

Circular



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Contact: Regional Office

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Distribution: Public Hospitals

Subject: Services to Non-Admitted Patients

From 1 July 1993 Victorian public hospitals are required to comply with the provisions of the 1993 Medicare Agreement between the Commonwealth and State Governments. This Agreement, copies of which have now been circulated to all public hospitals, prohibits the imposition of outpatient fees except in specific circumstances.

This Circular provides clarification of the provisions and recommends that hospitals review their services to non-admitted patients to ensure compliance with the 1993 Medicare Agreement.

Medicare Agreement

The relevant provisions of the Agreement are summarised in the following excerpts from the Hospital Conditions of Funding 1993/94:

- 2.3.1 The hospital will ensure that aftercare services for public patients and out-patients and accident and emergency services do not attract claims for Medicare benefits or claims for benefits under Veterans' Affairs legislation.
- 2.4.1 The hospital will ensure that except in emergency, a recognised hospital does not issue a prescription to an in-patient on discharge, an out-patient or an accident and emergency patient, that would attract pharmaceutical benefits as defined in the National Health Act 1953 or Veterans' Affairs legislation.
- 2.16.5 Hospitals will not raise fees for outpatient services except for:
 - (a) dental services;
 - (b) spectacles and hearing aids;
 - (c) pharmaceuticals;
 - (d) surgical supplies, prosthetics and aids and appliances for home modifications; and
 - (e) compensable and ineligible patients.

(These provisions apply to services provided and funded by the hospital, not to services provided by privatised business units.)

Service Classification

Section 2.16.5 should be interpreted as meaning that "outpatient services" include:

- . all accident & emergency services,
- . all medical outpatient clinics, and
- . all non-medical outpatient clinics where the services relate to a previous or potential/actual subsequent admission at a public hospital.

Whether an outpatient service relates to a previous or potential/actual subsequent admission is a matter of clinical judgement.

Regarding outpatient services relating to a *previous admission*, hospitals may wish to use a two-month period as a guide.

Regarding outpatient services relating to a *potential or actual subsequent admission*, hospitals should include all those services which are undertaken to determine whether an admission is necessary, irrespective of whether an admission subsequently occurs.

In terms of the specific categories of services to non-admitted patients listed on the Department's monthly return (Forms 306/S2, 308/S2 and 314/S2 in the Agency Information Management System), hospital outpatient services for the purposes of the Medicare Agreement (and only such services) should be recorded in the following lines:

1. Emergency Medical Treatment
2. Medical/Surgical Clinics
3. Pathology
4. Radiology & Organ Imaging
5. Radiotherapy
6. Pharmacy
7. Allied Health
8. Psychiatric
9. Alcohol & Drug
10. Dental.

These services are generally funded through the Acute Health Services Program (Program 306).

The following categories of services, listed in lines 12 to 18 of the monthly return, are not covered by the provisions of the Medicare Agreement:

12. Community Health
13. Day Hospital
14. Day Centre
15. Off Campus Health Professional Services - District Nursing
16. Other Off Campus Health Professional Services
17. Off Campus Non-Medical & Social Support Services
18. Other Services to Individual Non-Admitted Patients.

These services are mainly funded through the Acute Health Services Program (Program 306) or the Aged Care Program (Program 308). It is intended that in due course they will be funded by the Primary Care Program (Program 314) if they are not already funded by the Aged Care Program (Program 308).

The above distinctions raise issues about the nature and classification of Allied Health Services and whether fees and charges may be raised.

Allied Health Services

It is proposed that during 1993/94 (or, if possible, before finalising the 1993/94 Health Service Agreement) hospitals should move towards adopting the following service distinctions in relation to allied health services.

If allied health services are provided which relate to:

- a previous or potential/actual subsequent admission,
or
- emergency treatment,

then they should be classified and reported as Allied Health (line 7). These services are subject to the Medicare Agreement and hence no fees may be charged.

If allied health services are provided which do not relate to:

- a previous or potential/actual subsequent admission,
or
- emergency treatment,

then they should be classified and reported as Community Health (line 12). Fees and charges may be raised for these services. Funding for these services will need to change from the Acute Health Services Program (Program 306) to the Primary Care Program (Program 314).

It should be noted that emergency treatment need not involve contact with a medical practitioner and may include follow-up visits subsequent and directly related to an initial attendance for emergency treatment.

Hospitals should review the provision of allied health services to non-admitted patients in order to ensure appropriate classification and capacity to raise fees. Information about fee and benefit levels is currently being collated by the Department. The appropriate current funding source should be identified as part of the 1993/94 budget and health service agreement negotiations. Possible future program funding sources might also be canvassed during these negotiations.

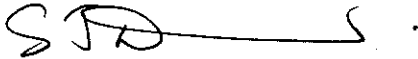
Statistical Reporting:

Hospitals should ensure that the reporting of statistics for non-admitted patients to the Agency Information Management System (AIMS) and in Health Service Agreements is consistent with the definitions applying from 1 July 1993. The relationship between the three categories for non-admitted patients in para B1.3.3 of the 1993/94 Health Services Agreement Pro-Forma and the categories used for AIMS (Forms 306/S2, 308/S2 and 314/S2) is as follows:

Health Services Agreement	AIMS Categories (Form 306/S2)
Emergency Medical Treatment	Line 1
Outpatient Services	Lines 2 to 10
Other Services	Lines 12 to 19

Only those occasions of service funded by Program 306 should be reported in that Program's component of the Health Service Agreement. Day hospitals or day centre services funded by Program 308 should be reported separately under that Program's component of the Health Service Agreement. Form 314/S2 should be used by public hospitals funded by Primary Care Program 314.

Services provided to non-admitted private patients by medical practitioners or other health professionals on a private basis should not be counted in these statistics; these services are provided by the practitioner rather than the hospital. Services provided on a private basis involve patients being charged directly by the private practitioner or in the private practitioner's name and may include services provided to compensable patients.

A handwritten signature in black ink, appearing to read 'S J DUCKETT', with a long horizontal line extending to the right.

S J DUCKETT
DIRECTOR
ACUTE HEALTH SERVICES