charges to be applied for health services by Ministerial Order, either absolutely or by reference to a scale of fees or charges that are determined by a Commonwealth body, such as Medicare. Where the Minister for Health has fixed the fees or charges to be applied, Health Service Providers are not permitted to apply fees or charges in excess of that amount (see s55(4) HSA).

- **The Director General can set restrictions on any applicable fees and charges.**
  The Director General may issue policy frameworks, to ensure consistent approaches to the provision of services by Health Service Providers; this includes setting limits on the fees or charges to be applied for both health services and other goods and services, or specifying fixed rates to be applied in all cases. Restrictions set by the Director General will be documented in this Manual, which is mandatory under the Financial Management Policy Framework, and binding on all Health Service Providers (see s27(1) HSA).
If a fee or charge is not prohibited, or otherwise regulated by the Minister for Health or Director General, the Health Service Provider may determine the fee or charge to be applied.

To enable a decision to be made by the Minister for Health or Director General on whether a fee or charge for health services needs to be regulated, Health Service Providers must submit a request for approval to the Department of Health prior to applying any proposed new fee or charges that relates to a health service.

For fees and charges relating to ‘other goods and services’ or ‘commercial activity’ approval is not required by DoH or the Minister of Health. If a HSP would like to implement a new charge that falls into this category then it is recommended that the HSP checks with DoH to agree the suggested fee does indeed falls into this category. If it does, the HSP is not required to seek approval for the new fee or charge. Health Service Providers should note that all fees and charges determined by them are subject to annual review in accordance with Treasurer's Instruction 810.

HSPs need to maintain their own database of fees and charges not located within this manual along with costing methodology and justification of any increases.

If there are any difficulties interpreting or understanding a particular section of the manual, users may contact Revenue Strategy and Support, Department of Health, in the first instance, at: RevenueStrategyandSupportUnit@health.wa.gov.au.
Using the Fees and Charges Manual

Overall Content and Structure of the Manual

The Manual sets out the rules in relation to fees and charges that Health Service Providers may apply when providing ‘health services’ and ‘other goods and services’.

The Manual is divided into several sections, providing guidance on discrete subjects that are relevant in the context of fees and charges, particularly those applicable to patients:

- Chapter 1: Medicare Eligibility
- Chapter 2: Reciprocal Health Care Agreements
- Chapter 3: Patient Fees and Charges
- Chapter 4: Non-Chargeable Patients
- Chapter 5: Chargeable Patients
- Chapter 6: Other Fees and Charges
- Chapter 7: Charging Liability
- Chapter 8: Fees and Charges Guidelines
- Overview of Public Hospital Fees and Charges
- Amendments to Fees and Charges Manual
- Schedule A1: Fees and Charges Regulated by the Minister for Health
- Schedule A2: Fees and Charges Regulated by the Director General
- Schedule A3: Fees and Charges not fixed by the Minister for Health
- Schedule B: Summary of Patient Fees and Charges
- Schedule C: Application Form for New Fee or Charge
- Schedule D: Standing Exemptions
- Schedule E: Appendices

Distinguishing Fees, Charges and Deposits

For the purposes of this Manual, it should be noted that there is a significant difference between a fee, a charge and a deposit:

- a fee is a price set at cost recovery level; this is generally applied in the context of health services, which are not discretionary from the consumer’s perspective
- a charge is a price set above cost recovery level; this is generally applied in the context of other goods and services, which are discretionary from the consumer’s perspective
- a deposit is a sum of money collected from a person, with an expectation that the money will be returned to that person after certain conditions are met; these are not considered to be a fee or a charge within the context of this Manual.
Note: Prices should not be set at a level below cost recovery, unless otherwise approved by the State Government (see Costing and Pricing Government Services Guidelines 2015, published by Department of Treasury). Deposits, on the other hand, are almost invariably set at a level below cost recovery.

Applying a Fee or Charge for a Service

When deciding whether a fee or charge may be applied for a service, and determining at which rate the fee or charge may be applied, users should follow these steps (in sequence):

1. **Determine whether the service is a non-chargeable health service.**
   - No fees or charges are to be applied in relation to health services:
     - that are to be provided free of charge under the NHRA
     - that the Minister for Health has specified are to be provided free of charge.
   - The principles for determining Medicare eligibility, which dictate whether a health service is provided free of charge under the NHRA, are set out in Chapter 1.
   - The fees and charges regulated by the Minister for Health are set out in Schedule A1.

2. **Determine whether the fees and charges are regulated by the Minister for Health.**
   - Where the Minister for Health has fixed the fees or charges by Ministerial Order, a fee or charge cannot be applied in excess of that amount.
   - The fees and charges regulated by the Minister for Health are set out in Schedule A1.

3. **Determine whether the fees and charges are regulated by the Director General.**
   - Where the Director General has set limits on the fees or charges, or specified a fixed rate to be applied, a fee or charge cannot be applied contrary to those restrictions.
   - The fees and charges regulated by the Director General are set out in Schedule A2.

4. **Determine if a fee or charge has been approved by the Department of Health.**
   - If fees or charges are not prohibited, or otherwise regulated by the Minister for Health or Director General, the Health Service Provider may determine the fee or charge to be applied, provided that approval has been obtained from the Department of Health.
   - If approval has not been obtained, a request must be submitted to the Department of Health, in accordance with the process described further below.
   - If approval has been obtained, the fee or charge may be applied in accordance with any restrictions specified by the Accountable Authority of the Health Service Provider.

5. **Determine if a fee or charge is for a ‘health service’ or ‘other goods and services’.**
   - If fees or charges are for a ‘health service’, then an application to DoH for approval is required.
   - If the proposed fee or change is for ‘other goods and services’, then the HSP is not required to seek approval but it is recommended that they discuss the fee or charge with the Department prior to implementation.
   - If the fee or charge is determined to be for ‘other goods and services’ then the HSP is able to determine the charge themselves.
- HSPs must keep a record of all fees and charges applicable to their hospital, including all fees and charges for 'other goods and services'.

For the convenient reference of hospital admission staff, a summary of all the patient fees and charges regulated by the Minister for Health and the Director General are set out in Schedule B; this will assist them in quickly completing Steps 1 to 3 above.

Health Service Providers should develop their own summary schedule of local fees and charges that they are approved to determine on their own, to assist staff in completing Step 4 above. The summary schedule is not to contain anything inconsistent with, or contrary to, this Manual.
Requesting Approval to Determine a New Fee or Charge for a Service

Where a Health Service Provider may determine the fee or charge to be applied, approval is to be obtained from the Department of Health prior to applying the fee or charge if the fee or charge is for a health service.

To this end, an Application Form is to be submitted to Revenue Strategy and Support.

The Application Form is included as Schedule C, and requires the following information:

- a description of the services to be provided
- a statement of whether those services are health services, or other goods and services
- an explanation of the motivation for applying a fee or charge to those services
- the proposed fee or charge to be applied for those services, and a statement of whether the fee or charge has been set at cost recovery level
- an explanation of the method for determining the estimated cost of those services.

The Application Form is to be endorsed by the Health Service Provider’s Chief Finance Officer, Chief Executive Officer, Chair of Finance Sub-Committee and Chair of Health Service Board prior to submission to the Department of Health.

A response from the Department of Health will generally take one of the following forms:

- notice that the fee or charge is to be regulated by the Minister for Health
  
  Note: This is likely in situations where the application of a fee or charge has potential to adversely affect WA Health as a whole, or is considered controversial in nature.

- notice that the fee or charge is to be regulated by the Director General
  
  Note: This is likely in situations where there is a strategic advantage in standardising the fee or charge, such as minimising potential inequity between Health Service Providers.

- notice that the Health Service Provider may set the fee or charge, either subject to the conditions specified in the notice, or unconditionally.

Revenue Strategy and Support will maintain a register of fees and charges approved to be determined by Health Service Providers (either conditionally or unconditionally); this will be updated regularly, and made available online for staff to review before submitting requests to the Department of Health for approval to apply a new fee or charge.

Standing Exemptions

Where it is deemed, as a matter of policy, that all Health Service Providers should be approved to determine the fees or charges to be applied for provision of a particular service, a standing exemption will be added to this Manual, in Schedule D.

Health Service Providers are not required to submit an application for approval to apply a new fee or charge, if the service is included as a standing exemption in Schedule D. If there is any doubt as to whether a service falls within the ambit of the standing exemption, advice should be sought from Revenue Strategy and Support, in the first instance.
Annual Review Process of Fees and Charges

All fees and charges determined by the Department of Health or Health Service Providers are subject to annual review in accordance with Treasurer’s Instruction 810.

Accountable areas in the Department of Health and Health Service Providers are responsible for reviewing their fees and charges, and as part of the annual review, they are:

- to provide sufficient detail of the cost of the services provided
- to ensure their costing method is sufficiently robust to provide a reasonable estimate of the percentage level of cost recovery.

Amendments to the Fees and Charges Manual

Revenue Strategy and Support is responsible for maintaining this Manual, and is to ensure that it is a living document which is regularly updated and made available online.

A summary of all amendments to the Manual will be listed at the end of this document.

Further Information

Any requests for further information can be directed to Revenue Strategy and Support at: RevenueStrategyandSupportUnit@health.wa.gov.au.

Enquiries relating to patient billing can be directed to the relevant Health Service.
Chapter 1: Medicare Eligibility

1.1. Overview of Access to Medicare

Australia’s public health care funding system is called Medicare. It is a system that provides eligible people with access to free treatment as a public patient, as well as free or subsidised treatment on a private basis by doctors (both general practitioners and specialists), participating optometrists, and in certain circumstances dental practitioners. Eligibility for Medicare provides access to the Pharmaceutical Benefits Scheme (PBS), which covers most prescription pharmaceuticals provided by pharmacies.

Medicare eligibility is generally restricted to people living permanently in Australia who are:

- Australian citizens (whom have residence in Australia)
- Permanent Australian residents (who have permanent visas)
- New Zealand citizens or
- Certain persons with applications for permanent visas under consideration. This excludes applicants for some parent visas or applicants for protection visas who have also applied for a parent visa.

While overseas visitors and temporary residents do not have access to Medicare, there are exceptions:

- Australian citizens who go overseas retain their access to Medicare for any return visits to Australia for up to five years from when they were last residing in Australia; and
- Visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA). They have restricted access to Medicare. Foreign students studying in Australia are generally not covered by RHCA’s.

Note: Refer to Schedule E, Appendix E (Flow Chart on Medicare Eligibility), to assess patient access to Medicare.

1.2. Medicare Exemptions

Under Medicare eligibility, some categories of patients are exempt:

Prisoners

Under the Health Insurance Act 1973, prisoners are ineligible to access Medicare whilst incarcerated.

The Act precludes benefits for medical services provided under the control of a government authority, which prevents a service being funded twice from public resources. Sub-section 19(2) prohibits State governments from transferring costs to the Commonwealth. The States are responsible for ensuring prisoners have access to appropriate health care including associated treatment and pharmaceuticals.
Non-charging Arrangements to Corrective Services for Prisoners Attending Public Hospitals

An MOU is in place between the Department of Justice and Health, which provides the governance framework to allow for the health care needs of people serving custodial terms in prison.

Clause 6.6 states; “The Department of Health provides secondary and tertiary health services for offenders in WA, including inpatient and outpatient public hospital services, psychiatric services and dental services. These costs are not recouped from the Department of Justice.”

Exemptions to Charge Pathology Services and Highly Specialised Drugs Supplied to Prisoners

Ministerial arrangements allow for the charging of pathology services. PathWest charges the Department of Justice for prisoners' pathology services on a ‘fee for service’ basis.

The Commonwealth extended funding of the Highly Specialised Drugs (HSD) program to prisoners incarcerated in prisons. While such exemption allows claiming on the Pharmacy Benefit Schedule, all program rules apply. For Medicare eligibility and program rules, refer to the Chief Pharmacist at the relevant Pharmacy Unit.

Immigration Detainees

On admission to a public hospital, detainees' financial classification is to be assigned in Patient Administration Systems as ‘Overseas’ in Metropolitan Health Services and Bunbury Regional Hospital or ‘34-Detainee’ for systems which allow this classification.

In accordance with a MOU between the Department of Health (DoH) and the Commonwealth’s Department of Home Affairs ‘Immigration Detainees’ are to be charged at full cost recovery; where systems allow.

As the Department of Home Affairs is responsible for the full cost of medical treatment, the DoH will be reimbursed centrally for detainees and there are no services or items that are subject to direct billing arrangements between the hospitals and health services in WA.

Asylum Seekers

In order for asylum seekers to be eligible for public treatment, they need to complete Medicare’s paper work to be issued with a Medicare card and they need to produce this on attendance at a public hospital. Otherwise they need to be classified as ‘Overseas’.

Asylum seekers need to establish they are legally entitled to hold one of the visas listed below or provide copy of a letter from Department of Home Affairs that confirms their visa status. However, some asylum seekers are being given Bridging Visas with work rights and full Medicare coverage for emergencies.

Current visas with access to Medicare;

- Global Special Humanitarian (subclass 202)
- Protection visa (subclass 866)
- Refugee (subclass 200)
- In-Country Special Humanitarian (subclass 201)
- Emergency Rescue (subclass 203)
- Woman at Risk (subclass 204)
- Temporary Protection visa (subclass 785)
- Safe Haven Enterprise visa (subclass 790)
- Temporary (Humanitarian Concern) Visa (subclass 786)

Repealed visas;
- Secondary Movement Offshore Entry (Temporary) (subclass 447) (repealed 09/08/08)
- Secondary Movement Relocation (Temporary) (subclass 451) (repealed 09/08/08)
- Bridging Visa R (subclass 070) (Removal Pending)
- Return Pending Visa (subclass 695) (repealed 09/08/08)
- Temporary Protection Visa (subclass 785) (repealed 09/08/08)

*Note: Those visas with a repeal date are no longer granted, however, they may still be in operation.*

**Specified Persons or Class of Persons Declared as being Medicare Eligible**

Under subsection 6(1) of the Health Insurance Act 1973, the Commonwealth Minister may, by order, declare that a specified person, or specified class of persons, as being Medicare eligible:

- A person visiting Australia financed via the Australian – American Educational Foundation;
- A person released into the community on a visa from a detention facility, such as a Temporary (Humanitarian Concern) visa (Subclass 786). To enrol for Medicare, a Temporary visa holder has to attend Medicare with identity documents that validate their residence in Australia; and
- Certain visas:
  - Witness Protection (Trafficking) – Subclass 787 (no longer issued)
  - Contributory Parent (Offshore) – Subclass 173
  - Contributory Parent (Onshore) – Subclass 884
Chapter 2: Reciprocal Health Care Agreements

2.1. Overview of Reciprocal Health Care Agreements

Overseas visitors holding a valid visa and being a resident of a Reciprocal Health Care Agreement country are eligible for ‘medically necessary’ treatment. ‘Medically necessary’ treatment covers ill-health or injury that occurs while visiting Australia and requires treatment before their return home.

The general principle underpinning the access to services under RHCA’s is that visitors receive treatment within Australia’s public health system on the same terms as an Australian resident.

Note: All agreements exclude medical coverage for residents of one partner country who enters the territory of the other partner country for the specific purpose of seeking medical treatment.

RHCA’s only provide for public treatment, in a public hospital or in a publicly contracted bed in a private hospital (i.e. Joondalup Health Campus, Peel Health Campus and St John of God Midland Public Hospital). If an overseas visitor elects to be private, they are ineligible under a RHCA and will be charged as an ineligible patient.

RHCA’s, apart from those with New Zealand and Norway, provide diplomats, staff of diplomatic missions and their families with Medicare cover for their length of stay. The Agreement entitles diplomats from the Republic of Ireland, consular officers and their families to a broader range of treatment that covers private medical treatment and is not restricted to being ‘medically necessary’. Diplomatic visitors will be issued Medicare cards endorsed ‘Visitor RHCA’.

The Commonwealth Government has signed RHCA’s with the Governments of the following countries. RHCA’s are valid from the dates specified in the right hand column of the listing below:

<table>
<thead>
<tr>
<th>Country</th>
<th>Operational Date</th>
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<tbody>
<tr>
<td>Belgium</td>
<td>1 September 2009</td>
</tr>
<tr>
<td>Finland</td>
<td>1 October 1993</td>
</tr>
<tr>
<td>Italy</td>
<td>1 September 1988</td>
</tr>
<tr>
<td>Malta</td>
<td>6 July 1988</td>
</tr>
<tr>
<td>New Zealand (includes Tokelau and Niue islands)</td>
<td>1 September 1999 (amended)</td>
</tr>
<tr>
<td>Norway</td>
<td>1 March 2004</td>
</tr>
<tr>
<td>Republic of Ireland</td>
<td>25 May 1998</td>
</tr>
<tr>
<td>Slovenia</td>
<td>1 July 2011</td>
</tr>
<tr>
<td>Sweden</td>
<td>1 May 1989</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>4 January 1992</td>
</tr>
<tr>
<td>United Kingdom (includes Northern Ireland)</td>
<td>1 July 1986</td>
</tr>
</tbody>
</table>
Medicare-eligible visitors admitted as a public patient during their visit to Australia should inform hospital staff that they wish to be treated as a Medicare public patient under the relevant RHCA. Admissions staff should request evidence of their Medicare eligibility. RHCA eligibility generally depends on a person being a resident of their home country (and not resident in Australia).

In most cases, the patient will have enrolled in Medicare and will have a reciprocal Medicare card. In most other cases, a valid passport and/or European Health Insurance Card for the relevant country will be adequate evidence of eligibility.

The RHCA’s with the Netherlands, Slovenia and Belgium, however, require that a person is eligible for health insurance under the national health insurance schemes of those countries to be eligible. In these cases, a passport alone is not sufficient evidence of eligibility – the person must also have a European Health Insurance Card or other documentation establishing their eligibility for their home country’s national insurance scheme.

RHCA’s provide access to affordable medicines under the Pharmaceutical Benefits Scheme (PBS). Eligible persons are requested to produce evidence of their eligibility when presenting prescriptions at community pharmacies. Only medicines prescribed for treatment are covered.

**Difference between a Citizen and a Resident**

A citizen is usually a person who is born in a country, or granted citizenship of that country through naturalisation, and who has not renounced or lost their citizenship - this may vary in some countries depending on the custom or law of that country.

A resident refers to a person’s living status in a country of which they are not a citizen. Residency status can be separated into temporary and permanent residency.

Depending on whether a person is a citizen or resident of a country they may or may not be covered under a RHCA with Australia. To check whether a person is covered under a RHCA with Australia, please refer to the Department of Human Services.

**Differences in Medicare Access under RHCA’s**

The RHCA’s with Belgium, Finland, Italy, Malta, the Netherlands, Norway, Slovenia, Sweden and the United Kingdom provide for free treatment as a public patient in a public hospital, Medicare benefits for out-of-hospital medical treatment and subsidised medicines under the PBS.

The RHCA’s with New Zealand and the Republic of Ireland provide for free treatment as a public patient in a public hospital and subsidised medicines under the PBS, but they do not cover out-of-hospital medical treatment (i.e. visiting a general practitioner).

**Period of Cover**

A person’s period of cover starts on the day of arrival to Australia and ends depending on the country’s RHCA with Australia.
If the person is from Finland, Norway, the Republic of Ireland, Sweden or the United Kingdom, their period of cover ends on the day their visa expires,

If the person is from Belgium, the Netherlands or Slovenia their period of cover ends on the day their European Health Insurance Card expires or the day their visa expires if earlier.

Visitors from Malta and Italy are covered for 6 months from their initial date of arrival in Australia.

Visitors from New Zealand are covered up until the day they leave Australia.

For more information on RHCA and countries participating go to: https://www.humanservices.gov.au/customer/enablers/participating-rhca-countries

**Medical Services not Covered by Medicare under a Reciprocal Agreement**

Medicare will not cover:

- Medicines not subsidised under the Pharmaceutical Benefits Scheme
- Accommodation and medical treatment in a private hospital, and
- Accommodation and medical treatment as a private patient in a public hospital

Ancillary services not covered:

- Private patient hospital costs (including accommodation and theatre fees)
- Dental examinations and treatment
- Ambulance services
- Home nursing
- Allied health services not listed on the Medicare Benefits Schedule (private Medicare Services)
- Acupuncture (unless part of doctor’s consultation)
- Glasses and contact lenses
- Hearing aids and other appliances
- The cost of prostheses
- Medical costs for which someone else is responsible (e.g. compensable insurer or employer)
- Medical services which are not ‘medically necessary’
- Surgery solely for cosmetic reasons
- Examinations for life insurance, superannuation or membership of a friendly society
- Eye therapy
Reciprocal Eligibility for Child Birth

RHCA’s include medical coverage for the birth of a child. The only exclusion is where a person has come to Australia for the sole purpose of having their child delivered here. No exclusions apply if the necessary hospital treatment was required as a result of a medical emergency.

Reciprocal Eligibility for Inter-Hospital Transfer

Reciprocal Health Care Agreements provide for public hospital treatment for any ill-health or injury, which includes inter-hospital transfers within Australia. However, reciprocal agreements do not cover repatriation of a patient to their home country, which is the patient’s financial responsibility.

2.2. Specific Issues Relating to Reciprocal Health Care Agreements

Guidelines Covering Reciprocal Agreements with Australia (excluding the Republic of Ireland and New Zealand)

Eligibility:

That the person/visitor:

- Holds a current passport and valid visa covering their stay in Australia;
- Requires ‘medically necessary’ treatment, which is necessary before the visitor returns home;
- Treatment commenced after the operational date of their country’s reciprocal agreement; and
- They are treated as a public patient, which includes both inpatient and outpatient treatment.

Procedure for Enrolling in Medicare

Reciprocal visitors can enrol in Medicare by attending a Department of Human Services–Medicare office and present their passport or proof of enrolment in their country’s national health scheme (usually, a European Health Insurance Card). Once approved eligible reciprocal visitors receive an Australian reciprocal Medicare card, with the expiry date being the expiry date on their visa.

Enrolment may take place after services have been provided either to confirm eligibility for public hospital services or to obtain Medicare benefits for out-of-hospital medical treatment such as visiting a GP (excluding New Zealand and Republic of Ireland visitors) and subsidised medicines under the PBS.

Reciprocal Agreement Conditions for the Republic of Ireland and New Zealand

These RHCA’s cover ‘medically necessary’ treatment as a public patient, including both inpatient and outpatient care and subsidised prescription drugs through the PBS. These RHCA’s do not entitle visitors to Medicare benefits for out-of-hospital medical care and do not apply where a person enters Australia for the sole purpose of accessing medical treatment.
RHCA access to public hospital treatment in Australia for visitors from Ireland and New Zealand is restricted to a person who is ordinarily resident in those countries and is temporarily in Australia.

Because New Zealander and Irish visitors are not eligible for Medicare benefits for out-of-hospital services, Medicare does not enrol them or issue them with Medicare cards. A current Irish or New Zealand passport is sufficient proof of eligibility for visitors from these countries to receive public hospital treatment and PBS medicines.

*Note: The Irish RHCA excludes students, who need to enter in a special private health insurance scheme.*

**Reciprocal Health Care Agreement Conditions for Dialysis Services**

The priority of the Department of Health is to provide public Renal Dialysis services to eligible patients based on their clinical need. However, the ability of the health system to fund eligible overseas patients must not interfere with the physical, clinical and / or financial capacity of Health Services to meet the clinical priorities of Australian residents.

Currently, there are reciprocal dialysis arrangements with the United Kingdom, New Zealand and the Netherlands, which provide access to renal dialysis to eligible residents visiting either country.

However, there are no dialysis agreements with other RHCA countries. RHCA eligible visitors are entitled to use renal dialysis services free of charge as public patients. However, the number of dialysis treatments that a person receives depends on the availability of resources of the treating hospital and Health Service Providers may impose limits on the number of free treatments.

**Renal Service Limits**

The Department has imposed limits on the provision of dialysis treatment to the residents of reciprocal countries. It has been agreed to provide RHCA visitors free dialysis services for the lesser, of either a maximum period of four weeks (covering all service sites) or a maximum of 12 sessions within a 12-month period commencing from the date of first treatment.

**Capacity Guidelines**

Dialysis is limited to one patient at each service site and is subject to availability of staffing / other resources and that no eligible public patient is disadvantaged due to this decision.

**Clinical Referral Requirements**

Prior to arrival in Australia, RHCA eligible dialysis patients need to request their treating physician contacts one of the tertiary hospitals seeking formal approval to receive dialysis treatment. If the tertiary hospital has capacity to meet their specific needs, the accepting hospital then assumes clinical governance for the patient during their stay and a clinical nurse manager will then organise treatment at a privately contracted satellite dialysis unit.
**Satellite Renal Units**

Private satellite dialysis units are located throughout the metropolitan area, with contracted sites at Cannington, Joondalup, Midland, Rockingham, Stirling and Spearwood.

**Reciprocal Agreement Conditions for Magnetic Resonance Imaging (MRI)**

Under RHCA’s no treatment is excluded. However, RHCA’s are structured on the basis that an eligible visitor may access inpatient and outpatient services, as a public patient, for ‘medically necessary’ treatment. Services such as MRI should be provided only where it is ‘medically necessary’.

**Clinical Referral Requirements**

Medicare will only cover MRI services when a physician provides a letter of referral, which indicates that MRI is required as a matter of urgency.

**Eligibility of RHCA Overseas Patients Treated as a Public Patient in a Privately Managed Hospital (Joondalup Health Campus, Peel Health Campus and St John of God Midland Public Hospital)**

An overseas visitor, who is entitled to be treated as an eligible person under the National Health Reform Agreement (NHRA) by virtue of a Reciprocal Agreement is entitled to receive free care as a public patient, where treatment is ‘medically necessary’. Under the NHRA definition of a public patient, this applies irrespective of whether hospital services are owned or managed by the State.

**Reciprocal Agreements and Certain Visa Classes**

If a RHCA visitor holding a temporary visa, has applied for permanent residence and has either a spouse, parent or child who is an Australian citizen or permanent resident, or has legal authority from DIBP, they are classified as an ‘Australian resident’ for the purposes of the Health Insurance Act 1973 and are fully Medicare eligible. They do not need to rely on a RHCA for Medicare access.

**Temporary Business (Long Stay) – Standard Business Sponsorship (Subclass 457)**

Holders of this visa are not eligible for Medicare unless they are residents of a country with which Australia has a RHCA. They are then eligible under the terms of the relevant agreement. It is a condition of the 457 visa that holders maintain adequate health insurance for this purpose.

