



Acute Health Services Division

Hospital Circular

Distribution: Public Hospitals
Extended Care Centres

Subject:

1. Changes in Fees for TAC patients 1996/97
2. Fees for admitted compensable (non TAC and for non VWA recipient) patients in 1996/97
3. Day Only Arrangements - Amendments to the Type C (exclusions) & Type B (day only) lists

Purpose: The purpose of this circular is to advise hospitals of the above.

1. Changes in Fees for TAC patients 1996/97

This circular is to advise public hospitals of a change from the per diem admitted patient fee arrangement to the new casemix based arrangement. This change to casemix-based charging will apply to TAC patients who are admitted to public hospitals on or after *1 May 1997 to 30 June 1997*.

This change to casemix from the per diem basis takes into account differences in case complexity and resource utilisation. Hence it has reasonable regard for services rendered and their associated expenses.

Effective on or after 1 May 1997 to 30 June 1997, fees for TAC compensable admissions will be based on AN-DRGs Version 3.1 and 1996-97 Victorian DHS cost weights. The formula for conversion of low and high outlier separations into inlier equivalent separations will be the same as the general hospital casemix funding formula as set out in *Victoria - Public Hospitals Policy and Funding Guidelines 1996-97*.

The base fee will be as in the table below:

TAC Base Fee

<i>Date effective</i>	<i>Base Fee</i>
<i>Admissions on or after 1 May 1997 to 30 June 1997</i>	<i>\$1,615 per WIES4</i>

As a result of this and other minor changes, could you please make the following updates to the *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals*:

replace page 18 with the attached pages 18 to 23, in part 1, Fees for admitted patients; and

replace Appendix C with the attached single page.

2. Fees for admitted compensable (non TAC and for non VWA recipient) patients in 1996/97

This is to advise public hospitals of the per diem patient fee charges for admitted compensable (non TAC and for non VWA recipient) patients, *effective 1 May 1997*.

Accordingly, could you please make the following update to the *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals*:

replace pages 11 and 12 in part 1, Fees for admitted patients.

3. Day Only Arrangements - Amendments to the Type C (exclusions) & Type B (day only) lists

The Commonwealth has advised that:

- with *effect from 16 April 1997*, the following Medicare Benefits item number has been removed from the Type C Exclusion list, and added to the Type B non-band specific list:

30124 (Tumours, cysts, ulcers or scars, up to 10mm in diameter, removal of more than 10 lesions from cutaneous or subcutaneous tissue or from mucous membrane)



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TAC Patients

1. 1996/97 Fees

*Effective on or after 1 May 1997 to 30 June 1997, fees for TAC compensable admissions will be based on AN-DRGs Version 3.1 and 1996-97 Victorian DHS cost weights. The formula for conversion of low and high outlier separations into inlier equivalent separations will be the same as the general hospital casemix funding formula as set out in *Victoria - Public Hospitals Policy and Funding Guidelines 1996-97*.*

The base fee will be as in the table below:

TAC Base Fee

<i>Date effective</i>	<i>Base Fee</i>
<i>admissions on or after 1 May 1997 to 30 June 1997</i>	<i>\$1,615 per WIES4</i>

2. Admission criteria

Acute admitted patients

TAC compensable patients should only be admitted to hospital in accordance with the Minimum Criteria for Admission as specified in Circular 19/1993 and hospitals shall set in place administrative procedures for the *certification* of non-private patients admitted for Type C Professional Attention Procedures of the Health Insurance Basic Table as defined by subsection 4(1) of the National Health Act 1953 (Cth).

Rehabilitation patients

Fees for patients admitted to Designated Rehabilitation Programs will be in accordance with the DHS ("the Department") payment schedule as set out in section 3 below, *Description of Fees*. The Department's PRS/2 Manual, Version 7.0, July 1996, lists Designated Rehabilitation Programs for the purpose of Care Type 2, 6 or 7.