**Retirement Visa (Subclass 410 – Temporary or Subclass 405 - Temporary)**

If a visitor applied for their Retirement (Subclass 410) visa prior to 1 December 1998, they may choose to enrol in the Medicare program under the RHCA of their home country.

However, if they applied for their 410 visa, on or after 1 December 1998, they are not eligible for enrolment in the Medicare program and are not eligible under the RHCA. Holders of the
Retirement Investor (Subclass 405) visa, which replaced the 410 visa in 2005, are also not eligible for Medicare. Retirement visa holders (if applied after 1 December 1998) can only be admitted to a public hospital as Medicare ineligible and are liable to meet 100% of the gazetted hospital fees.

**Note:** Refer to [Schedule E, Appendix F](#) (Medicare Eligibility Matrix for Commonwealth Visas) in the WA Fees Manual, to assess patient eligibility to Medicare for visa sub classes issued by the Commonwealth.

### Medicare Eligibility of Foreign Organ Donors limited to Kidney and Stem Cell Transplants

Where an Australian resident requires a foreign donor who is clinically compatible, the foreign donor is Medicare eligible only if it is a kidney or stem cell transplant. All medical costs associated with the transplant, incurred by both the donor and recipient can then be attributed to the Australian resident free of charge.

### Medicare Eligibility of Diplomats

A small number of members of the Diplomatic and Consular Corps (those belonging to missions or posts of New Zealand, the United Kingdom, the Netherlands, Sweden, Italy, Malta, the Republic of Ireland, Belgium, Norway and Slovenia) have access to Medicare, Australia's national health system. This arises from reciprocal health care arrangements between Australia and these countries. Further information on these arrangements is available from the Department of Human Services or Department of Foreign Affairs and Trade.

All other diplomatic and consular representatives are liable to pay the full rate for medical treatment received in Australia, including ambulance transport charges.

### Medicare Eligibility to Highly Specialised Drugs Program (HSD)

A RHCA visitor attending a participating public hospital as an admitted patient on discharge, same day patient or outpatient is eligible to receive highly specialised drugs at the PBS co-payment rate. The supply of HSD is limited to the original prescription and no repeat prescriptions are permitted.

In order to be eligible, public hospitals need to request proof of a valid Medicare card with ‘Reciprocal Health Care' (Irish and NZ visitors are eligible for PBS on presentation of their passport) or an ‘Interim Card’ for those who have applied for permanent residence. The supply of HSD must be ‘medically necessary’ and it cannot be for pre-existing conditions or pre-arranged treatment.

Most residents of RHCA countries will be limited to the supply of HSD in Australia by the length of their applicable visa. While for residents of NZ, they are able to apply for permanent residency in Australia without leaving the country and this enables them to seek continuity of HSD treatment. However, they must maintain their Australian residency status, which excludes living in a non-reciprocal country (e.g. Indonesia) and travelling to Australia for the specific purpose of seeking medical treatment.

**Note:** the limitation of the supply of highly specialised drugs to the original prescription does not stop reciprocal patients from attending another public clinician for a further original prescription.
2.3. **Overseas Student Health Cover (OSHC)**

Visitors to Australia on Student visas from the following countries are covered by the reciprocal health care agreements: New Zealand, United Kingdom, the Netherlands, Belgium, Sweden and Italy.

All foreign students studying in Australia, with the exception of students from New Zealand, Belgium, Sweden and Norway, are required to take out Overseas Student Health Cover (OSHC). Students should buy OSHC before they come to Australia to cover them from when they arrive. Students must maintain OSHC throughout their stay in Australia as part of their visa requirements.

OSHC assists students with the payment of medical and hospital expenses while studying in Australia and will contribute towards the cost of most prescription pharmaceuticals and emergency ambulance transport.

Swedish Students are not required to purchase OSHC as they have their own insurance, which is provided through the Swedish Government. However, Swedish students may choose not to purchase these products and instead, take out an OSHC policy in Australia.

Swedish students who are covered by CSN and Kammarkollegiet can demonstrate their health insurance status by showing their issued health policy card.

All Norwegian students are provided with adequate health insurance by the Norwegian government and are waived the compulsory OSHC visa requirement.

Belgian students are explicitly included by the Belgian reciprocal agreement and are not required to purchase OSHC.

New Zealand students are not issued with visas and so are not required to purchase OSHC.

Students who are covered by OSHC are issued with a certificate of purchase and a health membership card, which details whether they have current OSHC cover. Where a student does not have a card or the card has expired, eligibility should be confirmed with the relevant health fund.

2.4. **Provision of Treatment to Medicare Ineligible Patients**

Western Australian public hospitals are frequently requested to provide medical care for Medicare Ineligible patients including:

- Overseas travellers
- International students
- Non-permanent residents of Australia including holders of business, retirement and family visas
- Medical tourists who deliberately enter Australia to access treatment
- Emergency care and urgent treatment should be provided, irrespective of Medicare eligibility as a duty of care
- Medicare eligibility must be determined at the time of accepting a patient for care or at the point of admission
2.5. Treatment of Patients with Notifiable Infectious Diseases

- All fees and charges associated with notifiable infectious disease management are to be waived by the Health Service Provider managing the care of the patient. This applies to all patients regardless of Medicare eligibility status.
- The Public Health Act 2016 provides for the treatment of patients with notifiable infectious diseases. This includes the provision of free treatment to care for overseas patients admitted to public hospitals with tuberculosis or leprosy. Similarly, hospitals should provide free assessment, pathology services and treatment for all notifiable sexually transmitted infections including syphilis, gonorrhoea, chlamydia, HIV and hepatitis B.
- A proportion of these patients will be long-term residents in WA and must hold current private health insurance as a condition of visa approval. Hospitals must ensure that such patients are aware of the need for compliance with prescribed therapies and have systems in place to recoup treatment costs for privately insured patients. The patient’s treating physician is best placed to advise whether costs are likely to be recouped through insurance or if they should be written-off.
- If the anticipated cost of treatment exceeds $10,000 per annum, once agreement has been obtained from relevant clinical departments and approval granted by the hospital Executive Director and Health Service Chief Executive, final authorisation must be sought from the Director General.

In the event that a Health Service refuses subsidised HIV or hepatitis B treatment, the Health Service must provide an appeal process that recognizes compassionate or public health considerations.

2.6. Medicare Ineligible Involuntary Psychiatric Inpatients

- All fees and charges in relation to Medicare ineligible patients subject to an Inpatient Treatment Order (ITO) are to be waived by the Health Service Provider from the time an ITO is sanctioned.
Chapter 3: Patient Fees and Charges

3.1. Chargeable Patient Categories
   a. Category 1 – Compensable Patients
      - Motor Vehicle
      - Eastern States Motor Vehicle
      - Workers compensation
      - Shipping
      - Australian Defence Force
      - Department of Veterans Affairs
      - Compensable Other
   b. Category 2 – Other Chargeable Patients
      - Medicare Ineligible Overseas Patient
      - Overseas Student
      - Private
      - Foreign Defence Force

3.2. Non-Chargeable Patient Categories
   - Public
   - Unaccompanied / unknown

3.3. Procedure for Admitted Patients

In accordance with clause G24 of the Schedule G – Business Rules for the National Health Reform Agreement, national standards for public hospital patient admissions have been developed. Refer to Schedule E, Appendix A (National Patient Election Standards for Public Hospital Admitted Patients).

These standards cover the necessary information that should be provided to patients on the patient election form to assist patients in understanding the consequences of choosing to be treated as a public inpatient or private inpatient.

Health Service Providers should ensure that all patients who are admitted sign a patient election form regardless of their election status.

All WA hospitals should apply a standardised patient election admission form for all patients admitted.
Chapter 4: Non-Chargeable Patients

4.1. Public Inpatients (Medicare Eligible Australian Residents)

**Definition of Public Inpatient**

A public inpatient:

(i) is an eligible person (not being a compensable inpatient, nursing home type patient or private nursing home type private patient, or an inpatient who elects to be treated as a private inpatient); and

(ii) who elects to be treated as a public inpatient; and

(iii) in respect of whom the hospital concerned provides, in a hospital bed, accommodation, maintenance, nursing care and appropriate professional services and such other necessary services as are available.

**Reference:** Part 3 Section 12 (2) (a) Health Services (Fees and Charges) Order 2016

**Public Patient Election**

At the time of admission to a hospital, or as soon as practicable after admission, an eligible person (not being a compensable inpatient or a veteran) must elect whether they wish to be classified as:

(a) a public inpatient; or

(b) a private inpatient.

**Reference:** Part 3 Section 12 (4) Health Services (Fees and Charges) Order 2016

**Treatment Free of Charge**

An eligible person, who on admission to a hospital, or as soon as possible thereafter, elects to be treated as a public patient, is entitled to receive treatment free of charge including allied health, diagnostic, medical and nursing services. Accommodation charges may only be levied on public admitted patients if they are classified as a long stay Nursing Home Type Patient (NHTP).

**Hospital Nominated Doctor**

A public patient admitted as overnight stay or same day cannot choose a specific doctor. All medical treatment will be provided by a hospital nominated medical practitioner.
## Public Inpatient Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Admission</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients</td>
</tr>
<tr>
<td>Same Day</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients</td>
</tr>
<tr>
<td>Medical Services</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients</td>
</tr>
<tr>
<td>Surgically Implanted Prostheses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Section 6.8</td>
</tr>
<tr>
<td>Radiology – for each item of service</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients</td>
</tr>
<tr>
<td>Pathology – for each request</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients however, PathWest charge hospitals on ‘fee for service’ basis at 90% of the MBS</td>
</tr>
<tr>
<td>Specialised Orthoses</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients</td>
</tr>
</tbody>
</table>

### Drugs and medication:
- All drugs and medication as an inpatient $0.00 (No hosp. fee)
- Non-participating hospitals to PBS Reform – upon discharge drugs for up to 5 days $0.00 (No hosp. fee)
- Participating hospitals to PBS Reform – upon discharge drugs up to 30 days $6.50
- Benefit entitlement card holders:  
  - PBS items  
  - Non-PBS items  
    - Up to a max. of $40.30 $32.20
- Notifiable sexually transmitted disease management $0.00 (No hosp. fee)

Clause G1 of the NHRA – where an eligible person receives public hospital services as a public patient no charges will be raised
Clause G5 of the NHRA – States which have signed to Pharmaceutical Reform may charge the PBS for drugs supplied upon discharge

Refer to Section 2.5
4.2. Public Non-Admitted Patients (Medicare Eligible Australian Residents)

**Definition of Public Non-Admitted Patient**

An eligible person, who elects to be treated as a public outpatient, who attends at a hospital and receives treatment under an outpatient service provided by the hospital, or in respect of whom a hospital provides a service elsewhere than at the hospital.

**Reference:** Part 3 Section 14(c) Health Services (Fees and Charges) Order 2016

**NHRA Principles on Public Non-Admitted Patient Services**

Section G19 states:

An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

(a) There is a third party arrangement with the hospital or the State to pay for such services; or

(b) The patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

Where an eligible person receives public hospital services as a public patient no charges will be raised, except for the following services provided to non-admitted patients and, in relation to (f) only, to admitted patients upon separation:

(a) Dental services;

(b) Spectacles and hearing aids;

(c) Surgical supplies;

(d) Prostheses – however, this does not include the following classes of prostheses, which must be included free of charge:
   (i) Artificial limbs; and
   (ii) Prostheses, which either are surgically implanted, permanently or temporarily or are directly related to a clinically necessary surgical procedure;

(e) External breast prostheses funded by the National External Breast Prostheses Reimbursement Program;

(f) Pharmaceuticals at a level consistent with the PBS statutory co-payments;

(g) Aids, appliances and home modifications; and

(h) Other services as agreed between the Commonwealth and Western Australia.

**Reference:** Clauses G1 and G19 of the National Health Reform Agreement.
## Public Non-Admitted Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services (other than pathology and radiology) – for each individual occasion of service</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charges apply to public patients</td>
</tr>
<tr>
<td>Radiology Services – for each item of service</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charges apply to public patients</td>
</tr>
<tr>
<td>Pathology Services – for each request</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charge to public patients. PathWest charge hospitals on a ‘fee for service’ basis at 90% MBS</td>
</tr>
<tr>
<td>Home Modifications service and supply or loan</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer Section 6.10</td>
</tr>
<tr>
<td>- All occasions except Surgically Implanted Prostheses and Specialised Orthoses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Admitted service. Refer to Div. 5 Health Services (Fees and Charges) 2016</td>
</tr>
<tr>
<td>- Surgically Implanted Prostheses</td>
<td>Not applicable</td>
<td>Various</td>
</tr>
<tr>
<td>- Specialised Orthoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health and Nursing Treatment – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)</td>
<td>$0.00 (No hosp. fee)</td>
<td>No charges apply to public patients</td>
</tr>
<tr>
<td>Drugs and medication:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Benefit entitlement card holders:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- With a safety net entitlement card</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Section 6.1</td>
</tr>
<tr>
<td>- Without a safety net concession card</td>
<td>$6.50</td>
<td></td>
</tr>
<tr>
<td>- For all other public non-admitted patients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- At participating hospitals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PBS items</td>
<td>Up to a max. $40.300</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>- At non-participating hospitals:</td>
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</tr>
<tr>
<td>Notifiable sexually transmitted disease management</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Section 2.5</td>
</tr>
</tbody>
</table>
4.3. Guidelines to Changing a Patient Election Status Post-Admission

A change in patient election status after admission can only be changed from private to public in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:

- Patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
- Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
- Patients whose social circumstances change whilst in hospital (e.g. loss of job)

It is acceptable for a patient to change from public to private at any point during their admission if they have Private Health Insurance and wish to utilise it as it is the patient’s right to be admitted as either a private or public patient.

In situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission. **Reference:** Clause G24 (g-h) of Appendix C of the National Health Reform Agreement.

**Note:** Refer to **Schedule E, Appendix A** (National Patient Election Standards for Public Hospital Admitted Patients)
Chapter 5: Chargeable Patients

Chargeable patients have been split into two categories; compensable patients and other chargeable patients.

Category 1 – Compensable Patients

Overview

On admission, the classification of a patient as a compensable patient is established either by the patient knowing they are eligible, or they are likely to receive compensation, or that an officer within the hospital believes that a ‘prima-facie’ case for compensation is likely to exist.

Legal advice states unequivocally that a compensable patient does not have an election choice at admission to be a public or private patient and they must be admitted as a compensable patient.

It is the responsibility of compensable insurers such as the Department of Defence, the Insurance Commission of Western Australia (covering motor vehicle third party insurance) and Work Cover (covering workers compensation) to determine the liability of a compensable patient.

The only legitimate circumstances where a formally admitted compensable patient can exercise their election choice to be (re)-classified as a public or private patient, is when a compensable insurer determines that the patient does not meet the insurers’ liability criteria and they indicate this formally to either the patient or the hospital.

Hospital employees are not to be coerced into changing the classification of a compensable patient at admission to a public patient, by either the patient or any other third party.

5.1. Motor Vehicle Third Party Insurance Inpatient Fees

Overview

Direct charges are to be raised by hospitals for Motor Vehicle Third Party Insurance patients whose hospitalisation costs are the responsibility of the Insurance Commission of Western Australia (ICWA).

A Motor Vehicle Accident (MVA) patient must be classified as a compensable patient. ICWA is the sole compulsory third party personal injury insurer for Western Australia. If a WA registered vehicle is involved in a MVA and the primary reason for the hospital stay is MVA related, the classification of compensable has been established. If a MVA patient has received an allowance for future medical expenses in the settlement of their claim, then they are likewise admitted as a compensable patient.

Note: Under the provisions of the NHRA and the Health Services (Fees and Charges) Order 2016 a compensable patient is not able to elect to be a public or private patient.
Methodology for Calculation of Motor Vehicle Accident (MVA) Rates

There is a long-standing arrangement between the Insurance Commission of WA (ICWA) and the Department of Health that involves ICWA accepting upfront liability for medical expenses associated with legitimate Motor Vehicle Accident (MVA) patients. To compensate ICWA for those MVA’s which they are proven not to be liable for, they receive an upfront discount of 30% on inpatient fees.

Consequently, MVA inpatients are charged at 70% of the compensable inpatient and same day fees, plus an additional loading factor of 7.2% to compensate for non-admitted medical expenses, which in total results in MVA patients being charged at 77.2% of the compensable inpatient rate.

Accordingly, charges are not to be raised for MVA non-admitted fees, as ICWA has effectively pre-paid an outpatient loading on inpatients and by default are not liable for non-admitted fees.

Payment Arrangements with ICWA for Emergency Medical Treatment

This arrangement covers persons injured in MVA’s involving Western Australian (WA) registered vehicles and/or WA unregistered vehicles on public roads.

ICWA is notified of emergency type patient circumstances through the data that is provided to them by the Department of Health on a monthly basis. Accordingly, separate invoices are not to be raised as these circumstances are already factored into the methodology for the calculation of MVA rates.

Vehicles not covered, are those used on private property and not requiring registration. Examples of vehicles not covered are unregistered farm utility used solely for ‘on farm’ use and dune buggy/trail bike used for off-road recreational purpose. It also excludes non-WA, or Commonwealth registered vehicles that are the only vehicles involved.

In addition to the above changes in MVA liability coverage, ICWA has payment arrangements for Emergency Transport costs for MVA patients. These Emergency Transport service providers include St John Ambulance and the Royal Flying Doctor Service. This service extends for 48 hours from:

- The scene of the crash to the nearest nursing post/hospital; and
- Nursing post/hospital to the airport, or to a major hospital.

MVA claims in relation to emergency treatment costs should be submitted to: ICWA Business Support Co-ordinator (Motor Vehicle Personal Injury Division, GPO Box L920, Perth WA 6842).

The Insurance Commission of Western Australia (ICWA) will meet the costs of Emergency necessary medical treatment* for patients treated in an Emergency Department (ED) and/or admitted into an Intensive Care Unit (ICU), as a result of personal injury arising from a motor vehicle accident (MVA) involving a Western Australian (WA) registered vehicle irrespective of liability considerations. This does not apply to services provided within Emergency Department.

The Insurance Commission of Western Australia (ICWA) will meet the costs of Emergency necessary medical treatment* for patients as a result of personal injury arising from a motor vehicle accident (MVA) involving a Western Australian (WA) registered vehicle irrespective of liability considerations. This does not apply to services provided within Emergency Department.
*For the purpose of this policy ICWA considers that emergency treatment is required when an undue delay in the treatment of the patient would lead to a significant increase in a threat to life or body part. This would exclude treatment that may be beneficial to the patient, but is not immediately required.

Refer to Section E, Appendix G (Emergency Treatment Payment Matrix) for details on the new arrangements.

**Payment Arrangements with ICWA for Non-Emergency Medical Treatment**

MVA patients who do not require emergency treatment will be subject to ICWA’s normal liability considerations.

In summary, there are only five categories of motor vehicle accident that will be declined. They are accidents that involve:

1. Driver of a single vehicle accident.
2. A vehicle registered outside WA, and no Western Australian registered vehicle involved in the accident.
3. A vehicle owned by the Commonwealth Government and no WA registered vehicle involved in the accident.
4. Driver of a stolen vehicle.
5. Vehicle not required to be insured (not for use on a road e.g. farm vehicle, off road vehicle).

Under points 1 and 4 above, claims for parties, other than the driver, will be accepted.

The following two examples illustrate ICWA’s differential payment arrangements based on patient criticality.

**Example 1:** Lone Motorcycle Rider admitted into a Public Hospital:

A WA registered motorcyclist swerves to miss a kangaroo and is critically injured. The patient is transported to hospital and remains in ICU for two days. All treatment and accommodation costs are paid by ICWA. However, once transferred to general ward, the ongoing medical and accommodation costs are no longer paid by ICWA, as no liability can be established against a WA registered vehicle.

**Example 2:** Two-vehicle MVA where both drivers are admitted to a Public Hospital:

A two-vehicle collision occurs where driver one runs into the rear of driver two. Driver one is critically injured and both drivers transported to hospital. Driver one is admitted to ICU with all treatment and accommodation costs paid by ICWA. When driver one is transferred to a general ward, all ongoing ‘medical treatment’ costs are no longer paid by ICWA, as driver one is deemed negligent. However, driver one still has accommodation costs, prostheses and orthoses paid by ICWA. Whereas driver two will have all treatment and accommodation costs paid by ICWA.

**Example 3:** Two-vehicle MVA where one driver is admitted to a Public Hospital with a non-crash related condition:
Patient arrives by ambulance as a result of a motor vehicle accident (MVA) and is admitted. The initial diagnosis / investigation shows patient suffered a stroke and there are no crash related injuries. ICWA will cover the initial day accommodation fee in good faith. However, all subsequent days will not be paid by ICWA. Where a ‘third party’ insurer rejects liability the patient may elect an alternate election.

**Note:** where there are serious MVA related injuries in conjunction with an underlying condition, the accommodation will be paid by ICWA while the MVA injuries remain the primary reason for the stay. ICWA’s consideration of costs will be given to the treatment of MVA injuries only. Once MVA injuries are stabilised and the reason for the patient remaining in hospital is due to their underlying condition, no further accommodation costs will be paid by ICWA.

### 5.2. Accidents involving Other State Motor Vehicles / Overseas Visitors

**Other States and Territories Motor Vehicles**

In the event of a MVA involving only vehicles registered in other States, then the relevant interstate third party insurance authority should be charged the applicable compensable patient rate. Otherwise, in the event of a MVA involving vehicles registered interstate and in Western Australia, then ICWA should be billed the applicable Motor Vehicle Third Party Insurance patient rate.

**Overseas Visitors**

ICWA will cover MVA medical costs for overseas visitors who are Medicare ineligible, due to third party motor vehicle insurance being based on vehicle licensing, not the driver’s Medicare eligibility.

**Motor Vehicle Third Party Insurance Inpatient Fees**

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Admission</td>
<td>$2,087.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Overnight Admission – Catastrophic Injuries Support Scheme</td>
<td>$2,899.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Overnight Admission at Perth Children’s Hospital</td>
<td>$2,899.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Overnight Admission at Perth Children’s Hospital – Catastrophic Injuries Support Scheme</td>
<td>$2,899.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Same Day</td>
<td>$2,325.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Same Day at Perth Children’s Hospital</td>
<td>$3,229.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Details</td>
<td>Fee per Day or per Service</td>
<td>Most recent amendment and notes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical Services</td>
<td>$0.00 (No hosp. fee); However, medical practitioners charge at 100% of the applicable item in the Australian Medical Association (AMA) List of Medical Services and Fees</td>
<td>Fee may be raised by: • A salaried medical officer exercising a right to private practice; • Private medical practitioners direct; or • A hospital on behalf of medical practitioners</td>
</tr>
<tr>
<td>Ventilator Dependant (with tracheotomy requiring 24 hours individual care)</td>
<td>$6,540.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Surgically Implanted Prostheses</td>
<td>100% of relevant benefit amount for each listed item in Commonwealth Prostheses List.</td>
<td>Refer to Section 6.8</td>
</tr>
<tr>
<td>Radiology – for each item of service</td>
<td>Radiology services are charged at 100% of the applicable item in the Australian Medical Association (AMA) List of Medical Services and Fees.</td>
<td>Patient charged directly by radiologist, or by hospital on the radiologist's behalf</td>
</tr>
<tr>
<td>Pathology – for each request</td>
<td>Pathology services are charged against the Commonwealth MBS.</td>
<td>PathWest raise charges to ICWA on a ‘fee for service’ basis at the Commonwealth MBS</td>
</tr>
<tr>
<td>Specialised Orthoses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Div. 5 Health Services (Fees and Charges) Order 2016</td>
</tr>
<tr>
<td>Details</td>
<td>Fee per Day or per Service</td>
<td>Most recent amendment and notes</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Drugs and medication:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- All drugs and medication as an inpatient</td>
<td>$0.00 (No hosp. fee)</td>
<td>The current Memorandum of Understanding (MOU) with ICWA that details the charging arrangements</td>
</tr>
<tr>
<td>- Non-participating hospitals to PBS Reform - upon</td>
<td>$0.00 (No hosp. fee)</td>
<td>for MVA’s prohibits the charging of all non-admitted services.</td>
</tr>
<tr>
<td>discharge drugs for up to 5 days</td>
<td>$0.00 (No hosp. fee)</td>
<td></td>
</tr>
<tr>
<td>- Participating hospitals to PBS Reform – upon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>discharge drugs up to 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PBS items</td>
<td>$0.00 (No hosp. fee)</td>
<td></td>
</tr>
<tr>
<td>- Non-PBS items</td>
<td>$0.00 (No hosp. fee)</td>
<td></td>
</tr>
<tr>
<td><strong>Notifiable sexually transmitted disease</strong></td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Section 2.5</td>
</tr>
<tr>
<td>management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.3. Motor Vehicle Third Party Insurance Non-Admitted Patients

Overview

There is a long-standing arrangement between the Insurance Commission of WA (ICWA) and the Department of Health that involves ICWA accepting upfront liability for medical expenses associated with legitimate Motor Vehicle Accident (MVA) patients. To compensate ICWA for MVA’s which they are proven not to be liable for, they receive an upfront discount of 30% on inpatient fees.

Consequently, MVA inpatients are charged at 70% of the compensable inpatient and same day fees, plus an additional loading factor of 7.2% to compensate for non-admitted medical expenses, which in total results in MVA patients being charged at 77.2% of the compensable inpatient fees.

Accordingly, charges are not to be raised for MVA non-admitted fees, as ICWA has effectively already paid an outpatient loading on inpatients and by default are not liable for non-admitted fees. This includes patients eligible for the Catastrophic Injury Support Scheme (CISS).

Motor Vehicle Third Party Insurance Non-Admitted Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services (other than pathology and radiology) – for each individual occasion of service</td>
<td>If a motor vehicle is licensed in WA and there exists a Motor Vehicle Third Party Insurance episode – no charges are to be raised against non-admitted patients.</td>
<td>The current MOU with ICWA that details the charging arrangements for MVA’s prohibits the charging of all non-admitted services.</td>
</tr>
<tr>
<td>Radiology Services – for each item of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology Services – for each request</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allied Health and Nursing Treatment</strong> – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs and medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details</td>
<td>Fee per Day or per Service</td>
<td>Most recent amendment and notes</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Home Modifications service and supply or loan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer Section 6.10</td>
</tr>
<tr>
<td>- Surgically Implanted Prostheses</td>
<td>Not applicable</td>
<td>Admitted service.</td>
</tr>
<tr>
<td>- Specialised Orthoses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Div. 5 Health Services (Fees and Charges) Order 2016</td>
</tr>
</tbody>
</table>

5.4. Eligible War Service Veteran Inpatients

Overview

The Repatriation Commission, the Military Rehabilitation and Compensation Commission, the Commonwealth of Australia [through the Department of Veterans’ Affairs (DVA)] and the State of Western Australia (WA) have entered into an arrangement for the treatment and care in WA Public Hospitals of persons eligible for treatment under:

- Part V and s. 203 of the Veterans’ Entitlements Act 1986 or;
- s. 285 and s. 286 of the Military Rehabilitation and Compensation Act 2004 or;
- s. 16 of the Safety Rehabilitation and Compensation Act 1988 or
- s. 7 of the Australian Participants in British Nuclear Tests (Treatment) Act 2006 for the period 1 July 2014 to 30 June 2019.

Eligible war service veterans are collectively referred to as Entitled Persons (EP).

Note: Relevant details of the WA-DVA Hospital Services Arrangement are accessible at: http://www.health.wa.gov.au/dva_management/home/

EP who choose to use WA Public Hospital Services and be treated under the Arrangement are considered Repatriation private patients and are entitled to:

- Choice of public hospital; with a minimum shared ward accommodation; and
- Choice of doctor provided the doctor has admitting rights to the hospital.

EP have either a Gold or White treatment entitlement card indicating their eligibility status.

Identification of DVA Entitled Persons

All patients must be asked whether they have DVA treatment entitlements for the episode of care or attendance.

Identification of EP requires collection and electronic recording (in the relevant data collection systems) of three mandatory data items, on admission or in the case of non-admitted patients at attendance:

- Financial election - the value for EP should be ‘DVA’ or ‘VA’ or its equivalent
- DVA card or file number; and
- DVA card colour- Gold or White

**Gold Cardholders**

‘DVA Health Card – For All Conditions within Australia’ have full entitlement to treatment – subject to DVA approval. DVA should be contacted for prior approval for surgical / medical procedures not listed on the Medicare Benefits Schedule (MBS), non-listed prostheses items, in-vitro fertilisation (IVF) procedures, cosmetic surgery, or any other exceptional cases / treatments. DVA should be contacted on 1300 550 457 (metropolitan callers) or 1800 550 457 (non-metropolitan callers).

**White Cardholders**

‘DVA Health Card – For Specific Conditions’ are only eligible for treatment for specific injuries or diseases for which DVA accepts financial responsibility. Hospitals should confirm treatment eligibility using the guidelines above.

**Exclusions**

In cases where a patient with DVA status presents for admission with a condition covered by workers’ compensation, motor vehicle accident (Motor Vehicle Third Party Insurance), or other compensable claim, the patient must be classified as compensable and charged at the compensable rate. The DVA Gold or White card treatment entitlements do not apply under these circumstances.

The Department of Veterans’ Affairs will not accept financial responsibility for treatment, which is covered by compensation or damages claims.

**Nursing Home Type Patient (NHTP) Contribution for ex-Prisoner of War (POW) patients and Victoria Cross (VC) Recipients.**

Hospitals will not be able to raise accounts to DVA for the hospital accommodation fee, except for a patient contribution charge for NHTP. Entitled Persons who are admitted as, or re-classified to NHTP would be charged a patient contribution in line with the provisions of the Health Insurance Act 1973. If the patient is an ex-POW or a VC recipient, the DVA should be invoiced for the patient contribution. The POW status is usually printed on the Gold Card, however if there is some doubt, contact DVA on 1300 550 457 (metro) or 1800 550 457 (country) to confirm. NHTP contributions for non-ex-POWs or non-VC recipients should be billed directly to the patient and they cannot recover costs from the DVA.

**Services Subject to Direct Billing Arrangements**

There are services and items that are subject to direct billing arrangements between the hospitals and the DVA. These are detailed in:

- Section 8.4 (Arrangements for the Provision and Charging of Aids or Equipment, Home Assessment and Home Modification for the Department of Veterans’ Affairs Entitled Persons)
- **Section 8.5** (Inter-Hospital Transport Arrangements for DVA Entitled Persons)
- **Section 8.7** (Loan Equipment – Arrangements for the Provision and Charging for the Department of Veterans’ Affairs (DVA) entitled Persons)
- **Section 8.8** (Billing Arrangements for Selected Services Provided to DVA Entitled Persons)

It is essential that hospitals follow the procedures in place for the identification of all EP as detailed above or as amended from time to time.

Enquiries to the DVA Management Unit, 189 Royal St East Perth on telephone (08) 9222 2184.
## Eligible War Service Veteran Inpatient Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Admission</td>
<td>No charge to Eligible Patient</td>
<td>Centrally managed in DoH by DVA Management Unit</td>
</tr>
<tr>
<td>Same Day</td>
<td>No charge to Eligible Patient</td>
<td>Centrally managed in DoH by DVA Management Unit</td>
</tr>
<tr>
<td>Medical Services</td>
<td>Various</td>
<td>Refer to the Local Medical Officer Fee Schedule: <a href="http://www.dva.gov.au/providers/fee-schedules">http://www.dva.gov.au/providers /fee-schedules</a></td>
</tr>
<tr>
<td>Surgically Implanted Prostheses (SIP)</td>
<td>No charge to Eligible Patient</td>
<td>Centrally managed in DoH by DVA Management Unit</td>
</tr>
<tr>
<td>Radiology – for each item of service</td>
<td>No charge to Eligible Patient</td>
<td>Refer to the Local Medical Officer Fee Schedule: <a href="http://www.dva.gov.au/providers/fee-schedules">http://www.dva.gov.au/providers /fee-schedules</a></td>
</tr>
<tr>
<td>Pathology – for each request</td>
<td>No charge to Eligible Patient</td>
<td>PathWest raise charges to DVA on a ‘fee for service’ basis at 100% of the MBS</td>
</tr>
<tr>
<td>Specialised Orthoses</td>
<td>No charge to Eligible Patient</td>
<td>Eligible veterans may be able to access through the Rehabilitation Appliances Program. (RAP). Further information is available at: <a href="http://www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap">http://www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap</a></td>
</tr>
</tbody>
</table>

**Note:** Charges are levied to DVA and not the patient. The Health Insurance Commission (Medicare Australia) processes DVA claims.

**Note:** Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims.

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**Note:** Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims.
### Compensable Patients

#### Details

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugs and medication:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ All drugs and medication as an inpatient</td>
<td>No charge to Eligible Patient</td>
<td>Participating hospitals may charge DVA patients a co-payment, if they have not reached their Safety Net Entitlement Threshold.</td>
</tr>
<tr>
<td>▪ Non-participating hospitals to PBS Reform – upon discharge drugs for up to 5 days</td>
<td>Various</td>
<td></td>
</tr>
<tr>
<td>▪ Participating hospitals to PBS Reform – upon discharge drugs up to 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notifiable sexually transmitted disease management</td>
<td>No charge to Eligible Patient</td>
<td>Refer to Section 2.5</td>
</tr>
</tbody>
</table>

#### 5.5. Eligible War Service Veteran Non-Admitted Patients

##### Overview

Non-admitted patient services are covered by the arrangement between the Repatriation Commission, the Military Rehabilitation and Compensation Commission and the Commonwealth of Australia [through the Department of Veterans’ Affairs (DVA)] and the State of Western Australia (WA). Hospitals can verify eligibility of veterans using the information as above.


In cases where a patient with DVA status presents for treatment with a condition covered by workers’ compensation, motor vehicle accident, or other compensable claim, the patient must be classified as compensable and charged at the compensable rate. Therefore the DVA Gold or White card treatment entitlements do not apply under these circumstances.

Hospitals should not raise an account to DVA for non-admitted patient services except for those specified in:

- **Section 8.4** (Arrangements for the Provision and Charging of Aids or Equipment, Home Assessment and Home Modification for the Department of Veterans’ Affairs (DVA) Entitled Persons).
- **Section 8.7** (Loan Equipment – Arrangements for the Provision and Charging for the Department of Veterans’ Affairs (DVA) Entitled Persons).
- **Section 8.8** (Billing Arrangements for Selected Services provided to DVA Entitled Persons).

Invoices will be processed by the relevant HSP.

Enquiries about aids and appliances can be directed to the DVA Management Unit on telephone: (08) 9222 2184.
## Eligible War Service Veteran Non-Admitted Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services (other than pathology and radiology) – for each individual occasion of service</td>
<td>No Charge to Eligible Patient</td>
<td>Centrally managed in DoH by DVA Management Unit</td>
</tr>
<tr>
<td>Radiology Services – for each item of service. <strong>Note:</strong> Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims.</td>
<td>No Charge to Eligible Patient</td>
<td>Hospitals charge DVA on a ‘fee for service’ basis at 100% of the MBS. Refer to the Local Medical Officer Fee Schedule: <a href="http://www.dva.gov.au/providers/fee-schedules">http://www.dva.gov.au/providers/fee-schedules</a></td>
</tr>
<tr>
<td>Pathology Services – for each request. <strong>Note:</strong> Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims</td>
<td>No Charge to Eligible Patient</td>
<td>PathWest charge DVA on a ‘fee for service’ basis at 100% of the MBS.</td>
</tr>
<tr>
<td>Home Modifications service and supply or loan</td>
<td>No Charge to Eligible Patient</td>
<td>Admitted service. Refer to Div. 5 Health Services (Fees and Charges) Order 2016</td>
</tr>
<tr>
<td>- All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgically Implanted Prostheses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Specialised Orthoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health and Nursing Treatment – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)</td>
<td>Various</td>
<td>Centrally managed in the DoH by DVA Management Unit</td>
</tr>
<tr>
<td>Drugs and medication:</td>
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<td></td>
</tr>
<tr>
<td>- DVA Health Card Holder:</td>
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<tr>
<td></td>
<td>- not at Safety Net Threshold</td>
<td>Veterans Pharmaceutical Reimbursement Scheme Refer to Section 6.1</td>
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<tr>
<td></td>
<td>- at Safety Net Threshold</td>
<td></td>
</tr>
<tr>
<td>Notifiable sexually transmitted disease management</td>
<td>No Charge to Eligible Patient</td>
<td>Refer to Section 2.5</td>
</tr>
</tbody>
</table>
5.6. Nursing Home Type Patients

Definition of a Nursing Home Type Patient

A Nursing Home Type Patient (NHTP), in relation to a hospital, means a patient in the hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days (Health Insurance Act 1973 and Private Health Insurance Act 2007).

Under the terms of the NHRA any patient who has been in hospital for more than 35 continuous days and no longer requires acute care, may be deemed a Nursing Home Type Patient. The designation of care type (acute, rehabilitative, palliative, maintenance care) is the responsibility of the clinician responsible for care.

Qualifying Period

The 35-day qualifying period may accrue in a single hospital or two or more hospitals, but not in nursing homes. Hospitals in which the qualifying period is accrued may be public or private. Transferring between hospitals has no effect on the qualifying period.

The qualifying period is broken only if the patient leaves a hospital, and does not enter another hospital for at least seven days. In this case, the patient will commence a new 35-day qualifying period from day one of the next admission to a hospital. Periods of 7 days or less do not break the continuity of the qualifying admission.

Note: Patients who meet the qualifying period and remain in hospital for ongoing acute care will require acute care certification.

Long Stay Patients

Patients who remain in hospital for more than 35 days, in order to receive ongoing acute or other specified care (e.g. sub-acute care: rehabilitative and palliative), remain classified as ‘other admitted patients’ (not Nursing Home Type Patients). They are not deemed Nursing Home Type Patients until such time as the clinician authorises a change in care type to maintenance (non-acute) care.

Nursing Home Type Patients can be re-classified to acute/sub-acute care if there is a revision of the doctor’s opinion regarding the acuity of care required, such as may occur where the patient develops a secondary condition requiring medical attention.

It is expected that Nursing Home Type Patients will not actually remain in hospital but will be transferred to a nursing home, or allocated a nursing home type bed for their ongoing care.

Legislative Basis to Raise Charges for Nursing Home Type Patients

Under sub-section 6(2) of the Health Insurance Act 1973, Nursing Home Type Patients are declared as not being eligible persons. The effect of this declaration and provisions in the NHRA is that public hospitals are permitted to raise charges for Nursing Home Type Patients. Where a State provides services to NHTP in public hospitals, it is permitted to charge these patients fees in accordance with those determined by the Commonwealth Minister for Senior Australians and Aged Care. In this scenario, fees may be charged after the 35th day of continuous admission.
Current Fees Applicable to Nursing Home Type Patients in Public Hospitals

Under the definition of a ‘patient contribution’ in sub-section 3(1) of the Health Insurance Act 1973, the Commonwealth Minister for Health and Ageing may determine the maximum daily rate charged to Nursing Home Type Patients by a public hospital. In practice, NHTP rates are linked to the combined rate of the basic pension and rent assistance and are determined in consultation with each jurisdiction.

Admitted Nursing Home Type Patient Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Inpatient - Nursing Home Type</td>
<td>$61.30</td>
<td>8 May 2019</td>
</tr>
<tr>
<td>Private Nursing Home Type – Patient Contribution</td>
<td>$61.30</td>
<td>8 May 2019</td>
</tr>
<tr>
<td>Private Nursing Home Type – Inpatient</td>
<td>$199.40</td>
<td>8 May 2019</td>
</tr>
<tr>
<td><strong>Note:</strong> The patient contribution forms part of the private NHTP fee. The Health Fund pays the difference ($199.40 - $61.30 = $138.10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible Veteran Beneficiary Nursing Home Type – Patient Contribution</td>
<td>$61.30</td>
<td>8 May 2019</td>
</tr>
<tr>
<td>Eligible Veteran Beneficiary Nursing Home Type – Patient Contribution for ex-Prisoner of War (POW) or Victoria Cross (VC) recipient</td>
<td>$61.30</td>
<td>To be billed directly to DVA</td>
</tr>
<tr>
<td><strong>Note:</strong> POW’s status is printed on the Gold Card.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensable Nursing Home Type – Inpatient</td>
<td>Not applicable</td>
<td>Cannot be classified as a nursing home type patient</td>
</tr>
<tr>
<td>Motor Vehicle Third Party Insurance Nursing Home Type - Inpatient</td>
<td>Not applicable</td>
<td>Cannot be classified as a nursing home type patient</td>
</tr>
<tr>
<td>Medicare Ineligible Nursing Home Type - Inpatient</td>
<td>Not applicable</td>
<td>Cannot be classified as a nursing home type patient</td>
</tr>
</tbody>
</table>

(a) The increase in patient contribution relates to Commonwealth pension increase 20 March 2019.
(b) See 8.8 for DVA NHTP Contribution for ex-POWs and VC recipients

*Note: The nursing home type patient arrangement does not apply to either Medicare ineligible or compensable inpatients*
Derivation of the Nursing Home Type Patient Contribution

The chargeable daily rate for the Nursing Home Type – Patient Contribution is calculated as follows: NHTP – Patient Contribution = 87.5% x (adult single pension rate + ‘single/no child’ rent assistance)

The Commonwealth pension rates are adjusted in accordance with the movements in the Australian Consumer Price Index (refer to Catalogue no. 6401.0) and are set by the Commonwealth Minister for Social Services in March and September every year.

5.7. Boarders

Definition of a Boarder

A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Types of Boarders

There are many circumstances under which a health service is required to provide accommodation and meals to individuals who do not require formal admission to a hospital. The more frequent circumstances are listed below:

In some circumstances the need to have a boarder in hospital with a patient is necessary for the wellbeing of the patient. In these cases the treating medical officer documents, that the sick person (patient) is accompanied by a boarder. Examples of these types of boarders would be:

- A breast-fed or bottle fed infant of a sick mother or the breast-feeding or bottle feeding mother of a sick infant.
- In remote parts of the State, there may be the need for a patient to be accompanied by a family member who may not be able to obtain accommodation elsewhere. This is more likely in areas where the patient lives a considerable distance from the hospital.
- There are circumstances when clients may be able to attend visiting medical officers’ appointments or follow up treatments or appointments more easily if accommodated at the hospital as a boarder. These include appointments early in the day when the home may be a great distance from the hospital.
- Limited air flight and public road / train schedules to some remote areas may mean that patients travelling to, or returning from, a regional or city hospital may need to be accommodated at a hospital before or after receiving treatment. If accommodation but no treatment is provided these patients are classified as boarders.
- In some cases the presence of a family member staying at the hospital as a boarder may assist both the care of the patient during the hospital stay and ensure that the patient is able to be discharged at the appropriate time. The hospital stay may be better managed by the presence of a boarder during the hospital stay to ensure there is no delay before discharge from the hospital.
In cases of extremely ill patients or terminal illness, members of the family may wish to be present at the hospital during the critical period. The treating medical officer may decide that the presence of some family members as boarders will be of benefit to the patient.

Patients who stay overnight for dialysis or similar treatment who are discharged the following day are to be classified according to the Australian Coding Standards (ACS), 2005. This standard states that for same-day and overnight episodes of care, where the patient is discharged on the same date as the admission, or on the next day after admission, code as principal diagnosis either the admission for chemotherapy, or dialysis or for other similar type case scenarios.

Guidelines for Registration of Boarders

Documenting the presence of boarders should follow these guidelines:

- Due to current Information System constraints boarders will be admitted onto the hospitals patient administration system. This will register the boarder and these episodes will be removed from the HMDS extract for Commonwealth reporting of acute inpatient separations.

- People accompanying a sick person can only be classified as boarders if they stay overnight. Hotel services such as meals and a bed must be provided.

- Where applicable, the clinician should record that it is necessary for the hospital to accommodate the person as a boarder. For example, there should be documentation in the case of the breast-feeding or bottle feeding mother of a sick baby, or the breastfed or bottle fed baby of a sick adult.

- In transit patients who may be accommodated at the hospital while awaiting transportation to either another health care facility, or to their home, may be admitted as boarders if they do not meet the admission criteria to be an admitted patient.

- If a patient who is in transit does not meet the admission criteria, and while admitted as a boarder requires minor treatment or investigation, which would normally be performed as a non-admitted patient service, this treatment should be recorded as an occasion of service and does not alter the patient’s status as a boarder.

- In most circumstances there should be only one carer accompanying a patient as a boarder. The exceptional circumstances may include a mother breast-feeding or bottle feeding two infants.

- Family members may be accommodated as boarders in the case of terminal illness or extremely sick patients if the treating medical officer considers that it will assist the care of the patient.

- Babies aged 10 days and over, accompanying their mothers will be admitted as boarders unless they are receiving clinical care in their own right.

- Boarders accompanying a sick person admitted in the middle of the night with a subsequent discharge that day. The expectation is that the boarder will also be admitted. For example, a sick baby being breast-fed or bottle-fed and mother accompanies the child for the wellbeing of the child.
 Patients admitted during the day and who are same-day patients. Family members accompanying the patient are not to be admitted as boarders.

Charges for Boarders

The following rules regarding fees for boarders in hospitals or health services shall apply:

- The gazetted boarder’s fee per night is charged for properly accommodated boarders determined by hospital staff to be fee paying boarders on the basis of receiving dedicated accommodation facilities (either in a hospital bed and / or in dedicated areas / rooms) and other services (food).
- Those non-accommodated boarders occupying comfortable chairs without facilities or food are exempt. Non-accommodated boarders are also termed Distressed Relatives who need to remain with the patient for support. A distressed relative must not incur accommodation and food costs.
- No charges shall be raised for:
  - A mother accompanying a sick child for breast-feeding or bottle feeding; or
  - A breast-fed or bottle feed baby accompanying its sick mother; or
  - Person accompanying a sick child for the child's medical wellbeing, as determined by the doctor.

Boarder’s fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for boarders accompanying patients (excluding maternity boarders) who receive dedicated room facilities and food services, including eligible war service veteran patients</td>
<td>$39.00 (inclusive of GST)</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Non-accommodated boarders / distressed relatives whom are accompanying patients in comfortable chairs but do not receive any specific room facilities or food</td>
<td>$0.00</td>
<td>Determined by hospital staff</td>
</tr>
<tr>
<td>Accommodation for a mother accompanying a sick child for breast feeding, or a breast fed baby accompanying its sick mother, or persons accompanying a sick child for the medical well-being of the child (as determined by the doctor)</td>
<td>$0.00</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
5.8. Nursing Home and Hostel Residents

Overview

Public hospitals and health services can only charge patients fees, to the extent authorised by their governing legislation.

With the commencement of the Commonwealth Aged Care Act 1997, the Regulations were amended to remove their coverage of fees for nursing home patients. This was based on the premise that in order for public nursing homes to comply with the Aged Care Act 1997 and to meet Commonwealth funding requirements, this would provide authorisation to charge fees under the Aged Care Act 1997.

The resultant legal framework is that the Act does not allow for the charging of accommodation bonds, or accommodation charges, or daily care fees to recipients of aged care services. And this applies for both stand-alone public residential aged care services (i.e. public nursing homes) and for recipients of residential aged care services in a Multi-Purpose Service (MPS) setting.

However, the Act and Regulations does allow for the charging of daily care fees, in the form of the patient contribution for patients in hospital beds, which are classified as Nursing Home Type Patients.

Note: For further details on NHTP, please refer to Section 5.10 Nursing Home Type Patient Fees.

Nursing Home Fees

<table>
<thead>
<tr>
<th>As from 1 March 1998, Nursing Homes Fees are covered by the Commonwealth Aged Care Act</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term respite care patients</td>
<td></td>
<td>There is currently no legal basis under the Health Services Act 2016 or Health Services (Fees and Charges) Order 2016 for charging a respite care fee</td>
</tr>
<tr>
<td>Compensable Inpatients – Nursing Homes</td>
<td>$300.00</td>
<td>1 July 2019</td>
</tr>
</tbody>
</table>

5.9. Other Compensable Patients

Compensable Inpatients (excludes Motor Vehicle Third Party Insurance)

Definition of Compensable Inpatient

A compensable inpatient, namely, an inpatient who

(i) has received or established the patient’s right to receive in respect of any injury, illness or disease for which the patient is receiving health services payment by way of
compensation or damages (including payment in settlement of a claim for compensation or damages) under the law that is, or was, in force in a State or internal Territory; or

(ii) on attendance at a hospital appears prima facie to have the right to receive any such payment in respect of an injury, illness or disease for which the patient is receiving health services

Reference: Part 3 Section 12 (2) (c) Health Services (Fees and Charges) Order 2016

Compensable Patient Election

It is mandatory that compensable admitted patients complete a Patient Election Form issued by the Department of Health. There are provisions for the patient to elect an alternative classification, if the ‘third party insurer’ rejects liability of a specific compensable claim.

Admission Classification Procedure for Compensable Patients

Patients not eligible for Medicare can be classified as a compensable patient. Compensable status takes precedence over other types of treatment status including Medicare ineligible status. The hospital must not amend charges to compensable patients because the patient voluntarily waives any rights to compensation, as this does not constitute the failure of a claim. Under these circumstances, normal debt recovery procedures should apply.

Multiple Chargeable Services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 6.2 Charging Arrangements for Multiple Services on Same Day.

Setting Compensable Inpatient Charges

As part of the annual review of hospital fees and charges, fees for compensable inpatients admitted to a health service are set to achieve full cost recovery.
## Compensable Inpatient Fees (Excludes Motor Vehicle)

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Admission</td>
<td>$2,704.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Same Day</td>
<td>$3,014.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Medical Services</td>
<td>$0.00 (No hosp. fee);</td>
<td>Fee may be raised by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A salaried medical officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>exercising a right to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>private practice;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Private medical practitioners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>direct; or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A hospital on behalf of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>medical practitioners</td>
</tr>
<tr>
<td>Ventilator Dependant (with tracheotomy requiring 24 hours individual</td>
<td>$6,540.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Pathology – for each request</td>
<td>Various</td>
<td>Patient charged directly by</td>
</tr>
<tr>
<td></td>
<td></td>
<td>radiologist, or by hospital on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the radiologist’s behalf</td>
</tr>
<tr>
<td>Specialised Orthoses</td>
<td>Various</td>
<td>Refer to the Div. 5 Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services (Fees and Charges)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Order 2016</td>
</tr>
<tr>
<td>Details</td>
<td>Fee per Day or per Service</td>
<td>Most recent amendment and notes</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Drugs and medication:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All drugs and medication as an inpatient.</td>
<td>$0.00 (No hosp. fee)</td>
<td>The Health Services (Fees and Charges) Order 2016 does not authorise the charging of pharmaceuticals to compensable inpatients</td>
</tr>
<tr>
<td>Non-participating hospitals to PBS Reform – upon discharge drugs for up to 5 days</td>
<td>$0.00 (No hosp. fee)</td>
<td>Clause G5 of the NHRA – States which have signed to Pharmaceutical Reform may charge the PBS for drugs supplied upon discharge</td>
</tr>
<tr>
<td>Participating hospitals to PBS Reform – upon discharge drugs up to 30 days</td>
<td>Up to a max. of $40.30 $32.20</td>
<td></td>
</tr>
<tr>
<td>- PBS items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-PBS items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notifiable sexually transmitted disease management</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Section 2.5</td>
</tr>
</tbody>
</table>
5.10. Compensable Non-Admitted Patients

Definition of Compensable Non-Admitted Patient

A compensable outpatient, namely, an outpatient who

(i) has received or established the patient’s right to receive in respect of any injury, illness or disease for which the patient is receiving health services payment by way of compensation or damages (including payment in settlement of a claim for compensation or damages) under the law that is, or was, in force in a State or internal Territory; or

(ii) who on attendance at a hospital appears prima facie to have the right to receive any such payment in respect of an injury, illness or disease for which the patient is receiving health services.

Reference: Part 3 Section 14(2)(a) Health Services (Fees and Charges) Order 2016

Multiple Chargeable Services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 6.2 Charging Arrangements for Multiple Services on Same Day.

Applicable Classes of Compensable Outpatients

Due to different charging arrangements with the Insurance Commission of Western Australia (ICWA) and the Commonwealth Department of Veterans’ Affairs (DVA), this section only applies to workers’ compensation and merchant shipping patients. Please refer to Sections 5.6 and 5.7 for charges applying to defence force personnel and Section 5.10 for motor vehicle accident patients.

The table below details outpatient charges applying to workers’ compensation and merchant shipping patients.
## Compensable Non-Admitted Fees (Excludes Motor Vehicle)

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
</table>
| Outpatient Services (other than pathology and radiology) – for each individual occasion of service | $310.00 | 1 July 2019  
Drugs supplied at the time of the initial service being treated as included in that service |
| Radiology Services – for each item of service | $310.00 | 1 July 2019  
Charged directly by hospital on salaried radiologist’s behalf |
| Pathology Services – for each request | Various | PathWest charges the compensable insurer on a ‘fee for service’ basis at 100% of the MBS |
| Home Modifications service and supply or loan | $0.00 (No hosp. fee) |  
Refer to Section 6.10  
Admitted service.  
Refer to Div. 5 Health Services (Fees and Charges) Order 2016 |
| Allied Health and Nursing Treatment – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services) | $310.00 | 1 July 2019 |
| **Drugs and medication:** | | |
| Compensable non-admitted patients: | | |
| At participating hospitals: | | |
| PBS items | Up to a max. $40.30 |
| Non-PBS items | $32.20 |
| At non-participating hospitals: | | |
| | $32.20 |
Category 2 – Other Chargeable Patients

5.11. Private Inpatients (Medicare Eligible Australian Residents)

**Definition of Private Inpatient**

A private inpatient, namely, an inpatient:

(i) who is an eligible person (not being a compensable inpatient, nursing home type patient or private nursing home type patient); and

(ii) who elects to be treated as a private inpatient, and

(iii) in respect of whom the hospital concerned provides, in a hospital bed, accommodation, maintenance, nursing care and such other necessary services as are available, other than professional and dental services provided by a practitioner acting in a private capacity or midwifery services provided by a midwife acting in a private capacity.

**Reference:** Part 3 Section 12(2)(b) Health Services (Fees and Charges) Order 2016

**Private Patient Election**

At the time of admission to a hospital, or as soon as practicable after admission, an eligible person (not being a compensable inpatient or a war service veteran) must elect whether they wish to be classified as:

(a) a public inpatient, or

(b) a private inpatient.

**Reference:** Part 3 Section 12(4) Health Services (Fees and Charges) Order 2016

**Multiple Chargeable Services**

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 6.2 Charging Arrangements for Multiple Services on Same Day.

**Allocation of Single Room Accommodation**

The allocation of single room accommodation is based primarily on clinical need, determined by the treating medical practitioner and subsequently on the availability of single rooms. As a rule there is limited single room capacity in most WA public hospitals.

**Setting Private Inpatient Charges**

Fees for private inpatients admitted to a hospital or health service are set as part of the annual review of hospital fees and charges.

The shared room fee is set according to the Commonwealth Minimum Benefit tables in the Private Health Insurance (Benefit Requirements) Rules 2011 and is the minimum level that health funds provide benefits for shared ward accommodation. The Department’s practice is for
the Minister for Health to set the private shared room fee at the Minimum Benefit to avoid ‘out-of-pocket’ costs;

The single room fee is not regulated by the Commonwealth. The private single room fee is set through benchmarking other jurisdictions and escalation based on hospital cost growth modelling; and

The same day fee is set according to the Commonwealth Minimum Benefit tables in the Private Health Insurance (Benefit Requirements) Rules 2011 and is the minimum level that health funds provide benefits for same day accommodation. The Department’s practice is for the Minister for Health to set the private same day fee at the Minimum Benefit to avoid ‘out-of-pocket’ expenses.

**Private Inpatient Fees**

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Admission – Shared Room</td>
<td>$363.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Overnight Admission – Single Room (occupied at the patient’s request)</td>
<td>$661.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Nursing Home Type – Patient Contribution</td>
<td>$61.30</td>
<td>8 May 2019</td>
</tr>
<tr>
<td>Nursing Home Type – Private Inpatient</td>
<td>$199.40</td>
<td>8 May 2019</td>
</tr>
<tr>
<td><strong>Note:</strong> The patient contribution forms part of the private NHTP fee. The Health Fund pays the difference ($199.40 - $61.30 = $138.10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same Day</td>
<td>$300.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Medical Services</td>
<td>$0.00 (No hosp. fee)</td>
<td></td>
</tr>
<tr>
<td>Fee may be raised by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ A salaried medical officer exercising a right to private practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Private medical practitioners direct or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ A hospital on behalf of medical practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgically Implanted Prostheses</td>
<td>Relevant benefit amount for each listed item in Commonwealth Prostheses List</td>
<td>Refer to Section 6.8</td>
</tr>
</tbody>
</table>
## Details

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology – for each item of service</td>
<td>Various</td>
<td>Patient charged directly by radiologist, or by hospital on the radiologist’s behalf</td>
</tr>
<tr>
<td>Pathology – for each request</td>
<td>Various</td>
<td>PathWest raise charges to private patients on a ‘fee for service’ basis at 100% MBS</td>
</tr>
<tr>
<td>Specialised Orthoses</td>
<td>Various</td>
<td>Refer to Div. 5 Health Services (Fees and Charges) Order 2016</td>
</tr>
</tbody>
</table>

### Drugs and medication:
- All drugs and medication as an inpatient
- Non-participating hospitals to PBS Reform – upon discharge drugs for up to 5 days
- Participating hospitals to PBS Reform – upon discharge drugs up to 30 days
- Benefit entitlement card holders:
  - For all other private admitted patients:
    - PBS items
    - Non-PBS items

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00 (No hosp. fee)</td>
<td>Clause G4 of the NHRA – pharmaceutical services to private patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the PBS</td>
</tr>
<tr>
<td></td>
<td>$0.00 (No hosp. fee)</td>
<td>Clause G5 of the NHRA – States that have signed up to the Pharmaceutical Reform may charge the PBS for drugs supplied upon discharge.</td>
</tr>
<tr>
<td></td>
<td>$6.50 Up to a max. of $40.30 $32.20</td>
<td></td>
</tr>
<tr>
<td>Notifiable sexually transmitted disease management</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Section 2.5</td>
</tr>
</tbody>
</table>

### Inter-Hospital Transfer Costs for Privately Insured Patients in Public Hospitals

All privately insured patients requiring an ambulance transfer between public hospitals will have the cost met by the ‘sending’ public hospital.

Inter-hospital transport includes transfers of hospital admitted or registered emergency department patients from:
- A public hospital to another public hospital
- A public hospital to the airport where the patient is to be transported by air to another public hospital
- The airport to a public hospital where the patient is to be transported by air to another public hospital.
**Exclusions**

The following groups of patients are excluded from these arrangements:

- Workers Compensation
- Motor Vehicle Insurance Trust
- Other compensation
- Department of Veterans’ Affairs – see section 8.5
- Department of Defence and
- Medicare Ineligible Overseas visitors

The patient must still meet the cost of ambulance transfers from a public to a private hospital. (except DVA).

5.12. **Private Non-Admitted Patients (Medicare Eligible Australian Residents)**

**Definition of Private Non-Admitted Patient**

An eligible person, who elects to be treated as a private outpatient, who attends at a hospital and receives treatment under an outpatient service provided by the hospital, or in respect of whom a hospital provides a service elsewhere than at the hospital.

**Reference:** Part 3 Section 14(c) Health Services (Fees and Charges) Order 2016.

**Multiple Chargeable Services**

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to [Section 6.2](#) Charging Arrangements for Multiple Services on Same Day.
## Private Non-Admitted Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
</table>
| Outpatient Services (other than pathology and radiology) – for each individual occasion of service | $0.00 (No hosp. fee)        | • Patient charged directly by the private medical practitioner, or  
|                                                                        |                             | • by hospital on the doctor’s behalf |
| Radiology Services – for each item of service                           | Various                     | • Patient charged directly by the radiologist, or  
|                                                                        |                             | • by hospital on the radiologist's behalf. |
| Pathology Services – for each request.                                  | Various                     | PathWest charge private patients on a ‘fee for service’ basis at 85% MBS |
| **Note:** Private patients are chargeable, provided that the requesting doctor or medical consultant has exercised their ‘rights of private practice’ |                             |                                 |
| Home Modifications service and supply or loan                          | $0.00 (No hosp. fee)        | Refer Section 6.10               |
| • All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses | Not applicable             | Admitted service.  
| • Surgically Implanted Prostheses                                      | Various                     | Refer to Div. 5 Health Services (Fees and Charges) Order 2016 |
| • Specialised Orthoses                                                  |                             |                                 |
| **Allied Health and Nursing Treatment** – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services) | $0.00 (No hosp. fee)        | There are no private outpatient charges prescribed in the Health Services (Fees and Charges) Order 2016 |
### Compensable Patients

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugs and medication:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit entitlement card holders:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>With a safety net entitlement card</td>
<td>$0.00 (No hosp. fee)</td>
</tr>
<tr>
<td></td>
<td>Without a safety net concession card</td>
<td>$6.50</td>
</tr>
<tr>
<td></td>
<td>For all other patients:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At participating hospitals:</td>
<td>Up to a max. $40.30</td>
</tr>
<tr>
<td></td>
<td>PBS items</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-PBS items</td>
<td>$32.20</td>
</tr>
<tr>
<td></td>
<td>At non-participating hospitals:</td>
<td>$32.20</td>
</tr>
<tr>
<td></td>
<td>Notifiable sexually transmitted disease management</td>
<td>$0.00 (No hosp. fee)</td>
</tr>
</tbody>
</table>

### 5.13. Medicare Ineligible Overseas Inpatients

**Definition of Medicare Ineligible Inpatient**

An ineligible inpatient, namely, an inpatient

(i) who is not an eligible person (other than a person or a member of a class of persons to whom or which a declaration made under the Health Insurance Act 1973 (Commonwealth) section 6(2) applies in the relevant circumstances); and

(ii) who is not a compensable inpatient; and

(iii) in respect of whom the hospital concerned provides, in a hospital bed, accommodation, nursing care and such other necessary services as are available, other than professional and dental services provided by a practitioner acting in a private capacity.

**Reference:** Part 3 Section 12(2)(g) Health Services (Fees and Charges) Order 2016

**Multiple Chargeable Services**

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 6.2 Charging Arrangements for Multiple Services on Same Day.

**Setting Medicare Ineligible Inpatient Charges**

As part of the annual review of hospital fees and charges, fees for Medicare ineligible inpatients admitted to a hospital or health service are set to achieve full cost recovery.
### Medicare Ineligible Inpatient Fees

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Admission</td>
<td>$2,887.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Same Day</td>
<td>$2,580.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Emergency Department Services*</td>
<td></td>
<td>1 July 2019</td>
</tr>
<tr>
<td>• Triage Level 1</td>
<td>$2,155.00</td>
<td></td>
</tr>
<tr>
<td>• Triage Level 2</td>
<td>$1,255.00</td>
<td></td>
</tr>
<tr>
<td>• Triage Level 3</td>
<td>$885.00</td>
<td></td>
</tr>
<tr>
<td>• Triage Level 4</td>
<td>$540.00</td>
<td></td>
</tr>
<tr>
<td>• Triage Level 5</td>
<td>$315.00</td>
<td>*The patient will be charged pathology and radiology in addition to the ED fees. The ED fees are also in addition to subsequent accommodation and professional fees if the patient is admitted. ED fees cover the cost of the patient being triaged so there may be costs for professional fees by VMPs in addition to this fee.</td>
</tr>
<tr>
<td>Medical Services</td>
<td>$0.00 (No hosp. fee);</td>
<td></td>
</tr>
<tr>
<td>Surgically Implanted Prostheses</td>
<td>Relevant benefit amount for each listed item in Commonwealth Prostheses List</td>
<td>Refer to Section 6.8</td>
</tr>
<tr>
<td>Radiology – for each item of service</td>
<td>Various</td>
<td>Patient charged directly by radiologist, or by hospital on the radiologist’s behalf</td>
</tr>
<tr>
<td>Pathology – for each request</td>
<td>Various</td>
<td>PathWest raise charges to ineligibles on ‘fee for service’ basis at 100% of the MBS</td>
</tr>
</tbody>
</table>
### Details | Fee per Day or per Service | Most recent amendment and notes
--- | --- | ---
Specialised Orthoses | Various | Refer to Div. 5 Health Services (Fees and Charges) Order 2016

**Drugs and medication:**
- All drugs and medication as an inpatient.

**Note:** Medicare Ineligible persons (overseas residents) by definition are not Medicare eligible so they cannot access PBS Reform Arrangements

- Drugs and medication:
  - All drugs and medication as an inpatient.
  - Medicare Ineligible persons (overseas residents) by definition are not Medicare eligible so they cannot access PBS Reform Arrangements

**Notifiable sexually transmitted disease management**

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services (other than pathology and radiology) – for each individual occasion of service</td>
<td>$310.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Radiology Services – for each item of service</td>
<td>$310.00</td>
<td>1 July 2019</td>
</tr>
</tbody>
</table>

---

### 5.14. Medicare Ineligible Overseas Non-Admitted Patients

**Definition of a Medicare Ineligible Outpatient**

A Medicare ineligible outpatient is an outpatient, who is not a Medicare eligible person, who is receiving services from a hospital or health service, is not admitted to the hospital or health service as an inpatient, and who is not a compensable non-admitted patient.

**Multiple Chargeable Services**

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to **Section 6.2 Charging Arrangements for Multiple Services on Same Day**.

**Overseas Residents**

A Medicare ineligible overseas student with compulsory Overseas Student Health Cover or a Medicare ineligible overseas visitor attending an outpatient department will be charged the outpatient fee.

**Medicare Ineligible Non-Admitted Fees**
### Compensable Patients

<table>
<thead>
<tr>
<th>Details</th>
<th>Fee per Day or per Service</th>
<th>Most recent amendment and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology Services – for each request</td>
<td>Various</td>
<td>PathWest raises charges to Medicare ineligible patients on a ‘fee for service’ basis at 100% of the MBS</td>
</tr>
<tr>
<td>Home Modifications service and supply or loan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer Section 6.10</td>
</tr>
<tr>
<td>- Surgically Implanted Prostheses</td>
<td>Not applicable</td>
<td>Admitted service.</td>
</tr>
<tr>
<td>- Specialised Orthoses</td>
<td>$0.00 (No hosp. fee)</td>
<td>Refer to Div. 5 Health Services (Fees and Charges) Order 2016</td>
</tr>
<tr>
<td><strong>Allied Health and Nursing Treatment</strong> – per occasion</td>
<td>$310.00</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>(chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drugs and medication:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medicare Ineligible non-admitted patients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-PBS items</td>
<td>$32.20</td>
<td>Clinically appropriate amounts only. Refer to section 6.1 for more details.</td>
</tr>
<tr>
<td><strong>Note:</strong> Medicare ineligible patients are to be supplied all clinically necessary medicines (whether PBS listed or non-PBS) are charged as non-PBS items</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 6: Other Fees and Charges

6.1. Pharmacy

Pharmaceutical Benefits Scheme Fees

The Pharmaceutical Benefits Scheme (PBS) provides access to medicines at an affordable price. The current provisions governing PBS are embodied in part VII of the National Health Act 1953 together with the National Health (Pharmaceutical Benefits) Regulations 1960 made under the Act. Eligibility to PBS is restricted to Australian residents and RHCA visitors. Clause G5 of the NHRA states private inpatients cannot be charged for pharmaceuticals, nor claimed against PBS.

PBS Medicines Charging Arrangements

For medicines prescribed to Benefit Entitlement Card holders, patients are charged the concession co-payment rate of $6.50 per item.

Non-PBS Medicines Charging for General Patients Under the Co-Payment Upper Limit

To allow for equitable patient pricing within WA Health and improve patient access to medication, the following algorithm will be applied for non-PBS medication under the co-payment upper limit for General Patients.

Patient Price = 
\[\text{Medication Cost} + 10\% + \text{Dispensing Fee}] \leq \text{Non-PBS General Cap}\]

Note: The above fee algorithm is built into iPharmacy.

Medication Cost\(^1\) = [Quantity of Medication] x [Average Weighted Price]
Dispensing Fee\(^2\) = As defined in Section 99 (2AB) of the National Health Act 1953 and subject to annual indexation under Regulation 99G of the National Health Act 1953.
Non-PBS General Cap\(^3\) = As defined in the Health Services (Fees and Charges) Order 2016 Sch 1, Div 1, (5)(C)(i)(II)

Note: Medication Cost is exclusive of GST

Pharmaceutical Benefits Scheme Reform – Implications to Public Hospitals

The Commonwealth Department of Health and Ageing offered the DOH a pharmaceutical reform proposal under the NHRA. The proposal has two fundamental parts:

- The ability for public hospitals to charge against the Pharmaceutical Benefits Scheme for drugs and medications supplied to non-admitted patients and inpatients on discharge; and
- The moving of cytotoxic drugs into the highly specialised drugs program.
Hospitals are permitted to charge for medications supplied to outpatients. This includes items on the BPS list, Section 100 Highly Specialised Drugs (HSD) and items that are not PBS/HSD. The State and Commonwealth PBS public hospital reform agreement allows for the levy of a patient co-payment for the supply of medicines at discharge, outpatients (including emergency department visits) and for day admitted chemotherapy patients.

All public hospitals in WA are participating in the PBS Reform.

**PBS Reform Charging Arrangements**

There is no charge for holders of a Safety Net Entitlement Card. For drugs dispensed at participating hospitals to Benefit Entitlement Card holders they are charged $6.50 per item. All other patients prescribed PBS drugs are charged up to a maximum of $40.30 per item (items costing less are charged that amount)

*Note: As part of the pharmaceutical reforms, up to one month’s prescription of PBS drugs will be supplied to patients when they are discharged, or when an outpatient attends a public health service.*

**Pharmaceutical Benefits Safety Net Arrangements**

The Commonwealth has established safety net arrangements to protect individuals / families from large overall medicinal expenses when a person or their family reaches a defined Safety Net Threshold.

Expenditure above the Safety Net Threshold for a general patient enables further PBS prescriptions to be dispensed at the concession co-payment rate, while concession cardholders are dispensed PBS prescriptions free of charge for the rest of the calendar year. Note that in order to access safety net arrangements, patients need to maintain records of PBS expenditure on a Prescription Record Form.

<table>
<thead>
<tr>
<th>Benefit Entitlement Cardholder’s</th>
<th>$390.00 (1/1/2019)</th>
<th>Expenditure above this threshold entitles patients to the issue of a Safety Net Entitlement Card and further prescriptions are then <strong>free of charge</strong> for the rest of the calendar year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Patients</td>
<td>$1,550.70 (1/1/2019)</td>
<td>Expenditure above this threshold entitles patients to the issue of a Safety Net Concession Card and further prescription items at the concession rate of <strong>$6.50</strong> per item for the rest of the calendar year.</td>
</tr>
</tbody>
</table>
### Charges by Medication Type

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Hospital Type</th>
<th>PBS listed Item</th>
<th>Non-PBS (item or indicator)</th>
<th>HSD (S100) listed item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Net Entitlement</td>
<td>PBS &amp; Non PBS</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Concession Pension Repat</td>
<td>PBS &amp; Non PBS</td>
<td>$6.50</td>
<td>$6.50</td>
<td>$6.50</td>
</tr>
<tr>
<td>General</td>
<td>PBS</td>
<td>DPMQ* up to max $40.30</td>
<td>$32.20</td>
<td>$32.20</td>
</tr>
<tr>
<td>General</td>
<td>Non PBS</td>
<td>$32.20</td>
<td>Fee calculation *</td>
<td>$32.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Price = [Medication Cost] + 10% ] + [Dispensing Fee] Medicines charged up to $32.20</td>
<td></td>
</tr>
<tr>
<td>Non Eligible (no Medicare)</td>
<td>PBS &amp; Non PBS</td>
<td>$32.20#</td>
<td>$32.20</td>
<td>$32.20#</td>
</tr>
</tbody>
</table>


* The fee calculation for non-PBS medicines is to be applied and charged up to the non-PBS General amount $32.20

# For ineligible patients PBS/HSD listed items may be supplied but are not claimable and should be considered non-PBS for charging purposes. Ineligible patients may be charged $31.60 for a clinically appropriate quantity. This is defined as a full course of treatment or sufficient treatment until the next hospital appointment or one month’s supply, whichever is the lesser amount. For greater amounts patients should be referred to a community pharmacy except for medications that are manufactured internally, which may be charged at cost recovery plus a handling fee.

### Charging Psychiatric Outpatients for their Medications

Psychiatric non-admitted patients are to be charged for their medications in accordance with the procedures detailed above, except where the patient is deemed to be an exempt patient.

Patients exempt from charges include:

- People receiving treatment under the Mental Health Act 1996
- People whose medication non-compliance is likely, if exemption is not given

Exempt Patients are to be issued proof of their status in order to obtain their medications free from either the hospital pharmacy or psychiatric clinic. Exempt status is to be reviewed every six months.
Note: The treating medical practitioner may apply to the Mental Health Director for approval to supply medication free of charge, if raising charges may cause the patient not to take their medication and result in imminent risk of readmission, or put themselves and/or the community at risk.

**Elective Delivery of Medications**

Where a patient elects to receive a medication other than by attending the hospital nominated location for collection, a fee equal to the cost of delivery may apply.

This fee type is applicable to all patient election types.

*Reference: National Health (Pharmaceutical Benefits) Regulations 2017, Regulation 56*

**6.2. Multiple Services on Same Day**

**Overview**

A person may attend, or be admitted to, and discharged from, a health service more than once in the same day. Similarly, a patient of one health service may receive services at another health service when such services are part of the total treatment. The following rules are to apply to these situations.

**Chargeable Overnight Patients**

Where a chargeable overnight stay patient is transferred to another hospital or health service, and subsequently returns to the original hospital or health service, (or to a third hospital or health service) the total charges raised by the hospital or health service should not exceed the charges which would have been raised had the patient remained an overnight stay patient of the original hospital for the full period from original admission to final discharge.

Where a chargeable overnight stay patient of a hospital or health service obtains treatment not arranged by the hospital or health service in which the patient is being treated, the normal fees may be charged by the private medical practitioners, or other hospital providing the service.

**Chargeable Same Day Patients**

Where a chargeable same day patient is admitted and discharged, and then subsequently re-admitted and discharged within the period of one day (midnight-to-midnight) at the same hospital, only one same day patient account is to be issued.

Where a same day patient is for medical reasons retained (or if discharged, re-admitted on that same day) beyond midnight on the day of admission, they are to be reclassified as an overnight stay patient.
6.3. **Chargeable Occasions of Service at Scheduled Non-Admitted Clinics**

**Definition**

An occasion of service is any examination, consultation, treatment or other service provided to a patient in each functional unit of a health service; on each occasion such service is provided.

**Charging**

An outpatient charge is to be raised, each time a chargeable non-admitted patient receives a service from one of the separate functional units, of the following scheduled non-admitted clinics:

- Medical and Diagnostic Clinics includes; allergy, anaesthetic or pre-admission, antenatal, burns, cardiology, clinical haematology, communicable diseases, dermatology, development paediatrics, diabetic, endocrinology, family planning, gastroenterology, general medicine, genetics, gynaecology, infertility, haematology, immunology, maternity, medical oncology, menopause, microbiology, neonatology, nephrology, neurology, obstetrics, oncology, ophthalmology, pain clinic, paediatric, paediatric medicine, rehabilitation medicine, rheumatology and urology.

- Surgical Clinics includes; cardiothoracic, ENT, general paediatric surgery, general surgery, neck of femur, neurosurgery, orthopaedics, plastic surgery, spinal surgery and vascular.

- Allied Health, Nursing and Technical Services Clinics includes; antenatal, audiology, appointment scheduling, chiropody, continence, CTG, diabetic education, diabetic dietetics, ECG, family planning, maternity, medical illustration, neurophysiology, nutrition, occupational therapy, optometry, orthoptics, physiotherapy, plaster room, pre-admission clinic, podiatry, psychology, speech therapy, spirometry, social work, stomal therapy, ulcer clinic, Well Women’s Clinic.

- Dental
- Mental Health
- Pathology
- Pharmacy
- Radiology and Organ Imaging
- Community Health
- Domiciliary Care
- Other Outreach Services.
6.4. **MBS Billed Non-Admitted Services**

A separate manual has been developed for MBS Billed Non-Admitted Services. The manual can be found using the following link;  

6.5. **Dental Health Services**

**Overview**

Eligible public patients can receive subsidised dental treatment from government funded dental clinics, private practitioners who participate in the metropolitan or country Dental Subsidy schemes, or the Oral Health Centre of Western Australia (OHCWA), depending on the patients’ circumstances and location of residence.

**Eligibility Criteria**

To receive public dental care, patients must meet eligibility criteria, which are dependent on their concession status:

**Health Care Card and Pensioner Concession Card Holders**

A person, who is in receipt of a health care card or pension concession card, or a dependent listed on the card, may be eligible for emergency and general dental care at the basic rate of subsidy, which is 50% of the treatment fee.

**Pensions and Allowances**

A person who is in receipt of a full or near full pension or an allowance issued by Centrelink or the Department of Veteran’s Affairs, may upon production of a Statement of Benefit letter, be eligible for a higher rate of subsidy up to a maximum of 75% of the cost of the treatment.

Notes:

(i) Wards of the State, Department of Justice patients, patients registered with the Disability Services Commission and eligible for treatment at the Dental Health Services Special Needs Dental Clinic and public inpatients of teaching and non-teaching hospitals (for emergency care) will not be charged.

(ii) Children aged 5-16 years, who attend an educational facility recognised by the Department of Education, are eligible for free general dental care via the School Dental Service.

(iii) Inpatients of Graylands Hospital and psychiatric residents of hostels who attend the Graylands Dental Clinic are not charged.

**Eligible Persons**

Eligible patients who receive public subsidised dental care will be charged a co-payment. Dental fees are based on the Department of Veteran’s Affairs schedule of dental fees and the co-
payment will relate to the patient’s subsidy level entitlement. Patients entitled to a 50% or 75% subsidy will be charged 50% or 25% respectively for the dental fees incurred.

**Note:** Please contact the Manager Central Clinical and Support Services, Dental Health Services on telephone (08) 9313 0502 for information about the current Department of Health (DoH) scale of fees for general dental services.

**Other Sources of Information**

Contact OHCWA on (08) 6457 4400 for information about:
- Referral acceptance guidelines for specialist services
- Patient eligibility

**Department of Veterans Affairs Fee Schedule of Dental Services**

The Department of Veterans’ Affairs maintains a ‘Fee Schedule of Dental Services for Dentists and Dental Specialists’ (Effective 1 June 2014), which is available from their web site: [https://www.dva.gov.au/providers/dentists-dental-specialists-and-dental-prosthetists](https://www.dva.gov.au/providers/dentists-dental-specialists-and-dental-prosthetists)

**Note:** This is based on the Australian Schedule of Dental Services and Glossary, 10th edition.

### 6.6. Pathology Services

**Overview**

Pathwest Laboratory Medicine WA, a Health Service Provider, is the provider of pathology services for all Western Australian public hospitals. In addition, it provides pathology services to private patients, general practitioners, private hospitals, the State Coroner, the WA Police and other commercial companies.

**Legislative Background**

Charges for pathology services provided to patients in the public hospital system are set out in Div. 4 Health Services (Fees and Charges) Order 2016.

**Charges Applicable to Payment Classes Receiving Pathology Services**

The charge payable in respect of a pathology service specified in the Commonwealth Medicare Benefits Schedule (CMBS) is:
- 100% of the CMBS amount for the service for all patients, except;
  - if the service is rendered to a private pathology outpatient – 85% of the CMBS amount for the service.

**Public Patients in Public Hospitals**

Public patients of public hospitals together with patients of public emergency departments are treated free of charge. Pathwest raises an account for its services with the public hospital concerned. These fees are reviewed from time to time but from 1 July 2012, they have been set at 90% of the CMBS.
Private Inpatients

Billed directly to the patient at 100% of the CMBS rate. There are no ‘out-of-pocket’ expenses to the patient. Charges are covered by Medicare Australia and private Health Fund rebates. Identified Hospital Benefit Fund (HBF) members’ pathology services are billed directly to HBF.

Compensable Inpatients

Billed directly to the patient at 100% of the CMBS rate or to a third party insurer, when identified.

Private Nursing Home Type Patients

For Medicare rebatable tests, if the patient signs a Medicare assignment of benefits forms, the account is bulk billed to Medicare Australia, otherwise the patient is billed at 85% the CMBS rate.

Medicare Ineligible Inpatients

Billed directly to the patient at 100% of the CMBS rate

Compensable Day Patients

Billed directly to the patient at 100% of the CMBS rate or to a third party insurer, when identified

Medicare Ineligible Outpatients

Billed directly to the patient at 100% of the CMBS rate

Compensable Outpatients

Billed directly to the patient at 100% of the CMBS rate or to a third party insurer, when identified

Medicare Ineligible Outpatients

Billed directly to the patient at 100% of the CMBS rate

Private Same Day Patients

Billed directly to the patient at 100% of the CMBS rate. There are no ‘out-of-pocket’ expenses to the patient. Charges are covered by Medicare Australia and private Health Fund rebates. Identified Hospital Benefit Fund (HBF) members’ pathology services are billed directly to HBF

Compensable Same Day Patients

Billed directly to the patient at 100% of the CMBS rate or to a third party insurer, when identified

Medicare Ineligible Same Day Patients

Billed directly to the patient at 100% of the CMBS rate
Private Outpatients

For Medicare rebatable tests, if the patient signs a Medicare assignment of benefits forms, the account is bulk billed to Medicare Australia, otherwise the patient is billed at 85% the CMBS rate.

Non Hospital Patients

For Medicare rebatable tests, if the patient signs a Medicare assignment of benefits forms, the account is bulk billed to Medicare Australia, otherwise the patient is billed at 85% the CMBS rate. Non Medicare rebatable tests are billed directly to the patient.

Eligible War Service Veterans

Charges for pathology services provided to Eligible War Service Veterans are billed directly to the Commonwealth Department of Veterans’ Affairs (DVA) at 100% of the CMBS rate, to the following classes:
- Veteran Affairs inpatients;
- Veteran Affairs outpatients;

6.7. Magnetic Resonance Imaging and Positron Emission Tomography Services

This section applies to Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) services rendered by, in or at:
- Fiona Stanley Hospital
- Fremantle Hospital (MRI only)
- Perth Childrens Hospital (MRI only)
- Royal Perth Hospital (MRI only)
- Sir Charles Gairdner Hospital

Charges based on AMA rates are only payable in respect of MRI and PET scan services rendered to:
- Compensable inpatients;
- Medicare Ineligible inpatients;
- Compensable outpatients;
- Medicare Ineligible outpatients;
- Compensable same day patients;
- Medicare Ineligible same day patients; or
- Any person for the purposes of research

Note: A hospital is not authorised to charge for MRI & PET scan services provided to private inpatients, private same day patients or eligible outpatients.
Charging against Medicare for MRI Services to Eligible Patients

- A Medicare benefit is only payable if the MRI unit is licensed for the purpose of Medicare eligibility.
- A Medicare benefit is not payable if the service is provided by the hospital.
- A Medicare benefit is only payable if the contractual arrangement is between the medical practitioner and an eligible person who elects to be treated as a private patient, i.e. the doctor is providing the service to the patient in a private capacity – the hospital is not providing the service.
- A Medicare benefit is not payable for MRI services provided to public patients.

6.8. Surgically Implanted Prosthesis

Overview

The Commonwealth introduced legislative amendments on 10 March 2005 necessary for the implementation of new prostheses arrangements.

The amendments require registered health funds to offer a ‘no gap’ and ‘gap’ permitted range of prostheses in relation to every admitted hospital procedure on the Medicare Benefits Schedule (MBS) for which they provide cover.

At least one clinically effective no-gap prosthesis will be available for each admitted hospital MBS procedure specified in the Prosthesis List.

Under the new legislation, if the product has only a Minimum Benefit Level then a gap payment is not required (no gap prosthesis) and the health fund will cover the full cost. In these circumstances, the health fund member (if covered) will not incur any out of pocket costs for that prosthesis.

If a listed product has a Minimum Benefit Level and a Maximum Benefit Level then a gap payment may be required (gap prosthesis). The health fund will cover the cost of the gap prosthesis to at least the minimum benefit level and the health fund member will be responsible for any outstanding amount up to, but not exceeding, the difference between the maximum and the minimum.

The new prostheses arrangements implemented on 31 October 2005 include the new Prostheses List, which itemises the benefits payable against all no-gap and gap products.

Prostheses Fees to be Charged by Public Hospitals

The Commonwealth does not regulate prostheses fees charged by WA public hospitals; these fees are set by the State. The State has adopted the Commonwealth’s schedule of Benefit Levels for items in the Prostheses List, as the relevant fees and charges payable for the fitting of surgically implanted prostheses in WA public hospitals, as per Div. 6 Health Services (Fees and Charges) Order 2016.
Commencement Date

The Prostheses List is effective from 31 October 2005 when the new arrangements commenced and is applicable for prostheses and medical devices implanted on or after 31 October 2005.

However, to reflect arrangements negotiated between the States, Territories and Health Fund Insurers a discount will be applicable to the Prostheses List for any Cardio-thoracic or Ophthalmic claim for reimbursement processed from that date, subject to the conditions outlined in Clause 4 below.

Prostheses with Minimum Benefit Level Only

For items with a minimum benefit only, other than Cardio-thoracic and Ophthalmic items (as described under Categories in the Prostheses List), the fee charged will be the minimum benefit. No invoices are required to be submitted to health funds.

For Cardio-thoracic items on the List a 7.5% discount applies and for Ophthalmic items on the List a 20% discount applies. No invoices are required to be submitted to health funds.

If a public hospital is unable to procure any Cardio-thoracic or Ophthalmic items on the Prostheses List at or below the agreed percentage discount from the Prostheses List minimum benefit, then that hospital may provide a supplier invoice to the relevant health fund for reimbursement. The health fund under the current legislation is able to pay a benefit for that prosthesis up to the minimum benefit level listed on the Prosthesis List. Given the additional administrative and financial cost of procuring and sending an invoice to a fund, it is expected that hospitals will only provide an invoice where the cost is significantly above the discount level.

Prostheses with Maximum/Minimum Benefit Level

Certain items on the Prostheses List have a maximum and minimum benefit. The maximum charge for these prostheses is the maximum benefit level. Reimbursement from health funds above the minimum benefit is at the discretion of health funds.

Any prostheses charge above the benefit level paid by the health fund will be the private patient’s responsibility. Therefore the hospital or health service will need to ascertain from the relevant health fund for each prosthesis that has a maximum benefit, what benefit level above the minimum, if any, the health fund will pay. Note that discounts still apply to the minimum benefit level for Cardio-thoracic and Ophthalmic items as outlined above.

Note: Hospitals and health services must comply with this Operational Directive with respect to charging for Prostheses on the Prostheses List and are required to cease other charging practices with private health funds such as charging the supplier invoice price for prostheses on the Prostheses List except in exceptional circumstances as outlined above.

Informed Financial Consent

Hospitals are to ensure that patients in billed categories provide informed financial consent prior to surgery, and in doing so, understand that they are liable for any charges not covered by their health insurer for any prostheses items.
There are a small number of prostheses which are either not on the Commonwealth’s Prostheses List, or a benefit amount has not been determined. In these circumstances hospitals will need to ensure procedures are in place whereby informed financial consent is obtained from the patient in advance of their procedure where a gap payment may result.

**Categories of Patient to be Billed**

- Private inpatients
- Compensable inpatients
- Medicare Ineligible inpatients
- Private same day patients
- Compensable same day patients
- Medicare Ineligible same day patients
- Overseas visitors treated under Reciprocal Healthcare Agreements

**Web Link for the Latest Prostheses List**

The Australian Government’s Department of Health maintains the Prostheses List. The most current Prostheses List is accessible via the following hyperlink:


*Note: It remains the responsibility of WA public hospitals and health services to regularly access all relevant Commonwealth Private Health Insurance Circulars and monitor updates to the Commonwealth Prostheses List in order to obtain all determination benefit revisions.*
6.9. Specialised Orthoses

Overview

Advice from Parliamentary Counsel’s Office and the State Solicitor’s Office has indicated that the existing Hospitals (Services Charges for Specialised Orthoses and Prostheses) Determination 1994 is ‘ultra vires’ (without legal authority).

Application (of the Determination)

The Determination applies to the supply to chargeable patients of specialised orthoses at or by:

- Royal Perth Hospital
- Fiona Stanley Hospital
- Perth Children’s Hospital for Children

Charges Payable in Respect of Specialised Orthoses

The charges are payable in respect of the supply of specialised orthoses to:

- Private inpatients
- Compensable inpatients (excludes DVA)
- Medicare Ineligible inpatients
- Compensable outpatients
- Eligible outpatients
- Medicare Ineligible outpatients
- Private same day patients
- Compensable same day patients
- Medicare Ineligible same day patients

Web Link for the Charges Payable in Respect of Specialised Orthoses

The Determination contains a table which sets out in the 3rd column the charge for the specialised orthoses described in the 2nd column for:

- Royal Perth Hospital
- Fiona Stanley Hospital
- Perth Children’s Hospital

Reference: Div. 5 Health Service (Fees and Charges) Order 2016
6.10. Home Modification Services

Overview

Under the NHRA between the Commonwealth and Western Australia under Clause G1 (g), where an eligible person receives public hospital services as a public patient no charges will be raised, except for specific services provided to non-admitted patients. The effect of this particular clause is that public health systems may prescribe charges for non-admitted patients, in relation to the provision of aids, appliances and home modifications.

The Minister for Health has determined that inpatients (public, private, compensable, nursing home type and ineligible) will be provided with home modifications at no charge in accord with the NHRA. No determination has been made in respect to what charges may be levied on non-admitted patients. In effect, this silence means that hospitals should not charge non-admitted patients for this service.

Funding for Home Modifications in Western Australia

Whilst patients cannot be charged for home modification services there are currently two programs that provide funding to subsidise the cost of home modifications;

- National Disability Insurance Scheme (NDIS)
- Commonwealth Home Support Program (CHSP)
- Community Aids and Equipment Program (CAEP)

National Disability Insurance Scheme (NDIS)

The NDIS provides services to younger Western Australians with a disability, supporting them to maintain their independence at home. Home modifications is one of the services available and includes structural changes to the client’s home so they can continue to live and move safely about the house, including the fitting of rails and ramps, alarms and other safety and mobility aids. Further information about eligibility and services available through NDIS can be found at [www.ndis.gov.au](http://www.ndis.gov.au).

Commonwealth Home Support Program (CHSP)

On 1 July 2018, WA Home and Community Care (HACC) services for older people transitioned to the CHSP. Older people who require home modification services now have a new entry point to access these services. This entry point is My Aged Care ([www.myagedcare.gov.au](http://www.myagedcare.gov.au) or 1800 200 422).

Community Aids and Equipment Program (CAEP)

CAEP is the state-based aids and equipment program funded through the Department of Communities, for people with long-term disability living in the community. This program is currently available until 30 June 2020. It is anticipated CAEP funding will continue to reduce in line with full roll out of the NDIS.
Due to the aged care and disability reforms, all CAEP referrals should firstly be evaluated for eligibility to other Commonwealth and Disability programs. CAEP can be used during transition for existing CAEP clients who are being assessed for equipment inclusion in their plan as continuity of supports. People over 65 years not already accessing CAEP should test their eligibility for the CHSP before testing their eligibility for CAEP.

For more info on CAEP services and eligibility please contact Department of Communities, Disability Services on PH: 9426 9200 or 1800 998 214 (free call); or at http://www.disability.wa.gov.au/contact-us/.

6.11. Newborn Babies Whose Mother Elects to be Private

**Qualified Newborn**

Any newly born baby, who is less than ten days old on admission and meets one or more of the following criteria:

- Is the second or subsequent live-born infant of a multiple birth, whose mother is currently an admitted patient; or
- Is accommodated in a special care nursery. This includes Level 3 Neonatal Intensive Care Unit and Level 2 Special Care Nursery. The baby needs to be receiving special clinical care. ('Well' babies located in the nursery because the mother can’t give the baby complete care don’t meet this criteria and should be unqualified); or
- Remains in hospital without its mother; or
- Is admitted to hospital without its mother.

**Unqualified Newborn**

A baby under ten days old on admission, who does not meet the criteria of a qualified newborn. This includes the first born of a multiple birth or a singleton that stays in hospital with its mother for less than 10 days and is not accommodated in a special care nursery.

**Accommodation Definitions**

Level 3 Neonatal Intensive Care Facility:

A Level 3 Neonatal Intensive Care Unit is a separate and self-contained facility in a hospital capable of providing complex, multi-system life support for an indefinite period. The unit must be capable of providing mechanical ventilation and cardiovascular monitoring.

Criteria to Qualify for Treatment in a Level 3 Neonatal Intensive Care Unit:

One or more of the following criteria must be present if a newborn is to receive care in a L3 Neonatal Intensive Care Unit:

- Need for sustained assisted ventilation, either mechanical or continuous positive airway pressure;
- Need for cardio-respiratory monitoring for recurrent apnoea or bradycardia if condition is unstable;
- Extreme illness, e.g. sepsis, recurrent seizures;
- Need for parenteral nutrition by central line;
- Post major surgery, especially the first 24-48 hours; and
- During the first 48 hours of life if less than 30 weeks gestational age

Criteria to Qualify for Treatment or Care in a Level 2 Special Care Nursery:
One or more of the following criteria must be present if a newborn is to receive care in a L2 Special Care Nursery:
- There is a requirement for oxygen concentrations up to 40%);
- There is a need for continuous cardio-respiratory monitoring but the condition is relatively stable;
- There is a need for parenteral fluid therapy including via an umbilical arterial catheter;
- The newborn requires short term assisted ventilation to maintain the infant until the transport team arrives;
- There is a need for convalescent care following acute problems;
- There is a need for post minor surgery care for at least the first 24 hours;
- The newborn requires monitoring of transient problems, for example, observation of babies of drug addicted mothers; and
- There is a requirement for the monitoring of dying babies if parents do not wish the baby to stay with the mother.

Clinical Examples of Qualified and Unqualified Newborns

Example 1: Single Newborn

Baby is born at King Edward Memorial Hospital (KEMH) on 09/04/16. Then transferred from KEMH to a local health service on 14/04/16 and discharged on 25/04/16.

According to departmental policy a newly born baby remains unqualified for the first 9 days. However, on the 10th day (and thereafter), if baby remains in hospital the admission coding is changed to Acute.

So, for the newborn circumstances above the admission record would appear as follows:

09/04/18 to 19/04/18 – Unqualified Newborn
19/04/18 – A statistical discharge and re-admission should be processed changing care type to Acute for the remainder of the admission; and
19/04/18 to 25/04/18 – Acute Care, which means the newly born baby, is now a qualified newborn.

If the guardian of a qualified newborn elects the baby to be treated as a private inpatient, then they are chargeable at the private shared room rate, under this scenario from day ten.
**Example 2: Twins – Multiple Births**

The first twin is admitted as an unqualified newborn for the first 10 days and replicates the admission processes as described in Example 1.

The second twin is automatically admitted as a qualified newborn.

If the guardian of a qualified newborn elects the baby to be treated as a private inpatient, then they are chargeable at the private shared room rate, under this scenario from day one.
Chapter 7: Charging Liability

7.1. Waiver, Reduction or Write-Off of Fees and Charges

Waivers and Refunds


Write-Offs


Write Backs

A write back occurs if a debt is raised, but it is subsequently discovered that the debt is not legitimate; a reversal of the entry is required, instead of a write off.

This applies to patients who are found to be Medicare ineligible for insurance payments and are required to be admitted as public patients.

7.2. Medical Services and Treatment Exempt from Charges

Fees Related to the Diagnosis and Management of Tuberculosis and Leprosy

Patients do not incur any financial cost for the investigation of possible tuberculosis (TB) or Leprosy, or the management and treatment of proven TB or leprosy.

A key strategy in the control of chronic infectious mycobacterial diseases (TB and Leprosy) is the prompt and effective ‘free’ treatment. Ensuring that there is no financial barrier to investigation or treatment of these infections enables attendance and compliance and thereby reduces the risk of delayed diagnosis or poorly treated infection and therefore transmission in the community.

This policy is in line with the National Strategic Plan for TB in Australia: Beyond 2000 [National Tuberculosis Advisory Committee].

All fees and charges associated with TB and Leprosy management are to be ‘waivered’ by the Health Service managing the care of the client. These include, but are not exclusive of, radiology, pathology, pharmacy and inpatient charges.

All Public Hospital Pharmacies are required to provide drugs used for the treatment of TB or Leprosy ‘free of charge’ to the patient. The treating physician should annotate prescriptions to indicate that the drugs are for the treatment of TB and Leprosy and should therefore be dispensed ‘free of charge’.

Accounts for tests or inpatient charges in patients suspected of, or diagnosed with TB or Leprosy, should be ‘waived’. This policy especially applies to patients that are not Medicare eligible. Patients that receive accounts for these services should be advised to not pay them and the treating physician applies to the Director of Clinical Services in the relevant Health Service for the account to be ‘waived’.
Patients may be referred to the Tuberculosis Control Program for free investigation, drug therapy or management for TB and Leprosy.

All enquiries regarding fees and charges related TB and Leprosy can be directed to the Tuberculosis Control Program on telephone (08) 9222 8500.

**Charging Arrangements for Hospital Accommodation while an Admitted Overnight or Multi-day Inpatient is on Patient Leave**

If an admitted overnight or multi-day inpatient is statistically counted to be on a ‘Leave Day’ and they are not occupying a bed at midnight, no accommodation charges are to be raised.
Chapter 8: Fees and Charges Guidelines

8.1. Private Patients in WACHS Hospitals

In those hospitals that rely on general practitioners for the provision of medical services (normally small rural hospitals), eligible persons may obtain non-admitted patient services as private patients where they request treatment by their own general practitioner, either as part of continuing care or by prior arrangement with the doctor.

In most country hospitals, local general practitioners provide medical services, supported by resident and/or visiting specialists, as private practitioners. This situation has been in place prior to the existence of either the Australian Health Care Agreement or the NHRA. Local general practitioners are able to charge the patient a fee for the service provided, as a private patient. Under that arrangement, the patient can seek reimbursement from Medicare at the basic rate.

8.2. Provision of Medical Treatment on Compassionate Grounds

The attached guidelines are intended to offer clarity for the process of obtaining approvals for clinicians seeking to provide medical care to overseas patients sponsored by charitable organisations on compassionate grounds while also allowing Health Services and WA Health to anticipate the costs incurred by provision of such treatments. WA specialists seeking to accept overseas patients for medical treatments in WA on compassionate grounds are expected to have obtained prospective approvals from the relevant hospital executive director, Health Service Chief Executive and the Director-General for Health.

This guidance applies to both patients from countries with whom Australia shares and does not share reciprocal health care agreements.

- Patients from countries with which Australia does not share reciprocal health care agreements are not eligible for Medicare; the sponsoring charitable organisation is liable for all health care costs for the patient.
- Patients from countries which have reciprocal health care arrangements with Australia are not covered if the treatment was arranged prior to arrival in Australia or if the purpose of the travel is to receive medical treatment therefore the sponsoring charitable organisation is liable for all health care costs for the patient.

Eligibility Requirements for Patients

Proposed patients must have been granted or be eligible for a visa from the Department of Home Affairs permitting stays up to 3 months (Medical Treatment Visa – short stay subclass 675) or permitting stays between 3 to 12 months (Medical Treatment Visa – Long stay subclass 685) to enter Australia to obtain medical treatment. To obtain these visa patients would need to demonstrate that they have financial means to cover the cost of treatment in Australia, which may be in form of sponsorship by charitable organisation.
Eligibility Requirements for Procedures

Provision of medical care should not be at the expense of Australian residents. The following criteria need to be satisfied if the planned procedure is to be performed within Western Australia’s public health system:

- Intervention must be established and recommended treatments supported by a strong evidence base.
- The intervention proposed must offer a real prospect of success in this patient.
- Intervention is unavailable in patient’s home country

In obtaining approval from the hospital executive director, Health Service Chief Executive and Director-General; the WA specialist must provide:

- An indication of the duration and estimated cost of treatment proposed
- An indication regarding the nature of pre-intervention assessment
- The follow-up required
- The full cost of treatment including pre-intervention and follow-up phases
- Whether these costs will be met in full or partially by the referring charitable agency

Health Service Providers are to ensure that the estimated costs quoted in submission to Director General are correct and the provision of treatment is not at the expense of Australian residents. The health service Provider is to ensure that adequate services are available in the hospital to carry out the procedure and follow-up, and if the treatment requires a multidisciplinary approach then all the involved parties are in agreement.

The admitting specialist must advise the referring charitable organisation about estimated cost of treatment. The referring charitable organisation must provide their support in writing detailing the estimated cost they have agreed to sponsor.

8.3. Provision of Treatment to Medicare Ineligible Patients

At any given point of time, there are approximately one million overseas visitors in Australia (excluding New Zealand citizens). Some will require medical attention at a public hospital. Not all are eligible for Medicare coverage. The Health Services Act 2016, the Health Services (Fees and Charges) Order 2016 and the National Healthcare Agreement oblige Medicare ineligible patients to pay for their care.

Emergency and urgent treatment is to be provided to all patients regardless of Medicare eligibility as a duty of care. In addition, as it may not always be reasonable for long term visitors/temporary residents to travel to their home country for treatments, some Medicare ineligible patients may seek elective or non-urgent treatment. This operational guideline acknowledges the health service’s duty of care and seeks to ensure that where care is provided, measures are taken to enable later efforts of cost recovery. Having proper processes to determine eligibility enables cost recovery and reduces the risk of unpaid debt.
**Purpose of the Guidelines**

The purpose of this operational guideline is to ensure Health Services identify non-Medicare eligible (ineligible) patients at the point of admission and assess the ability of non-Medicare patients to pay for the full costs of care.

**Background**

Western Australian public hospitals are frequently requested to provide medical care for Medicare ineligible patients including:

- Overseas travellers
- International students
- Non-permanent residents of Australia including holders of business, retirement and family visas and;
- Medical tourists who deliberately enter Australia to access treatment.

The insurance coverage and eligibility for Medicare for each of the above groups varies and many patients do not have any form of health cover. WA Health has identified several issues which hamper later efforts at cost recovery. These issues include:

- Failure of Health Services to identify Medicare status of patients on presentation or admission
- Failure of Health Services to assess the ability of a Medicare ineligible patient to pay (in full or part) for treatment and
- Failure of Health Services to collect appropriate information to ensure successful debt collection.

As a consequence, Health Services are unable to commence debt recovery procedures for treatment costs when a Medicare ineligible patient does not pay for treatment. In other instances, Health Services have been obliged to consider waiving costs part-way through treatment to permit continuing care. Both issues frequently result in WA Health off-setting the cost of treatment provided to Medicare ineligible patients.

**Medicare Eligibility**

Medicare Eligibility must be determined at the time of admission. Medicare entitlement is not automatic and a person needs to apply for enrolment. A Medicare number may be issued on the day of application. Patients, who are eligible for Medicare but have not yet applied for a Medicare number, should be encouraged to apply as soon as possible.

Generally, Medicare eligibility is restricted to people living permanently in Australia who are:

- Australian citizens (who are resident in Australia)
- Permanent Australian residents (who have permanent visas)
- New Zealand citizens
- persons with applications for permanent visas under consideration (excluding applicants for aged parent visas -subclass 804), who also have:
authority from Department of Immigration and Border Protection (DIBP) to work, or are
an Australian citizen or permanent resident spouse, parent or child.

While overseas visitors and temporary residents generally do not have access to Medicare, there are exceptions. The WA Health Services Fees and Charges Manual and the Reciprocal Health Care Agreements (RHCA), describe these exceptions and provide guidance on how to determine Medicare eligibility. These exceptions include:

- Visitors from countries with which Australia has a RHCA. These visitors have restricted access to Medicare
- A person or classes of person declared by the Commonwealth Minister of Health to be Medicare eligible and
- Some asylum seekers.

**Provision of Care**

Emergency care and urgent treatment should be provided, irrespective of Medicare eligibility as a duty of care.

**Emergency Treatment**

Patients requiring emergency or urgent treatments will be treated in a comparable manner to Medicare eligible WA patients. This applies regardless of their Medicare eligibility, other health or travel insurance coverage or whether the patient (or proxy) agrees to pay treatment costs.

The relevant HSP will attempt to recover the cost of providing emergency or urgent treatments to non-eligible Medicare patients retrospectively. Appropriate processes should be in place to receive payment from the patient or obtain approval for payment from the travel insurer, for the urgent treatment provided to the patient prior to discharge from the health care facility. To facilitate this, such patients should be clearly identified and appropriate documentation collected. If a patient continues to require further treatment after emergency care has been provided, the process in Section 8.3 regarding provision of non-urgent care should be followed.

**Urgent Treatment**

Where treatment, although not medically necessary, cannot be deferred until the patient returns home or where there is a risk that a pre-existing or new medical condition may deteriorate into a life-threatening condition without timely treatment, patients should receive medically necessary care. The hospital should ascertain the patient’s Medicare eligible status. If the patient is Medicare ineligible, insurance coverage should be determined. Where appropriate, an upfront payment should be sought. Otherwise the provision of credit card or other personal payment details or approval from the travel insurer must be taken to cover the estimated treatment cost. The appropriate process in Section 8.3 should be followed.
Treatment of Patients with a Notifiable Infectious Disease

The provision of free treatment for patients with certain notifiable infectious diseases is mandated in all Australian states and territories, in order to protect public health. In WA, treatment is provided free of charge care for overseas patients admitted to public hospitals with tuberculosis or leprosy. Additionally, the Public Health Act 2016 provides for the free treatment of patients with a notifiable infectious disease. A list of Notifiable Infectious Diseases is located: [http://www.health.gov.au/internet/main/Publishing.nsf/Content/cdna-casedefinitions.htm](http://www.health.gov.au/internet/main/Publishing.nsf/Content/cdna-casedefinitions.htm)

All fees and charges associated with the treatment of these diseases, including patients who are Medicare ineligible, are to be waived by the Health Service.

Further information regarding tuberculosis and leprosy can be found in section 7.2.

Reference: Public Health Act 2016 s88 5(d) and 6(b)

Provision of Non-urgent or Extended Treatment

In the case of non-urgent or extended treatment, health services should adopt processes akin to that of private facilities in ensuring costs of treatment are met.

Where patients are Medicare ineligible or do not have private health or travel insurance coverage, up-front payment of anticipated treatment costs should be obtained two weeks prior to admission as per the Financial Management Manual.

Process for Accepting Patients not Eligible for Medicare

Please refer to [Schedule E, Appendix E](#) (Flowchart on Medicare Eligibility)

Clinician’s Responsibilities

- The admitting medical practitioner determines the urgency and necessity for treatment.
- To enable efficient and timely decision making, it is important that the medical practitioner work with the hospital executive team and provide information on the nature of treatments required, duration and cost estimates. This should include information on the nature of pre-intervention assessment, the follow-up required and the estimated total cost of treatment including pre-intervention and follow-up phases.
- It is the medical practitioner’s responsibility to ensure that approval for treatment (apart from the infectious diseases listed in section 2.5) is obtained from their Health Service Operations Manager or equivalent, Executive Director all Health Services, Chief Executive Metropolitan Health Service, Regional/Chief Executive WACHS.
- If the estimated cost of treatment exceeds $100,000, once approval has been obtained from the Chief Executive Metropolitan Health Service or Regional/Chief Executive WACHS, the signed submission form is to be forwarded to the Board of the relevant Health Service Provider for information.
Approval to incur costs should be based on the estimated costs as per the following table:

<table>
<thead>
<tr>
<th>Estimated Costs</th>
<th>Approval Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \leq $10,000 )</td>
<td>Operations Manager, or equivalent, Health Service</td>
</tr>
<tr>
<td>$10,000 and ( \leq $50,000 )</td>
<td>Executive Director, all Health Service</td>
</tr>
<tr>
<td>$50,000</td>
<td>Chief Executive, Metropolitan Health Service or Regional / Chief Executive WACHS</td>
</tr>
<tr>
<td>$100,000</td>
<td>For information – Board of relevant Health Service Provider</td>
</tr>
</tbody>
</table>

Once a Medicare ineligible patient is admitted, information must be submitted to the responsible department in the hospital.

**Hospital Responsibilities**

- It is recommended that health services establish treatment cost thresholds to support clinicians in their decision making for admission.
- Hospitals need to ensure that the provision of treatment would not disadvantage Australian residents.
- Upon admission (and/or leading to acceptance for care), the hospital should confirm a patient’s identity and eligibility status.
- Hospitals need to ensure that the written estimated costs are as correct as possible and that the patient has provided informed written financial consent.
- Hospitals need to ensure that either:
  - the payment is made two weeks in advance of admission, and / or
  - the patient is adequately covered by a private health insurance, and / or
  - sufficient identification information has been gathered to enable billing and debt recovery, and / or
  - pre-approval from the travel insurer has been sought and received.
- Hospitals should apply normal debt recovery and / or assurance of payment policies to facilitate the full payment of hospital fees. This may require one of the following methods:
  - taking credit card details and verification of available limits sufficient to cover estimated medical costs,
  - cash deposit or bank cheque to that amount, or
  - guarantee from a patient’s health insurance fund or referring agency.
- All hospitals, health services and clinical departments need to ensure adequate systems are in place with staff appropriately trained to:
o ensure Medicare ineligible patients are identified
o ensure patients are informed of their liability for the costs of treatment. This should be with written information and staff should have the knowledge and skills to convey such information and obtain informed financial consent
o interview patients to establish whether they are exempt from charges or liable for charges
o issue invoices.

Role of Delegated Officers

Hospitals are expected to identify specific staff to familiarise themselves with the contents of this document. The delegated officer would:

- counsel a patient about their entitlements and estimated costs of their treatment
- ensure that patient and clinician are aware of the patient’s Medicare ineligibility
- advise the patient about the option of receiving treatment in a private facility
- complete necessary forms for record keeping, information and audit purposes
- collect specific identification information from admitted patients according to circumstances, i.e. temporary Medicare number, passport and visa, sponsor details, address in Australia and overseas, travel insurance details
- liaise with external agencies like the Department of Home Affairs and the Health Insurance Commission to determine eligibility and travel insurance agency to obtain pre-approval for treatment costs.

HSPs will process all such accounts relevant to the hospitals that fall under their Health Service. They may also be contacted for specific advice.

Treatment Costs

Patients need to have written information on the estimated costs and eligibility of medical treatment.

It is the responsibility of the medical practitioner accepting a patient, to ensure that the patient is informed of all anticipated costs. The Medical practitioner should work with the delegated officer to ensure that this information is provided to the patient or referrer.

Clinicians and clinical departments need to refer to the current Health Services Fees and Charges Manual for detailed information on accommodation and associated medical services costs for prospective medical treatment.

Note: the Fees Manual only details hospital fees. It excludes clinicians’ fees, for which overseas visitors will be liable and which cannot be charged against the MBS. If a salaried doctor provides the service, it is recommended that medical practitioners use the AMA List of Medical Services and Fees as a basis for charging for medical treatment.

Additionally, patients need to be advised of other associated costs: pathology and imaging, surgically implanted prostheses, prostheses and orthoses, transport and medical escorts.
Where pre-operative assessment and follow-up are required, these should be considered in the cost of medical care.

The published Diagnosis Related Groups codes may assist in estimating the cost of a procedure.

**Billing and Debt Recovery**

Invoices should be issued to all patients not eligible for Medicare or where Medicare eligibility cannot be determined. HSPs will process all such accounts.

Defaulters will be recorded and debt recovery measures will be undertaken as appropriate.

**Appeal Process**

HSA enables the State Minister for Health, notwithstanding any other provision of the Act, where the Minister thinks it reasonable to do so, having regard to the means of the person indebted and the circumstances of the case, may reduce or waive payment of any fees for hospital service that would otherwise be payable.

Doctors can choose to waive their private billings but the hospital costs can only be waived by the Minister for Health.

**Accountability and Record Keeping**

Health services should make normal provisions for keeping updated records of treatment of Medicare ineligible patients. This information would be reported to the Director General annually. Special forms may need to be designed to collect data from Medicare ineligible patients.

**8.4. Provision of Aids, Equipment, Home Assessment & Home Modification Services for DVA Entitled Persons**

**Policy**

The Hospital Services Arrangement (HSA) between the Department of Veterans’ Affairs and Western Australia (WA) ensures that Entitled Persons receive a range of admitted and non-admitted hospital services in WA Funded Hospitals. Hospital staff can access the relevant details of the HSA here:


This arrangement covers the requirements for aids or equipment on discharge for admitted patients and non-admitted patients, including any required home assessment and home modification.

If an Entitled Person requires aids or equipment during their hospital stay, the items are part of the inpatient service and DVA should NOT be invoiced for the costs.

Where an Entitled Person is already in receipt of aids or equipment from the DVA prior to admission, the DVA will continue to provide the items upon discharge. Aids or equipment may be loaned to an Entitled Person on either a short-term or long-term arrangement.
Items issued under RAP are generally designed specifically for people with an illness or disability.

**Definitions**

‘Entitled person’ means a person who has elected to be treated under DVA arrangements and:

a) has been issued with:
   - a Gold Card, or
   - a White Card, or
   - an Orange Card (pharmaceuticals only), or
   - a written authorisation on behalf of the Repatriation Commission, or

b) is a Vietnam Veteran or his / her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

**Overview**

The Rehabilitation Application Program (RAP) is an Australian Government Program administered by the Department of Veterans’ Affairs (DVA). It provides aids and appliances to eligible veterans in their homes to enable them to maintain their functional independence.

**Products and services are supplied under six categories:**

- Continence
- Mobility and Functional Support
- Home Medical Oxygen
- Diabetes
- Personal Response Systems
- Continuous Positive Airway Pressure


Gold Card holders are eligible to receive aids and appliances subject to assessed clinical need.

White Card holders are eligible to receive aids and appliances subject to assessed clinical need in relation either to a disability accepted by DVA as service-related, and/or cancer, tuberculosis, anxiety, depression and post-traumatic stress disorder, whether or not these conditions are accepted by DVA as service-related. Further DVA information can be found here: [https://www.dva.gov.au/factsheet-hip72-providers-rehabilitation-appliances-program](https://www.dva.gov.au/factsheet-hip72-providers-rehabilitation-appliances-program)

The RAP Schedule contains details on the most appropriate allied health professional to assess/prescribe specific items or services. However, in cases where an allied health professional is not available, a GP is able to assess the veteran.
Where a home assessment is required prior to undertaking the home modification, hospitals should record the service as a community service in webPAS, HCARe and the Allied Health System. The DVA Management Unit, Department of Health will manage the cost recovery on behalf of all WA Funded Hospitals for this item. This excludes assessments undertaken by the Aged Care Assessment Team.

The RAP National Schedule lists items available through RAP.

The RAP Schedule is arranged by aid/appliance type (beds, wheelchairs etc.) and provides detailed information on eligibility, clinical assessment, functional criteria, contraindications, and Residential Aged Care Facility (RACF) and Community Aged Care Package (CACP) recipients. The entitled person’s responsibilities with regard to safe usage, care, maintenance and transport (if applicable) are also detailed.

There are items on the RAP Schedule that require prior approval by DVA. The RAP Schedule lists these items and any criteria that might need to be met in order for the item to be provided.

DVA has implemented national supply models for products in the Continence, Mobility and Functional Support, Home Medical Oxygen Therapy, and Personal Response System categories. This ensures that prices, service provision and reporting arrangements are consistent from State to State.

Several different suppliers are available within each group/class of equipment. For example, within the Mobility and Functional Support (MFS) category the suppliers contracted to provide products and services are Aidacare, Allianz Global Assistance, Country Care Group, and BrightSky.

Diabetes products are listed in the RAP Schedule.

Further information is available under the ‘Schedule and Guidelines’ link on the RAP website.

The ‘Provider Factsheets and Forms’ link on the RAP website contains order forms as well as contact details for contracted suppliers.

You may need to complete an assessment / application form in addition to an order form. Forms can be found here:

https://www.dva.gov.au/providers/forms-service-providers

Guidelines for specific categories, if available, can be accessed by clicking on the category name on the left-hand menu of the RAP websites.


**Home Modifications and Household Adaptive Appliances**

The Home Modifications section of the website contains an OT Assessment form, Information for Prescribers and veterans on major modifications, a direct order form, and an Authority to Install form. Please also refer to the DVA Factsheet HIP72 Rehabilitation Appliances Program for Providers:

RAP and Residential Aged Care

Entitled persons receiving high level care in an Australian Government funded residential aged care facility (RACF) are not generally provided with RAP aids and appliances. DVA does, however, routinely provide a range of items to entitled persons in low-level care. These may include custom made wheelchairs, continence products, low vision aids, compression stockings and medical grade footwear.

When an entitled person moves from low-level care to high-level care, RAP items previously issued may be taken with them subject to the approval of the RACF. DVA will maintain responsibility for the repair, maintenance and replacement of such items. Entitled persons receiving Extended Aged Care at Home (EACH) services or Community Aged Care Packages (CACP) are able to access RAP items where the service provider is not legally required to supply them.

Further information is available by calling the My Aged Care Contact Centre on 1800 200 422.

If your hospital does not have a contract with a RAP provider, please follow these steps.

The list of available items and equipment is derived from Schedule 3 of the GST Act. To access the Schedule, please click on the link below.

Schedule of Aids and Equipment

If the item’s cost is $500 or less, the hospital should supply the item and then invoice DVA. If the item’s cost is greater than $500 the hospital should then contact DVA for prior approval (contact details below). DVA will then advise whether they approve, or arrange alternative provision of the item directly through their suppliers.

The list is not exhaustive therefore, if the patient requires an item that is not in the list, hospitals should provide the item and the approval process applies if the cost is more than $500.

Should you have any additional queries or would like more information, please contact the DVA Provider Hotline:

1300 550 457 (metropolitan areas), or 1800 550 457 (regional areas) and, Select Option 1 for RAP.

8.5. Inter-Hospital Transport Arrangements for DVA Entitled Persons

Background

The Hospital Services Arrangement (HSA) between the DVA and Western Australia (WA) covers inter-hospital transport across WA for treatment purposes relating to the Entitled Person’s episode of care.

Policy

The WA-DVA Hospital Services Arrangement (HSA) ensures that DVA EP receive a comprehensive range of admitted and non-admitted patient services. Hospital staff can access the relevant details of the HSA here: http://www.health.wa.gov.au/dva_management/home/
The DVA contracts with Day Procedure Centres (DPCs), public hospitals, and private hospitals under a Tier 1 arrangement.

**Tier 1 hospitals** (including mental health facilities) and DPCs are facilities where admission of Entitled Persons does not require prior approval from DVA. All WA public hospitals are Tier 1 facilities. In addition, DVA has contracts with a number of private hospitals.

**Tier 2 hospitals** are private facilities where all admissions of Entitled Persons requires prior financial authorisation from DVA. These hospitals are used when treatment cannot be provided within a reasonable time in the Tier 1 hospitals. Currently no private hospitals are contracted under these arrangements.

All other private facilities are categorised as **Tier 3** where admission requires prior financial authorisation from the DVA and would only be granted if the treatment is not available or cannot be provided in the Tier 1 facilities.

**Definitions**

‘Entitled person’ means a person who has elected to be treated under DVA arrangements and:

a) has been issued with:
   - a Gold Card, or
   - a White Card, or
   - an Orange Card (pharmaceuticals only), or
   - a written authorisation on behalf of the Repatriation Commission, or

b) is a Vietnam Veteran or his/her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

**Roles and Responsibilities**

Inter-hospital transport refers to transfers of admitted and emergency patients between hospitals using road ambulance, Royal Flying Doctors Service (RFDS), Emergency Rescue Helicopter Service (ERHS), commercial flights, taxi in the metropolitan area, and taxi or other forms of patient transport in regional/remote areas. It also includes emergency transfer from nursing posts1 to a WA Funded Hospital.

Eligible DVA patients are entitled to all modes of inter-hospital transport that are available to all other patients. The inter-hospital transport arrangements in this circular do not cover transport costs of next of kin travelling with the patient.

When arranging inter-hospital transport, hospitals are required to notify the DVA Transport Bookings line on 1300 550 455 (metro areas) or 1800 550 455 (regional areas).

Inter-hospital transport includes transfers of admitted and emergency patients from a:

- WA Funded Hospital to another WA Funded Hospital
- WA Funded Hospital to a Tier 1 private facility
- WA Funded Hospital to a Tier 3 private hospitals where DVA has approved the transfer
- WA Funded Hospital to the airport where the patient is to be transported by air to another WA Funded Hospital
- Airport to a WA Funded Hospital
- Nursing post to a WA Funded Hospital
- WA Funded Hospital to a Transition Care facility and
- Transition Care facility to a WA Funded Hospital (and return) for medical appointments and/or treatment relating to the patient’s episode of care.

**Responsibilities of Hospitals**

a) Identify DVA treatment entitlements

All DVA patients must be asked whether they are treatment entitled according to the guidelines in ‘Identification of DVA Entitled Persons’.

Where entitlement could not be established before arranging the transport due to the patient’s clinical condition or if the event has occurred after hours (including weekends or public holidays), hospitals should verify the veteran’s entitlements the next business day or no later than five (5) working days and advise accordingly the:

- Ambulance provider if the patient was transported by road ambulance; or
- DVA if the patient was transported by commercial flight.

b) Determine the appropriate mode of transport based on the patient’s clinical condition.

c) Obtain financial approval from DVA, call 1300 550 457 (metro areas) or 1800 550 457 (regional areas) prior to booking the transport from a WA Funded Hospital to a Tier 2 or 3 facility. If approval is granted, DVA will arrange all transports and process all associated costs.

d) Notify the DVA Transport Bookings line by calling 1300 550 455 for:

- taxi within the metropolitan area
- appointments unrelated to the current episode of care.

For commercial flights, call 1300 550 455.

Non-metropolitan areas

Taxi may be used in some regional areas. Authorisation must be given by DVA before transport. Some remote regions may have other methods of transport. DVA should be contacted in these cases for review - call 1800 550 455.

Failure to check treatment entitlements and/or notify the DVA where required, could result in hospitals retrospectively paying for the cost of inter-hospital transport for Entitled Persons.

e) Booking of required transport
**Road ambulance**

The ‘fee for service’ for all admitted DVA patients requiring non urgent road based inter hospital patient transport will be met by the sending hospital. All hospitals will need to comply with relevant directives and policies around the use of providers.

St John Ambulance Australia (SJAA) is DVA’s preferred provider and will be contacted in the first instance. If SJAA decline the pickup location, do not provide coverage in the required region or the requested location is Halls Creek, Fitzroy Crossing or Derby then under these circumstances the hospital should contact WACHS Ambulance service.

Exceptions to fees for services are for Admitted patients requiring Inter Hospital Transport via road Ambulance when community services are required. In this case, the DVA Transport Bookings line should be contacted (1300 550 455 for metro and 1800 550 455 for regional) for eligibility determination and approval as DVA is responsible for this transportation and costs incurred.

Non Admitted patients: DVA entitled patients requiring clinically deemed necessary non urgent Road Ambulance Transport between Public Hospitals, Public Mental Health inpatient facilities, Private Health care facilities or Community facilities will call the DVA Transport Bookings line for eligibility determination and approval, or alternative methods arranged. DVA is responsible for the costs of patient transport under these circumstances. Generally DVA will arrange the transport via SJAA if approved.

Hospitals will provide the name and DVA file number of the Entitled Person to book an ambulance. If the DVA number is not recorded then the associated costs cannot be recovered.
## Summary Table of Financial Responsibility for Ambulance Transport for DVA eligible patients

<table>
<thead>
<tr>
<th>Transport From</th>
<th>Transport To</th>
<th>Responsible For Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health Facilities-admitted patients</strong></td>
<td>Public Hospital or public mental health facility</td>
<td>Sending Hospital</td>
</tr>
<tr>
<td></td>
<td>Diagnostic or public day procedure service</td>
<td>Sending Hospital</td>
</tr>
<tr>
<td></td>
<td>Private Health Facilities</td>
<td>Sending Hospital</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>DVA</td>
</tr>
<tr>
<td><strong>Public Health Facilities-non admitted patients</strong></td>
<td>Public Hospital or public mental health facility</td>
<td>DVA</td>
</tr>
<tr>
<td></td>
<td>Private Health Facilities</td>
<td>DVA</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>DVA</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Public Healthcare facilities</td>
<td>DVA</td>
</tr>
<tr>
<td></td>
<td>Private Healthcare facilities</td>
<td>DVA</td>
</tr>
<tr>
<td></td>
<td>Receive treatment at a medical facility, to receive diagnostic services, to attend appointments at non-admitted patient clinics or to return the patient to their point of origin following such transport and to be transported from one aged care residence to another providing the receiving aged care residence will provide a higher level of care.</td>
<td>DVA</td>
</tr>
<tr>
<td><strong>Private Health care facilities</strong></td>
<td>Public Hospital or public mental health facility</td>
<td>DVA</td>
</tr>
<tr>
<td></td>
<td>Diagnostic or public day procedure service</td>
<td>Sending Hospital</td>
</tr>
<tr>
<td></td>
<td>Private Health facilities</td>
<td>DVA</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>DVA</td>
</tr>
</tbody>
</table>
RFDS (where clinically required)
This arrangement covers RFDS transfers from remote and rural areas to the nearest hospital in the rural or metropolitan area, using the hospital booking process.

Note: Where a patient is transported by air and then taken to a hospital by road ambulance, the air transfer will be recorded as it takes priority over other modes of transport.

Emergency Rescue Helicopter Service (ERHS) (where clinically required)
The arrangement described in IC 0014/07 or as amended from time to time as applicable. Hospitals should advise SJAA that the patient is DVA-entitled to ensure that bills are sent to the DVA and not to the hospital. Payment for this service will be administered between DVA and SJAA.

Commercial flight (where medically certified)
Notify the DVA Transport Bookings line on 1300 550 455 for metro and 1800 550 455 for regional (during normal business hours) of the need to use a commercial flight. The DVA will be responsible for booking the flight, not the hospital. However, if the transport is required after hours including weekends and public holidays, hospitals should arrange the flight using the approved hospital booking process. Then advise the DVA Transport Bookings line of the transaction on the next business day or no later than five (5) working days. All relevant information including patient details, DVA number, flight details, hospital details and any other information will need to be provided to the DVA. Please use the hospitals standard procedures for collecting and recording this information.

Depending on the local hospital's policy, this information will either be processed locally or will need to be forwarded to the section responsible for hospital billing and invoicing.

Some regional hospitals may need to contact WACHS Patient Assisted Travel Scheme (PATS) staff to assist in this process. Local hospital staff should check with their internal systems to confirm the correct method to use. This method may change with time or differ between hospitals and regions.

Hospitals or other sections should forward the tax invoice for the cost of the flight directly to the DVA Transport Unit. The tax invoice must be accompanied by the required information detailed in the attachment to this circular. The DVA will make payments directly to the requesting party against the tax invoice if the transport has been approved.

Taxi services (where clinically appropriate)

Metropolitan areas
Taxi service is covered if the doctor determines that it is clinically appropriate. Hospitals should notify the DVA Transport Bookings line on 1300 550 455 of the need to use a taxi and DVA will book the transport and pay for the cost.

Regional areas
For regional areas, DVA should be contacted on 1800 550 455 and advice will be given on the best mode of transport.
Appointments unrelated to the current episode of care

Inter-hospital transport to and from appointments unrelated to the current episode of care (e.g. eye or dental) is not usually covered under this arrangement. Therefore, unless there is a medical need or other compelling reason, the patient is expected to reschedule any appointments booked prior to admission. Where it is necessary for appointments to be kept or in cases of long stay patients where appointments may need to be made during the course of the admission, the patient should:

- obtain a doctor’s clearance to leave the hospital to attend an appointment; and
- arrange for their own transport or hospital staff should notify the DVA Transport Bookings line on 1300 550 455 of the appointment. If agreed, DVA will arrange and pay for the transport.

**Reporting Requirements**

All hospitals should record all inter-hospital transfers in the Entitled Person’s record in the relevant feeder system under ‘Source of Referral-Transport’ using the current values in the Hospital Morbidity Data System (HMDS) Manual. The Department of Health is using this information as part of its reporting requirement to the DVA under the terms of the HSA.

The HMDS values are as follows:

1 = Private / public transport
2 = Hospital transport
3 = Ambulance – emergency
4 = Royal Flying Doctor Service
5 = Helicopter (evacuation)
6 = Other (includes commercial flight)

**Note:** Where a patient is transported by air and then taken to a hospital by road ambulance, the air transfer should be recorded as it takes priority over other modes of transport.

**8.6. Invoicing for Inter-Hospital Transport using Commercial Flights for DVA Entitled Persons**

All WA Funded Hospitals that utilise commercial flights for inter-hospital transport of DVA Entitled Persons after hours, weekend or public holidays should endeavour to collect the following information for their own internal reference and provide this to the DVA on the next business day (or no later than five (5) working days) when seeking approval.

**HOSPITAL DETAILS**

ABN:
Hospital Name:
Hospital Address:

**PATIENT DETAILS**
8.7. Loan Equipment for DVA Entitled Persons

Overview

This guideline outlines the arrangement for the provision of loan equipment for DVA Entitled Persons. This arrangement covers admitted patients on discharge and non-admitted patients.

Policy

The Hospital Services Arrangement (HSA) between the DVA and Western Australia (WA) ensures that Entitled Persons receive a range of admitted and non-admitted hospital services in WA Funded Hospitals. Hospital staff can access the relevant details of the HSA here:


This arrangement covers the requirements for aids or equipment on discharge for admitted patients and non-admitted patients. Hospitals should refer to related policy documents and authorization from the DVA Health Provider Hotline 1300 550 457.

If an Entitled Person requires aids or equipment during their hospital stay, the items are part of the inpatient service and DVA should NOT be invoiced for the costs.
Where an Entitled Person is already in receipt of aids or equipment from the DVA prior to admission, the DVA will continue to provide the items upon discharge. Aids or equipment may be loaned to an Entitled Person on either a short-term or long-term arrangement.

Where an Entitled Person is NOT in receipt of aids or equipment from the DVA prior to admission, the hospital will contact the DVA (DVA Health Provider line: 1300 550 457 (metropolitan areas) or 1800 550 457 (non-metropolitan areas), pre discharge and seek approval to arrange appropriate equipment as per the patient’s clinical need.

If the loan equipment is approved by the DVA, no further action will be required by the hospital staff. The DVA will arrange for delivery and address any costs relating to this equipment.

Should the loan equipment request be rejected by the DVA, the hospital staff will follow normal hospital policy and procedures for issuing loan equipment to patients.

**Definitions**

‘Entitled person’ means a person who has elected to be treated under DVA arrangements and:

a) has been issued with:
   - a Gold Card, or
   - a White Card, or
   - an Orange Card (pharmaceuticals only), or
   - a written authorisation on behalf of the Repatriation Commission, or

b) is a Vietnam Veteran or his/her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

To determine whether the patient’s condition is approved, please follow the steps below:

**Financial Authorisation – Gold and White Card Holders**

**How to obtain DVA financial authorisation**

a) Make sure you have the patient’s name, DVA card colour and file number, and information about the treatment or procedure required.

b) Ring the DVA Health Provider line: 1300 550 457 (metropolitan areas) or 1800 550 457 (non-metropolitan areas).

c) From the series of prompts, select Option 3 ‘Prior approval, eligibility checks and provider registration’.

d) This will lead to three further options. Select Option 1: ‘Prior approvals, eligibility checks, and all general Medical & Allied Health queries’. The information required by DVA will depend on the nature of the condition(s) for which the patient requires the loan equipment.

e) If approved, the DVA will provide confirmation accordingly.

f) If approval is not granted the loan equipment should be provided to the patient as per public patient procedures.
Loan Equipment and Residential Aged Care

Entitled persons receiving high level care in an Australian Government funded residential aged care facility (RACF) are not generally provided with loan equipment. DVA does, however, routinely provide a range of items to entitled persons in low-level care. These may include custom made wheelchairs, continence products, low vision aids, compression stockings and medical grade footwear.

When an entitled person moves from low-level care to high-level care, Rehabilitation Appliances Program (RAP) items previously issued may be taken with them subject to the approval of the RACF. DVA will maintain responsibility for the repair, maintenance and replacement of such items. Entitled persons receiving Extended Aged Care at Home (EACH) services or Community Aged Care Packages (CACP) are able to access loan equipment where the service provider is not legally required to supply them.

Further information is available by calling the My Aged Care Contact Centre on 1800 200 422.

Should you have any additional queries or would like more information, please contact the DVA Provider Hotline:
1300 550 457 (metropolitan areas), or
1800 550 457 (regional areas) and,
Select Option 1 for RAP.

8.8. Billing for Selected Services Provided to DVA Entitled Persons

Overview

This guideline outlines the billing arrangements between Western Australia (WA) and the Department of Veterans’ Affairs (DVA) for pharmaceuticals, nursing home type patient (NHTP) contribution for ex-Prisoners of War (POW) and Victoria Cross (VC) recipients and post discharge services provided to Entitled Persons.

Policy

The Hospital Services Arrangement (HSA) between the DVA and WA ensures that Entitled Persons receive a range of admitted and non-admitted hospital services in WA Funded Hospitals. Hospital staff can access the relevant details of the HSA here:

Definitions

‘Entitled person’ means a person who has elected to be treated under DVA arrangements and:

a) has been issued with:
   ▪ a Gold Card, or
   ▪ a White Card, or
   ▪ an Orange Card (pharmaceuticals only), or
• a written authorisation on behalf of the Repatriation Commission, or

b) is a Vietnam Veteran or his/her dependent who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

**Roles and Responsibilities**

**Pharmaceuticals**

Entitled Persons will have the same access to pharmaceuticals as other admitted and non-admitted patients. Where an Entitled Person requires access to:

a) Highly Specialised Drugs (HSD)
b) Pharmaceuticals under the Special Access Scheme (SAS)
c) Pharmaceuticals not included in the hospital drug formulary

The hospital should first seek financial authorisation from the DVA by calling the Veterans’ Affairs Pharmacy Advisory Centre (VAPAC) on 1800 552 580. If approval for supply of these pharmaceuticals is granted, DVA should be invoiced for the cost.

Under the Pharmaceutical Benefits Scheme Reform Program, hospitals may charge a patient co-payment for pharmaceuticals provided (to admitted patients) on discharge or as a non-admitted patient.

**NHTP Contribution for ex-POWs and VC recipients**

Entitled Persons who are admitted as, or reclassified to, NHTP would be charged a patient contribution in line with the provisions of the Health Insurance Act 1973. If the patient is an ex-POW or a VC recipient, the DVA should be invoiced for the patient contribution.

The POW status is usually shown on the gold card, however, if there is some doubt contact DVA on 1300 550 457 (metropolitan callers) or 1800 550 457 (regional callers) to confirm. NHTP contributions for non-ex-POWs should be billed directly to the Entitled Person and they cannot recover the cost from the DVA.

**Post Discharge Services**

Where an admitted Entitled Person requires post discharge care, hospitals are encouraged to refer them to DVA-contracted health service providers. A list of providers for the relevant area can be obtained by contacting DVA on 1300 550 457 (metropolitan callers) or 1800 550 457 (regional callers).

If the DVA advises that there are no DVA-contracted providers in the area, hospitals should seek approval by contacting 1300 550 457 (metropolitan callers) or 1800 550 457 (regional callers) to provide the service themselves or arrange for the service to be provided by their subcontractors. Upon approval, the hospital should arrange the required service and the DVA should be invoiced for the cost.

The DVA Discharge Planning Resource Kit, which provides more information about post discharge services for Entitled Persons, can be accessed via the DVA website.

Entitled Persons may be eligible to access the Veterans’ Home Care (VHC). More information about VHC is available by calling 1300 550 450 or the DVA website.
Invoicing and Payment Process

The Health Support Services (HSS) will process all invoices on behalf of all metropolitan hospitals. Rural hospitals will continue to process their invoices as per current practice.

Metropolitan hospitals should provide HSS with a 'charge sheet' with the relevant hospital and patient details including the DVA card colour and file number, and the description and charge of the items. The HSS will use the information to produce a tax invoice, which will be sent to DVA. Where a metropolitan hospital engages a subcontractor to provide the post discharge service, the steps below should be followed. This will enable HSS to pay the subcontractor and the DVA to pay HSS. Hospitals should:

- authorise the subcontractor's invoice
- complete Form AP1 (Payment Request Form) and attach a copy of the invoice
- complete Form S60 (Debtor Advice Form) and attach another copy of the invoice and submit both forms to HSS for processing.

Rural hospitals should raise the tax invoice and complete the relevant attachment at the end of this circular as per current practice.

Where a rural hospital engages a subcontractor to provide the post discharge service, current practice continues where the subcontractor send the invoice to the hospital and the hospital pays the subcontractor. The hospital, in turn, invoices the DVA for the cost of the service, and DVA pays the hospital.

The DVA will make payments against the tax invoice directly to HSS (for metro hospitals) and to rural hospitals.
# Overview Fees and Charges for Admitted Patients

<table>
<thead>
<tr>
<th>Patient Payment Classification</th>
<th>Same Day Fee per Day</th>
<th>Overnight Fee per Day</th>
<th>Outpatient Fee per Service</th>
<th>Emergency Department Triage Fee</th>
<th>Ventilator Dependant</th>
<th>Airway Management</th>
<th>NHTP</th>
<th>NHTP Patient Contribution</th>
<th>Surgically Implanted Prostheses</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Specialised Orthoses</th>
<th>Drugs and Medication</th>
<th>Medical Services</th>
<th>Notifiable Sexually Transmitted Disease Management</th>
<th>Home Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Patients</td>
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<td>No Charge</td>
<td>N/A</td>
<td>No Charge</td>
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<tr>
<td>Private Patients – Shared Room</td>
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<tr>
<td>Private Patients – Single Room</td>
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<td>$661</td>
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<td>Note 10</td>
<td>Note 3</td>
<td>Note 5</td>
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<td>Note 8</td>
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</tr>
<tr>
<td>Nursing Home Type Patients</td>
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<td>N/A</td>
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<td>$61.30</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Private Nursing Home Type Patients (Insurer Pays $138.10)</td>
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<tr>
<td>Eligible War Service Veterans</td>
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<td>Note 11</td>
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<td>Note 11</td>
<td>Note 11</td>
<td>N/A</td>
<td>$61.30 or DVA pays if POW or VC. See s5.4 and s5.5</td>
<td>Note 11</td>
<td>Note 7</td>
<td>Note 7</td>
<td>Note 11</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>See s8.4</td>
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</tr>
<tr>
<td>Compensable Patients (includes Motor Vehicle CISS but excludes other MV and DVA)</td>
<td>$3,014</td>
<td>$2,704</td>
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<td>$6,540</td>
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<tr>
<td>Motor Vehicle Third Party Insurance (MVTPI) Patients</td>
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<tr>
<td>MVTPI Patients attending at Perth Children’s Hospital</td>
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<td>Medicare Ineligible Patients</td>
<td>$2,580</td>
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<td>Note 8</td>
<td>Note 1</td>
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</tr>
</tbody>
</table>
## Overview Fees and Charges for Non-Admitted Patients

<table>
<thead>
<tr>
<th>Patient Payment Classification</th>
<th>Same Day Fee per Day</th>
<th>Overnight Fee per Day</th>
<th>Outpatient Fee per Service</th>
<th>Ventilator Dependant</th>
<th>Airway Management</th>
<th>NHTP</th>
<th>NHTP Patient Contribution</th>
<th>Surgically Implanted Prostheses</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Specialised Orthoses</th>
<th>Drugs and Medication</th>
<th>Medical Services</th>
<th>Notifiable Sexually Transmitted Disease Management</th>
<th>Home Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>No Charge</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Note 1</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Private Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>No Charge</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Note 5</td>
<td>Note 6</td>
<td>Note 8</td>
<td>Note 1</td>
<td>Note 4</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Eligible War Service Veterans</td>
<td>N/A</td>
<td>N/A</td>
<td>Note 11</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Note 7</td>
<td>Note 7</td>
<td>Note 11</td>
<td>Note 11</td>
<td>Note 11</td>
<td>Note 11</td>
<td>See s8.4</td>
<td>Note 11</td>
</tr>
<tr>
<td>Compensable Patients (other than ICWA-MVA and DVA)</td>
<td>N/A</td>
<td>N/A</td>
<td>$310</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$310</td>
<td>$310</td>
<td>Note 8</td>
<td>Note 1</td>
<td>Note 2</td>
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<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Motor Vehicle Third Party Insurance (MVTPI) Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>Note 9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Note 9</td>
<td>Note 9</td>
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<td>Note 9</td>
<td>Note 2</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Medicare Ineligible Patients</td>
<td>N/A</td>
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<td>$310</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$310</td>
<td>$310</td>
<td>Note 8</td>
<td>Note 1</td>
<td>Note 2</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

Note 1: Refer to Section 6.1.

Note 2: Medical services fees may be raised by visiting medical practitioners, salaried medical officers exercising a right to private practice, private medical practitioners, or by the hospital on behalf of medical practitioners.

Note 3: Refer to Section 6.8.

Note 4: All medical services are charged directly to the patient either by the medical practitioner or by the hospital on their behalf.

Note 5: All radiology services are charged directly to the patient (or ‘compensable insurer’) either by the radiologist, or by the hospital on behalf of the radiologist.

Note 6: All pathology services are charged directly to the patient (or ‘compensable insurer’) by PathWest Laboratory Medicine WA.

Note 7: All radiology and pathology services to Eligible War Service Veterans are charged directly to DVA on a ‘fee for service’ basis.

Note 8: Refer to the Health Services (Fees and Charges) Order 2016 for ‘Charges payable in respect of specialised orthoses: Royal Perth Hospital and Fiona Stanley Hospital’ and ‘Charges payable in respect of specialised orthoses: Perth Children’s Hospital’.

Note 9: If the Motor Vehicle Accident (MVA) is a Western Australian (WA) case covered by the Insurance Commission of WA (ICWA) no outpatient charges are raised. MVA cases from other States or where out of court settlements have been awarded use compensable rates for non-admitted patients.

Note 10: Refer to Section 5.13.

Note 11: Centrally managed within the DOH by the DVA Management Unit.

Note 12: Refer to Section 5.8.
### Overview Fees and Charges for Nursing Home and Hostel Residents

<table>
<thead>
<tr>
<th>Patient Payment Classification</th>
<th>Same Day Fee per Day</th>
<th>Overnight Fee per Day</th>
<th>Outpatient Fee per Service</th>
<th>Ventilator Dependant</th>
<th>Airway Management</th>
<th>NHTP</th>
<th>NHTP Patient Contribution</th>
<th>Surgically Implanted Prostheses</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Specialised Orthoses</th>
<th>Drugs and Medication</th>
<th>Medical Services</th>
<th>Notifiable Sexually Transmitted Disease Management</th>
<th>Home Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Private Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Eligible War Service Veterans</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Compensable Patients (other than ICWA-MVA and DVA)</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Motor Vehicle Third Party Insurance (MVTPi) Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicare Ineligible Patients</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</table>

### Overview Fees and Charges for Boarders

<table>
<thead>
<tr>
<th>Patient Payment Classification</th>
<th>Same Day Fee per Day</th>
<th>Overnight Fee per Day</th>
<th>Outpatient Fee per Service</th>
<th>Ventilator Dependant</th>
<th>Airway Management</th>
<th>NHTP</th>
<th>NHTP Patient Contribution</th>
<th>Surgically Implanted Prostheses</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Specialised Orthoses</th>
<th>Drugs and Medication</th>
<th>Medical Services</th>
<th>Notifiable Sexually Transmitted Disease Management</th>
<th>Home Modifications</th>
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</thead>
<tbody>
<tr>
<td>Boarders</td>
<td>N/A</td>
<td>$39.00</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>
# Amendments to Fees and Charges Manual

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
<th>Amendment</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Schedules

Schedule A1 – Fees and Charges Regulated by the Minister for Health

Schedule A2 – Fees and Charges Regulated by the Director General

Schedule A3 – Fees and Charges not Fixed by Order of the Minister

Schedule B – Summary of Patient Fees and Charges

Schedule C – Application to Determine a New fee or Charge

Schedule D – Standing Exemptions

Schedule E – Appendices

Appendix A – National Patient Election Standards for Public Hospital Admitted Patients

Appendix B – Administration Process for Private Inpatients

Appendix C – Public Hospitals and Health Services in Western Australia

Appendix D – List of Health Related Contacts

Appendix E – Flow Chart on Medicare Eligibility and Access to Medicare

Appendix F – Medicare Eligibility Matrix for Commonwealth Visa Sub Classes

Appendix G – Emergency Treatment Payment Matrix for Motor Vehicle Accidents

Appendix H – Pricing Policy

Appendix I – Process for applying for a new fee or charge

Appendix J – Information on Governance of Medical Practitioner details within the Doctor’s Provider and Arrangement Listing System Policy
## Schedule A1: Fees and Charges Regulated by the Minister for Health – July 2019/20

<table>
<thead>
<tr>
<th>Division</th>
<th>Item</th>
<th>Maximum Fee Chargeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>Accommodation, Maintenance, Nursing Care and Other Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public Inpatients</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Private Inpatients – in Single Bed Wards (if taken at patient’s request)</td>
<td>per day $661.00</td>
</tr>
<tr>
<td></td>
<td>Private Inpatients – in Other Wards</td>
<td>per day $363.00</td>
</tr>
<tr>
<td></td>
<td>Nursing Home Type Patients</td>
<td>per day $61.30</td>
</tr>
<tr>
<td></td>
<td>Nursing Home Type Private Patients</td>
<td>per day $199.40</td>
</tr>
<tr>
<td></td>
<td>Medicare Ineligible Inpatients</td>
<td>per day $2,887.00</td>
</tr>
<tr>
<td></td>
<td>Eligible Veteran Inpatients</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatients</td>
<td>Home Modifications Services</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Home Modifications Service and Supply or Loan of such Aids and Appliances, Orthotics and Prostheses, Oxygen, Gas and Equipment, Wigs, Surgical Implants or Devices as approved by the Director General</td>
<td></td>
</tr>
<tr>
<td>Day Patients</td>
<td>Accommodation, Maintenance and Other Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible Day Patients</td>
<td>No Charge</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Outpatient Services, except for Medicines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible Outpatients</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Eligible Veteran Outpatients</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Medicare Ineligible Out-patient – for each individual service rendered</td>
<td>$310</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Medicines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Holders of an Entitlement Card</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Veterans who hold a Gold Card or a White Card</td>
<td>for each item $6.50</td>
</tr>
<tr>
<td></td>
<td>Pensioners</td>
<td>for each item $6.50</td>
</tr>
<tr>
<td></td>
<td>Concessional Beneficiaries</td>
<td>for each item $6.50</td>
</tr>
<tr>
<td></td>
<td>All other people at a participating hospital – for an item on the PBS list</td>
<td>PBS price up to a maximum of $40.30</td>
</tr>
<tr>
<td></td>
<td>All other people at a participating hospital – for an item not on the PBS list</td>
<td>$32.20</td>
</tr>
<tr>
<td></td>
<td>All other people at a hospital that is not a participating hospital</td>
<td>$32.20</td>
</tr>
</tbody>
</table>
## Schedule A2: Fees and Charges Regulated by the Director General – July 2019/20

<table>
<thead>
<tr>
<th>Division</th>
<th>Item</th>
<th>Maximum Fee Chargeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Emergency Department fees for Medicare Ineligible Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Triage Level 1</td>
<td>$2,155.00</td>
</tr>
<tr>
<td></td>
<td>Triage Level 2</td>
<td>$1,255.00</td>
</tr>
<tr>
<td></td>
<td>Triage Level 3</td>
<td>$885.00</td>
</tr>
<tr>
<td></td>
<td>Triage Level 4</td>
<td>$540.00</td>
</tr>
<tr>
<td></td>
<td>Triage Level 5</td>
<td>$315.00</td>
</tr>
</tbody>
</table>
**Standing Exemptions**

The fees listed below for medical reports are relating to those required for legal purposes. Most commonly these reports are requested by lawyers and insurance companies acting on behalf of patients. Reports are to be prepared from clinical notes and other information held in regard to the patient. These fees are not for the provision of copies of discharge summaries or redacted clinical notes.

<table>
<thead>
<tr>
<th>Item</th>
<th>Information</th>
<th>Fee Chargeable FY 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical and Related Reports</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Base Medical Report</strong></td>
<td>This fee includes assessment, obtaining documents, review of documents by a clinician and preparation of the report (up to 1 hour), copying (up to 10 pages) and sending the finalised report.</td>
<td>base fee $385.00</td>
</tr>
<tr>
<td><strong>Medical Report Copying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copying per page</td>
<td>This is an additional charge to the base fee if copying of the report is required and the report is over 10 pages</td>
<td>per page $1.10</td>
</tr>
<tr>
<td><strong>Report by Clinical Staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staff</td>
<td>These fees are to be charged in addition to the Base Medical Report Fee if the preparation of the report involves more than 1 hour of clinical time.</td>
<td>per hour $242.00</td>
</tr>
<tr>
<td>Allied Health/ Nursing</td>
<td></td>
<td>per hour $110.00</td>
</tr>
<tr>
<td><strong>Medical Report Search Fee</strong></td>
<td></td>
<td>$110.00</td>
</tr>
<tr>
<td>Search Fee</td>
<td>This fee is for a basic search to determine if the HSP has relevant records about the patient. It is a standalone fee and should not be charged additionally to the Base Medical Report Fee.</td>
<td></td>
</tr>
<tr>
<td><strong>Follow Up Report</strong></td>
<td></td>
<td>$110.00</td>
</tr>
<tr>
<td>Report</td>
<td>Follow up reports are applicable where further information has been requested following provision of an initial report. This fee is to be charged in addition to the number of hours involved for clinical staff to prepare the follow up report.</td>
<td></td>
</tr>
</tbody>
</table>

Note: Reports to the following are not chargeable: Police, Coroner, Child Protection, State Ombudsman, Commonwealth Ombudsman or specific cases approved by the appropriate Executive Director.

Fees include GST.
## Schedule B: Summary of Patient Fees and Charges – July 2019/20

<table>
<thead>
<tr>
<th>Item</th>
<th>Fee Chargeable FY 2018/19</th>
<th>Fee Chargeable FY 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private Patients (Medicare Eligible Australian Residents)</strong></td>
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<td></td>
</tr>
<tr>
<td>Shared Room</td>
<td>$356.00</td>
<td>$363.00</td>
</tr>
<tr>
<td>Single Room</td>
<td>$649.00</td>
<td>$661.00</td>
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<tr>
<td>Same Day</td>
<td>$294.00</td>
<td>$300.00</td>
</tr>
<tr>
<td><strong>Compensable Patients</strong></td>
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<td></td>
</tr>
<tr>
<td>Inpatients – Hospitals</td>
<td>$2,794.00</td>
<td>$2,704.00</td>
</tr>
<tr>
<td>Inpatients – Nursing Homes</td>
<td>$294.00</td>
<td>$300.00</td>
</tr>
<tr>
<td>Same Day</td>
<td>$2,645.00</td>
<td>$3,014.00</td>
</tr>
<tr>
<td>Outpatients – per Occasion of Service</td>
<td>$280.00</td>
<td>$310.00</td>
</tr>
<tr>
<td>Ventilator Dependent (with Tracheostomy, requiring 24 Hours Care)</td>
<td>$6,442.00</td>
<td>$6,540.00</td>
</tr>
<tr>
<td>Airway Management (with or without Tracheostomy, requiring 24 Hours Care)</td>
<td>$3,852.00</td>
<td>$3,911.00</td>
</tr>
<tr>
<td><strong>Medicare Ineligible Patients (Overseas Residents including 457 Visas)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>$2,778.00</td>
<td>$2,887.00</td>
</tr>
<tr>
<td>Same Day</td>
<td>$2,366.00</td>
<td>$2,580.00</td>
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<tr>
<td><strong>Emergency Department Services</strong></td>
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<td>• Triage Level 1</td>
<td>$2,090.00</td>
<td>$2,155.00</td>
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<td>• Triage Level 2</td>
<td>$1,160.00</td>
<td>$1,255.00</td>
</tr>
<tr>
<td>• Triage Level 3</td>
<td>$840.00</td>
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<td>• Triage Level 4</td>
<td>$500.00</td>
<td>$540.00</td>
</tr>
<tr>
<td>• Triage Level 5</td>
<td>$295.00</td>
<td>$315.00</td>
</tr>
<tr>
<td>Outpatients – per Occasion of Service</td>
<td>$280.00</td>
<td>$310.00</td>
</tr>
<tr>
<td><strong>Motor Vehicle Third Party Insurance Patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>$2,157.00</td>
<td>$2,087.00</td>
</tr>
<tr>
<td>Inpatients – Catastrophic Injuries Support Scheme</td>
<td>$2,995.00</td>
<td>$2,899.00</td>
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<tr>
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<td>$2,042.00</td>
<td>$2,325.00</td>
</tr>
<tr>
<td>Ventilator Dependent (with Tracheostomy, requiring 24 Hours Care)</td>
<td>$6,442.00</td>
<td>$6,540.00</td>
</tr>
<tr>
<td>Airway Management (with or without Tracheostomy, requiring 24 Hours Care)</td>
<td>$3,852.00</td>
<td>$3,911.00</td>
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<tr>
<td>Item</td>
<td>Fee Chargeable FY 2018/19</td>
<td>Fee Chargeable FY 2019/20</td>
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<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td><strong>Motor Vehicle Third Party Insurance Patients (PCH)</strong></td>
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<tr>
<td>Inpatients</td>
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<td>$2,899.00</td>
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<tr>
<td>Inpatients – Catastrophic Injuries Support Scheme</td>
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<td>$2,899.00</td>
</tr>
<tr>
<td>Same Day</td>
<td>$2,835.00</td>
<td>$3,229.00</td>
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<td>Ventilator Dependent (with Tracheostomy, requiring 24 Hours Care)</td>
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<td>$6,540.00</td>
</tr>
<tr>
<td>Airway Management (with or without Tracheostomy, requiring 24 Hours Care)</td>
<td>$3,852.00</td>
<td>$3,911.00</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boarders</td>
<td>$38.45</td>
<td>$39.00</td>
</tr>
<tr>
<td><strong>Note:</strong> The rate per day is inclusive of GST</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Home Type Patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Home Type Patient Contribution</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> The increase in patient contribution on 8th May 2019, relates to the Commonwealth pension increase of 8th May 2019.</td>
<td>Per day $60.05</td>
<td>Per day $61.30</td>
</tr>
<tr>
<td><strong>Private Nursing Home Type Patients</strong></td>
<td>Per day $198.75</td>
<td>Per day $199.40</td>
</tr>
</tbody>
</table>
Schedule C: Application to Determine a New Fee or Charge

Please refer to Schedule C Application Form to Determine a New Fee or Charge located in the Appendices and Schedules section of the main webpage:

Schedule E - Appendices

Appendix A – National Patient Election Standards for Public Hospital Admitted Patients
Appendix B – Administration Process for Private Inpatients
Appendix C – Public Hospitals and Health Services in Western Australia
Appendix D – List of Health Related Contacts
Appendix E – Flow Chart on Medicare Eligibility and Access to Medicare
Appendix F – Medicare Eligibility Matrix for Commonwealth Visa Sub Classes
Appendix G – Emergency Treatment Payment Matrix for Motor Vehicle Accidents
Appendix I – Process for applying for a new fee or charge
Appendix J – Information on Governance of Medical Practitioner details within the Doctor’s Provider and Arrangement Listing System Policy
Appendix A: Patient Election Standards for Public Hospital Admitted Patients

In accordance with the National Health Reform Agreement (NHRA) between the Commonwealth of Australia and the States and Territories, public hospital admitted patient election processes for eligible persons should conform to the following national standards. Health Services should review existing processes to ensure they are consistent with these standards.

**Admitted Patient Election Forms:**

Admitted patient election forms can be tailored to meet individual State/Territory or public hospital needs. However, as a minimum, forms should include:

- A statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in Clause 3 of Schedule G - Business Rules for the NHRA. This Clause states that "Private patients, compensable patients and Medicare ineligible persons may be charged an amount for public hospital services as determined by the State."

- A private patient may be treated by a doctor of his or her choice, and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient, who requests and receives single room accommodation, must be admitted as a private patient. (Note: eligible veterans are subject to a separate agreement refer to section 5.4.)

- A statement that a patient with private health insurance can elect to be treated as a public patient.

- A clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for Nursing Home Type Patients):
  - Will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services;
  - Are treated by the doctor(s) nominated by the hospital.

- A clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:
  - Will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;
  - May not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital, and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and
- Are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital.

- Evidence that the form was completed by the patient or legally authorised representative before, at the time of, or as soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee.

- A statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:
  - Patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
  - Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
  - Patients whose social circumstances change while in hospital (e.g. loss of job).

- In situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission.

- It will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in Clause 7 apply.

- A statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision.

- A statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement might result in the refusal of their Health Fund to provide benefits.

- Where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

**Multiple and Frequent Admissions Election Forms:**

- A State / Territory or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specific period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.
Other Written Material Provided to Patients:

- Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross-reference to the admitted patient election form in any such written material.

Verbal Advice Provided to Patients:

- Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.

- Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election.

- To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.

- Through the provision of translation / interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.
Appendix B: Administration Process for Private Inpatients

Health Service Providers need to ensure that the financial election process for private inpatients is consistent with Clause 24 of Schedule G - Business Rules for the NHRA, titled “Public Hospital Admitted Patient Election Forms”.

The administrative processes outlined below are to be followed once an Inpatient episode of care has been determined clinically necessary.

- Elective Patients will be given the opportunity to discuss financial election, and provided additional information on the consequence of admission as a private patient. This will occur at either the Private Rooms or Outpatients Clinic following the clinical decision to be admitted as an inpatient.

- An Elective Admission form (EAF) is completed. This must include Medicare number, health fund type, health fund number and patient’s signature confirming informed financial election. Admitted public patient election forms must be consistent with the national standards for public hospital admitted patient election as set out in the Schedule G - Business Rules for the NHRA. The national standards set out the minimum information to be included in patient election forms.

- Doctor’s clerk or Outpatients will send the EAF to Area Health Service Waitlist Department. The waitlist clerks input financial election information onto the Patient Management System. If a financial election has not been made, the waitlist clerks input financial election as “Unknown”.

- The Private Patient Liaison Officer (PPLO) or equivalent will review information, which indicates:
  - Booked inpatients with financial election unknown.
  - Booked inpatients with private insurance who have booked in as a public election.
  - Inpatients that have come in through ED who have elected as Private Inpatients.
  - In the event of financial election being unknown the PPLO will send the patient a letter, seeking financial election prior to booking into hospital, by completing the attached Financial Election form (660). A leaflet and a self-addressed and stamped envelope will be included in this package. Once the information is received the PPLO will make a record and forward to the Area Health Service Waitlist Department.

- When the Area Health Service Waitlist Department receives the form 660, the financial election information is logged and the form is forwarded to Booked Admissions.

- On the patient’s admission to hospital, if the patient has elected as a Private Inpatient, the Booked Admissions clerk will confirm e.g., “I see you have opted to use your health fund and book in as a private patient”. The clerk will then complete a register for the PPLO with patient labels and provide the Patient with their Incentive Pack including the voucher booklet.

- If at this stage there is still no financial election on the patient management system, staff proceed as usual, i.e. provide a form 660 and ask for their financial election. Staff could
also provide a leaflet and inform patients of the PPLO and provide them his/her business card.

- Emergency Department patients to be provided with information leaflets to enable them to make an informed financial election.
- At the time of admission to ward Emergency Department patients will be consulted on their financial election. Should the patient elect as Private, the clerk will complete a register for the PPLO with patient labels and provide the Patient with their Incentive Pack including the voucher booklet and letter to patient.
- The PPLO will liaise with Private Inpatients to discuss their election and ensure that they have had the appropriate and adequate information to make their decision. In addition the PPLO provides the patient with the following:
  - Completes any additional Health Fund requirements, which is sent to Patient Fees, and
  - Informs the patient that he/she can assist with any financial election queries and is the person to contact should their stay be longer than a week’s duration, for additional vouchers.
  - Inpatient survey form.
- Upon receipt of all financial documentation from Booked Admissions (form 660 and HA92) and PPLO (Medibank claim form), Patient Fees collate these forms and claims from Private Health fund and upon receipt provide this information to PPLO for his/her records.
- Payments are usually received within 4-6 weeks of submission to the Private Health fund; however should there be an issue (e.g. pre-existing illness) the patient would then be contacted to request the patient to discuss the issue with the health fund. In the event of excess gap, Patient Fees will ensure that hospital policy on “Gap” is implemented.
- Key Areas such as radiology and pathology will need to be consulted to ensure these accounts are combined with hospital accounts. The intention is to reduce the documentation to patients.
Appendix C: Public Hospitals and Health Services in Western Australia

Metropolitan Hospitals

North Metropolitan Health Service (NMHS)
- Graylands Psychiatric Hospital
- King Edward Memorial Hospital for Women
- Osborne Park Hospital
- Sir Charles Gairdner Hospital

South Metropolitan Health Service (SMHS)
- Fiona Stanley Hospital
- Fremantle Hospital
- Murray District Hospital (Pinjarra)
- Rockingham General Hospital
- Royal Perth Hospital (Non-Tertiary)
- Woodside Maternity Hospital

East Metropolitan Health Services (EMHS)
- Armadale Kelmscott Memorial Hospital (includes Specialist Centre)
- Bentley Hospital
- Kalamunda District Community Hospital
- Royal Perth Hospital (Tertiary)

Child and Adolescent Health Service (CAHS)
- Perth Children’s Hospital
- Reports to the Director General, administratively managed via NMHS.

Privately Managed Hospitals (Contracted to provide medical services to public inpatients)
- Joondalup Health Campus (North Metropolitan Health Service)
- Peel Health Campus (South Metropolitan Health Service)
- St John of God Midland Public Hospital (East Metropolitan Health Service)
### Western Australian Country Health Services (WACHS)

#### South West Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augusta District Hospital</td>
<td>Harvey District Hospital</td>
</tr>
<tr>
<td>Boyup Brook Hospital (Upper Blackwood)</td>
<td>Margaret River District Hospital</td>
</tr>
<tr>
<td>Bridgetown District Hospital</td>
<td>Nannup District Hospital</td>
</tr>
<tr>
<td>Bunbury Regional Hospital</td>
<td>Pemberton District Hospital</td>
</tr>
<tr>
<td>Busselton District Hospital</td>
<td>Warren District Hospital (Manjimup)</td>
</tr>
<tr>
<td>Collie District Hospital</td>
<td></td>
</tr>
<tr>
<td>Donnybrook District Hospital</td>
<td></td>
</tr>
</tbody>
</table>

#### Great Southern Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Regional Hospital</td>
<td>Kojonup District Hospital</td>
</tr>
<tr>
<td>Denmark District Hospital</td>
<td>Plantagenet District Hospital (Mt Barker)</td>
</tr>
<tr>
<td>Gnowangerup District Hospital</td>
<td>Ravensthorpe District Hospital</td>
</tr>
<tr>
<td>Katanning District Hospital</td>
<td></td>
</tr>
</tbody>
</table>

#### Wheatbelt Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beverley District Hospital</td>
<td>Merredin District Hospital</td>
</tr>
<tr>
<td>Boddington District Hospital</td>
<td>Moora District Hospital</td>
</tr>
<tr>
<td>Bruce Rock Memorial Hospital</td>
<td>Narembeen District Memorial Hospital</td>
</tr>
<tr>
<td>Corrigin District Hospital</td>
<td>Narrogin Regional Hospital</td>
</tr>
<tr>
<td>Cunderdin District Hospital</td>
<td>Northam Regional Hospital</td>
</tr>
<tr>
<td>Dalwallinu District Hospital</td>
<td>Dumbleyung District Memorial Hospital</td>
</tr>
<tr>
<td>Dumbleyung District Memorial Hospital</td>
<td>Quairading District Hospital</td>
</tr>
<tr>
<td>Goomalling District Hospital</td>
<td>Southern Cross District Hospital</td>
</tr>
<tr>
<td>Kellerberrin Memorial Hospital</td>
<td>Wagin District Hospital</td>
</tr>
<tr>
<td>Kondinin District Hospital</td>
<td>Wongan District Hospital</td>
</tr>
<tr>
<td>Kununoppin District Hospital</td>
<td>Wyalkatchem-Koorda District Hospital</td>
</tr>
<tr>
<td>Lake Grace District Hospital</td>
<td>York District Hospital</td>
</tr>
</tbody>
</table>
Goldfields and South East Coastal Hospitals

Esperance District Hospital       Leonora District Hospital
Kalgoorlie Regional Hospital    Norseman District Hospital
Laverton District Hospital

Midwest Hospitals

Dongara Health Service         Mullewa District Hospital
Carnarvon Regional Hospital   Geraldton Regional Hospital
Northampton District Hospital  Kalbarri Health Service
North Midlands District Hospital (Three Springs)
Meekatharra District Hospital  Morawa District Hospital
Exmouth District Hospital

Pilbara Hospitals

Onslow District Hospital        Paraburdoo District Hospital
Hedland Health Campus         Roebourne District Hospital
Newman District Hospital      Tom Price District Hospital
Nickol Bay Hospital (Karratha)

Kimberley Hospitals

Broome District Hospital       Halls Creek Hospital
Derby Regional Hospital       Kununurra District Hospital
Fitzroy Crossing Hospital     Wyndham District Hospital
Appendix D: List of Health Related Contacts

Western Australian Department of Health (DoH):

DVA Management Unit, DOH
Tel: (08) 9222 2184

Motor Vehicle Third Party Insurance Cases:

Insurance Commission of WA Metro (S/w)
Tel: (08) 9264 3333
E-mail: mvpdeng@icwa.wa.gov.au Country (S/w) Tel: 1800 643 338

Commonwealth Department of Health and Ageing Central Office:
E-mail: enquiries@health.wa.gov
Switchboard
Tel: (02) 6289 1555
General Fax
Fax: (02) 6281 6946

Private Health Insurance (PHI) - Health Services Reform Section:
E-mail: privatehealth@health.gov.au
General Enquiries
Tel: (08) 9346 5111
General Fax
Fax: (08) 9346 5222

Commonwealth Department of Veterans’ Affairs (DVA)

Metropolitan areas
Tel: 1300 550 457
Non-metropolitan areas
Tel: 1800 550 457

Other Commonwealth Department’s – National Information Lines:

Centrelink – General Enquiries
Tel: 13 10 21
Medicare Australia – General Enquiries
Tel: (02) 6124 6333
Medicare – General Enquiries
Tel: 13 20 11

Centrelink - Information on Concession and Health Care Cards:

Pharmaceutical Benefits Scheme (PBS Information Line)
Tel: 1800 020 613

For information on pharmaceutical benefits, see the Department of Health and Ageing web site:

Overseas Student Health Cover (OSHC)
Appendix E: Flow Chart on Medicare Eligibility and Access to Medicare

(1) Is this person an Australian resident?

Note: An Australian resident means a person who resides in Australia and whom is an Australian citizen, or a person who holds a permanent visa, or a New Zealand citizen lawfully residing in Australia.

Yes  
Australian residents are eligible to access Medicare.

No

(2) Are they an overseas visitor and do they have residence in a Reciprocal Health Care Agreement (RHCA) country?

Note: RHCA agreements are based on residence, and not necessarily citizenship, nor their country of birth.

Yes  
This visitor is eligible to access Medicare. Note: whilst Ireland & NZ visitors can access free care as a public hospital patient and subsidised medicine under the PBS they are not covered for out-of-hospital care (i.e. visiting a doctor).

No

(3) Do they come from any one of the following Specific Visitor Classes?

(a) A Retirement visa (subclass 410 – Temporary), issued prior to 1 Dec 1998 is Medicare eligible under the RHCA of their resident country;

(b) A valid Temporary visa holder, who has applied for permanent residence and has either a spouse, parent or child who is an Australian citizen or permanent resident, or who has authority from DIMIA to work;

(c) An asylum seeker with one of these visas:
   - Secondary Movement Offshore Entry Visa S/c 447;
   - Secondary Movement Relocation Visa S/c 451;
   - Bridging Visa R (Removal Pending) Visa S/c 070;
   - Return Pending Visa S/c 695;
   - Temporary Protection Visa S/c 785; and
   - Temporary (Humanitarian Concern) Visa S/c 786.

(d) An American Fulbright scholar in Australia.

Yes  
This overseas visa holder is eligible to access Medicare.

No

(4) Is this visitor a foreign spouse of an Australian resident and have applied or received permanent residence?

Note: Marriage to an Australian citizen is not sufficient in itself to enable residency, nor to access Medicare.

Yes  
This temporary resident is eligible to access Medicare.

No  
Medicare Ineligible (unable to access Medicare).
## Appendix F: Medicare Eligibility Matrix for Commonwealth Visa Sub Classes

<table>
<thead>
<tr>
<th>Visa Sub Class</th>
<th>Meaning</th>
<th>Eligibility</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>010,020,030</td>
<td>Bridging Visa</td>
<td>YES</td>
<td>Take receipt, DIBP letter and related documents to Medicare office</td>
</tr>
<tr>
<td>040,050,051</td>
<td>Only entitled if they have applied for Permanent Residency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100-299</td>
<td>Permanent Resident</td>
<td>YES</td>
<td>Permanent card</td>
</tr>
<tr>
<td>173</td>
<td>Aged Parent</td>
<td>YES</td>
<td>Take Passport to branch or certified copies by post.</td>
</tr>
<tr>
<td>300</td>
<td>Prospective Marriage</td>
<td>YES</td>
<td>Requires DIBP receipt and letter. Take to branch or certified copies by post.</td>
</tr>
<tr>
<td>(Fiancée)</td>
<td>If from RHCA (9 months to get married) and application for Permanent Residency lodged. For other non-RHCA countries, after marriage and Permanent Residency has been granted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>309, 445</td>
<td>Provisional</td>
<td>YES</td>
<td>Interim card</td>
</tr>
<tr>
<td>310, 445</td>
<td>If they have applied for Permanent Residency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>410</td>
<td>Retiree Visa</td>
<td>NO</td>
<td>If applicable RHCA only. Must have been approved by National Office.</td>
</tr>
<tr>
<td></td>
<td>Unless applied before 01-Dec-98 RHCA only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>417</td>
<td>Temporary Resident</td>
<td>YES</td>
<td>Take Passport to branch or certified copies by post.</td>
</tr>
<tr>
<td>(Working holiday visa usually 12 months)</td>
<td>Only if from RHCA or they have applied for Permanent Residency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>447, 451</td>
<td>Temp Protection Visa</td>
<td>YES</td>
<td>Processed in Branch Office or SHQ</td>
</tr>
<tr>
<td></td>
<td>If appears on Protection Schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visa Sub Class</td>
<td>Meaning</td>
<td>Eligibility</td>
<td>Action</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>457, 686</td>
<td>Temporary Resident business visa usually 4 years</td>
<td>YES Only if from RHCA or they have applied for Permanent Residency.</td>
<td>Take Passport to branch or certified copies by post.</td>
</tr>
<tr>
<td>560, 570, 571</td>
<td>Student Visa</td>
<td>NO Overseas Student Health Cover (OSHC) only, unless they have applied for Permanent Residency</td>
<td>Requires DIBP receipt and letter. Take to branch or certified copies by post.</td>
</tr>
<tr>
<td>572, 573, 574</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>575, 576</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>685</td>
<td>Medical Visa</td>
<td>YES RHCA only.</td>
<td>For items only not related to the reason for the visa. Reason for Medical Grant from Doctor</td>
</tr>
<tr>
<td>686</td>
<td>Visitor Visa</td>
<td>YES Only if from RHCA</td>
<td>RHCA card only. Passport and National Health Card. Take to branch or certified copies by post.</td>
</tr>
<tr>
<td>785</td>
<td>Temporary Protection Visa</td>
<td>YES</td>
<td>Interim card only.</td>
</tr>
<tr>
<td>801, 845</td>
<td>Permanent Residency Visa</td>
<td>YES</td>
<td>Existing Interim card. Requires DIBP receipt and letter. Take to branch or certified copies by post.</td>
</tr>
<tr>
<td>820, 826</td>
<td>Provisional Spouse Visa</td>
<td>YES Applicants for Residence.</td>
<td>Interim card. Requires DIBP receipt, letter and visas. Take to branch or certified copies by post.</td>
</tr>
<tr>
<td>880</td>
<td>Permanent Residency</td>
<td>YES</td>
<td>DIBP receipt and letter. Take to branch or certified copies by post.</td>
</tr>
</tbody>
</table>
### Appendix G: Emergency Treatment Payment Matrix for Motor Vehicle Accidents

<table>
<thead>
<tr>
<th>Accident Type</th>
<th>Registration</th>
<th>Non Admitted</th>
<th>Admitted</th>
<th>Non Admitted</th>
<th>Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICWA's payment arrangements are irrespective of whether WA vehicle(s) are registered or unregistered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver of Single Motor Vehicle Accident (MVA)</td>
<td>WA</td>
<td>Note 1</td>
<td>Note 2</td>
<td>Note 3</td>
<td>Note 2</td>
</tr>
<tr>
<td></td>
<td>Cwlth/ Non-WA</td>
<td>Note 1</td>
<td>Note 2</td>
<td>Note 4</td>
<td>Note 1</td>
</tr>
<tr>
<td>Liable Driver in Two (or more) Motor Vehicle Accident</td>
<td>At least one vehicle WA registered</td>
<td>Note 1</td>
<td>Note 2</td>
<td>Note 2</td>
<td>Note 1</td>
</tr>
<tr>
<td></td>
<td>Cwlth/ Non-WA</td>
<td>Note 1</td>
<td>Note 2</td>
<td>Note 4</td>
<td>Note 1</td>
</tr>
</tbody>
</table>

Notes: 1,2 & 5-8 Doctor Revenue                        Notes: 3 & 4 Hospital Revenue                           ICWA not liable

**Note 1.** Whilst a patient is receiving Emergency treatment the treating medical practitioner, or his agent, is able to bill ICWA without regard to liability issues as long as there is a current Critical Care certificate in force.  

**Note 2.** Under the new arrangements the payment of these types of services by ICWA is NOT subject to a liability determination. Note: Under the previous arrangement ICWA would not have accepted liability.  

**Note 3.** Under the revised arrangements Health Service are now able to raise a bed-day charge against ICWA. Note: Previously, ICWA was not liable.  

**Note 4.** Under prior arrangements accommodation is not subject to a liability determination. This arrangement continues.  

**Note 5.** Under prior arrangements non-admitted services provided by the hospital (e.g. allied health, outpatient services) are covered in the inpatient bed-day accommodation rate. Accordingly, the hospital cannot raise a charge on its behalf for these services.  

**Note 6.** Under prior arrangements the payment of these types of services by ICWA are subject to a liability determination. This arrangement continues for non-accommodation costs. This is non-hospital related revenue.  

**Note 7.** ICWA require the treating medical practitioner to determine a patient's Emergency status, based on whether the treatment is immediately necessary.
Appendix H: Pricing Policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated ‘free of charge’. This arrangement is consistent with the Medicare principles which are embedded in the Health Services Act 2016 (WA).

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients’ fees and charges for:

Nursing Home Type Patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or Medicare ineligible patients

Patients who are either ‘private’ or ‘compensable’ and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient ‘contribution’ based on March and September pension increases. To achieve consistency with the Commonwealth Private Health Insurance Act 2007, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans’ Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients; instead medical charges are fully recouped from the Department of Veterans’ Affairs.

The following fees and charges also apply:

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.

The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans’ Affairs Fee Schedule of dental services for dentists and dental specialists.
Eligible patients are charged the following co-payment rates:

- 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, Magnetic Resonance Imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.
Appendix I: Process for applying for a new fee or charge

1. **Health Service Provider**
   - Start
   - Is the fee or charge in the Fees and Charges Manual?
     - Yes → Fees and charges already approved for use
     - No → Is the fee or charge a health service or an other goods and service?
       - Yes → Other goods or service
       - No → Speak to the Revenue Strategy and Support team to discuss costs and whether the fee or charge is a health service or an other goods and service.

2. **Revenue Strategy and Support (RSS)**
   - Complete costs and section A and B of the Schedule C application form. Send to RSS to progress.
   - RSS reviews application and costing methodology and provide advice/guidance.
   - RSS determines which channel to progress application and take action.
   - Briefing note with costing is sent to the MH with advice to not fix the fee or charge.
   - RSS adds the new fee or charge into the Fees and Charges Manual.
   - HSP can charge new fee or charge.

3. **Minister for Health (MH)/ Director General (DG)**
   - MH reviews advice on briefing note.
   - Charge fixed by MH.
   - MH decides to fix the charge goes through the Parliament gazetted process.
   - DG fixes the fee or charge.
   - Note: If the fee or charge is rejected, RSS will work with the HSP to rework the fee depending on the rejection reason.

Please note - HSPs must maintain their own register for all Fees and Charges that are not within the Fees and Charges Manual.
Appendix J: Information on Governance of Medical Practitioner details within the Doctor’s Provider and Arrangement Listing System Policy

1. Purpose

WA Health collects, stores and uses a vast amount of data, including patient health information and medical practitioner details. The accuracy of medical practitioner details recorded within WA Health’s information systems is paramount in ensuring optimal patient treatment, appropriate patient billing and correct payment of health service staff.

WA Health is responsible for maintaining medical practitioner details and ensuring this information is accurate, current and appropriately managed. There are a myriad of information systems within WA Health that are used to collect medical practitioner details. Of these systems, webPAS is the primary source used for information and reporting of medical practitioner details. Information systems such as the Radiology Information Systems, e-referrals, Ultra and Cardiobase rely on webPAS to source or match medical practitioner information.

Although webPAS is the primary source for patient billing, the system is not able to collect and store all relevant billing information required from the doctors to allow accurate and timely patient billing. In this regard, the ‘Doctor Provider and Arrangement Listing’ (DPAL) system is established to be viewed as the initial primary source of truth which means that subsequent systems must be reconciled back to the DPAL system including payroll and webPAS.

The DPAL (then known as the Doctor Register) was established in 2015 as a whole of health solution to capture information on doctors billing arrangements, restrictions and exemptions. Prior to the development of this module there had been no uniform process employed at hospital sites to record and maintain Doctor’s information that has the ability to bill or not bill on behalf of a particular Doctor. Currently, a number of database systems are being utilised and often Health Service/Hospital revenue department staff have to access and interrogate more than one database system to confirm whether billing can be processed for a particular Doctor.

The DPAL module is a subset of the CredWA module. CredWA is a WA Health system which operates as an administrative portal to Mercury eCredential. Mercury eCredential is a centralised secure portal for Australian health practitioners to create and manage their own online career profile. With a single interface for maintaining a complete clinical profile, practitioner’s details are available in a central, accessible location, enabling the practitioner to quickly and easily submit their details for the credentialing review process. It confirms these practitioners are appropriately qualified, registered and comply with their professional development obligations. It also maintains information essential to creating and validating clinical scope of practice. In addition, CredWA generates standardised credentialing letters and Medical Service Agreements contracts.
2. **Applicability**

   This Policy is applicable to the following Health Service Providers (HSPs):
   - Department of Health
   - North Metropolitan Health Service
   - South Metropolitan Health Service
   - East Metropolitan Health Service
   - Child and Adolescent Health Service
   - WA Country Health Service
   - PathWest

3. **Policy requirements**

   3.1 **Roles and Responsibilities**

   The Medical Executive Director at each HSP is to ensure that this policy and its procedures are complied with, and are accountable for the monitoring of any non-compliance.

   It is the responsibility of the revenue or relevant department within HSPs to ensure that all Doctors billing information is uploaded and maintained within the DPAL system.

   The following processes are to be adhered to by the relevant departments:
   - The Workforce / Medical Administration invite a doctor to create a profile under the relevant speciality on the CredWA system. Once the application has been processed and approved, the relevant department will advise Revenue staff that there is a new doctor in the system.
   - Revenue staff are to ensure that the Doctors’ details, including provider numbers, specialties, Private Practice Arrangement, contract dates and S19AB details, are uploaded into the CredWA and DPAL.
   - Revenue staff are to ensure all relevant billing information is collected from Doctors and uploaded into the DPAL system.
   - Revenue staff should ensure that all related systems have correct billing information.

   Each Health Entity must designate an accountable person to ensure all information is correctly collected, stored and maintained within each relevant system. The Health Entities’ accountable person is responsible for cross-checking all relevant systems on a regular on-going basis at least every three months.

3.2 **Further Information**

   This policy and its procedures are maintained by the Revenue Strategy and Support team. Any requests for further information can be directed to: RevenueStrategyandSupportUnit@health.wa.gov.au.
3.3 Process for Maintenance of the DPAL System

A Doctor must create their personal profile within the CredWA module and complete all mandatory information. Once the doctor has completed their profile, HSPs’ Medical Workforce or Medical Administration must upload all pertinent contract and credentialing information into the credentialing component of CredWA.

The designated authority within Workforce or Medical Administration must then inform the following groups that a Doctor has been entered into CredWA:

- Payroll
- Revenue staff
- webPAS coordinator
- Any other relevant system within each Health Entity as deemed necessary to capture Doctors’ information

Workforce or Medical Administration need to also inform the Revenue staff which Arrangement the Consultant has chosen (either A or B). If the doctor has not selected an arrangement, then they are to be defaulted to Arrangement A. Workforce needs to upload a copy of the signed Arrangement Agreement to allow Revenue staff to process the correct paperwork.

Once the Revenue staff have been informed in writing that a Doctor is active within the CredWA system it is their responsibility to ensure that the Doctors billing information is entered into the Doctor Register module. If the Doctor is new to the hospital, they must be given all relevant forms to sign. It is the Revenue staffs responsibility to monitor and follow up in a timely manner all relevant forms that have not been returned to ensure billing can be undertaken as soon as possible.

If a Doctor is already established at a hospital the Revenue staff need to ensure that all relevant billing forms and information are uploaded as soon as they are made aware that the Doctor has been added to CredWA. Revenue staff are to ensure that all information received is entered into the DPAL system correctly. The Revenue staff need to check all provider numbers that the Doctor has provided or upload the correct Provider number.

Revenue staff need to ascertain whether a new Consultant is an Overseas Trained Doctor and whether they have a 19AB exemption. If they do have an exemption a copy of the exemption letter needs to be uploaded into the DPAL system along with all other relevant information. All Health Fund forms need to be sent out to the Consultants for them to sign and be retuned and uploaded individually.

3.4 Record Keeping

Unless otherwise specified, Medical Administration / Revenue staff are to ensure that all records relating to Doctors employment and billing information are retained on an official file, in accordance with a relevant Recordkeeping Plan.

(Note: Where a document has been signed, the signed document is to be retained on file.)
4. Compliance monitoring

4.1 Subject to Audit

All revenue documentation is subject to review by Internal Audit, Medicare and/or the Office of the Auditor General, to ascertain compliance with this Policy, and any other applicable policies or legislation.

4.2 Relevant Legislation and Policy

- Health Services Act 2016
- WA Fees and Charges Manual 2017/18
- Australian Medical Association Awards 2016

5. Definitions

The following definition(s) are relevant to this Policy.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Health Service Provider (HSP)</td>
<td>A legal Health Service Provider in WA Health:</td>
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<tr>
<td></td>
<td>• Department of Health</td>
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<tr>
<td></td>
<td>• Board Governed Health Service Providers</td>
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<td></td>
<td>• Chief Executive Governed Health Service Providers.</td>
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<tr>
<td></td>
<td>• Queen Elizabeth II Medical Centre Trust</td>
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</tbody>
</table>

6. Policy contact

Enquiries relating to this Policy may be directed to:

Title: Revenue Strategy and Support

Directorate: System Finance

Email: revenuestrategyandsupportunit@health.wa.gov.au