Fees may be raised for TAC compensable patients admitted for same-day rehabilitation for provision of same day treatment. Criteria for admission as a same day admitted patient are that the patient:

- (i) attends a rehabilitation program designated for payment purposes by the Department; and
- (ii) attends for two or more therapy interventions; and
- (iii) receives treatment for a period of four hours or more.

Where these criteria are not met, the fees raised for attendance for rehabilitation would be in accordance with the appropriate non-admitted patient fee rate.

3. Description of fees

Acute admitted patient fees for TAC compensable admissions are charged to reflect the average cost of services provided as described by the patient's AN-DRG.

Base fee

For acute episodes of care, the base fee for TAC admissions:

- *on or after 1 May 1 1997 to 30 June 1997* is \$1,615 per Weighted Inlier Equivalent Separation (WIES4)

To calculate the acute admitted patient fee, the base fee is multiplied by the appropriate Weighted Inlier Equivalent Separation (WIES) value. Medical practitioner costs are excluded from the fee.

Rehabilitation

The following fees apply for patients admitted to rehabilitation programs designated by the Department of Human Services:

- Level 1 (Care Type 2): \$330 per day
- Level 2 (Care Type 6): \$290 per day
- Level 3 (Care Type 7): \$259 per day

Patients may only be coded to these care types in accordance with the Department's VIMD coding specifications.

Cost weights and related parameters

1996-97 cost weights and related parameters for TAC admitted patients are those published in the Department's *Victoria - Public Hospitals Policy and Funding Guidelines 1996-97*, in Section C - Supplementary Information.

4. Definitions of inliers and outliers for TAC compensable admissions 1996/97

Definitions for inliers and outliers for TAC admitted patients 1996/97 are those published in the Department's *Victoria - Public Hospitals Policy and Funding Guidelines 1996-97*.

5. Provisional statements

Provisional statements may be issued for high outlier patients whose length of stay exceeds 35 days. A provisional AN-DRG statement may be generated by the hospital's own accounts system based on the provisional AN-DRG to which a patient would be grouped and according to the program logic for per diem inlier equivalence of high outlier days. A final TAC Admitted Patient AN-DRG Statement for the entire patient episode will be issued by Health Computing Services Victoria Limited following separation of the patient.

In addition, hospitals may raise progressive invoices for patients admitted to designated rehabilitation programs.

6. TAC Statement & forwarding of invoices

Under the agreement with TAC, hospitals are required to provide details as set out overleaf in the 'Admitted Patient AN-DRG Statement'.

Date of effect: 1 May 1997

Reference: Circular No. 7/1997

TAC requires a primary code between 000 and 999 from Volume 1 of the International Classification of Diseases, 9th Revision, Clinical Modification for every inpatient. Other codes may be provided in addition to this primary requirement.

Before any rehabilitation treatment is commenced on a TAC inpatient, both a Rehabilitation Assessment and a Rehabilitation Plan must be completed, and submitted to the TAC for their approval. Copies of the Requirements and a Standard Rehabilitation Plan are to be obtained from the Health Services Branch of the TAC (Ph: (03) 9664 6042).

7. Magnetic Resonance Imaging Fees for Compensable Patients

Compensable patients may be charged a single fee of \$740 for an MRI service. If more than one service is required in a single day, then a medical certificate certifying the reason is to be provided. Copies of the format for accounts are to be obtained from the Health Services Branch of the TAC (Ph: (03) 9664 6042).

Date of effect: 1 March 1994

Reference: Circular No.4/1994

APPENDIX C

DRGs and cost weights for Victorian WorkCover and TAC

1996-97 cost weights and related parameters for Victorian WorkCover and TAC patients are those published in the Department's *Victoria - Public Hospitals Policy and Funding Guidelines 1996-97*, in Section C - Supplementary Information.

Compensable (excluding WorkCover and TAC recipients) Patients

The following fees are charged for all compensable patients other than WorkCover and TAC patients.

Accommodation Fees for Compensable (excluding WorkCover and TAC recipients) Inpatients

Patient Classification	Length of Stay	Fee per bed day (\$)
Advanced Surgical:	1 - 14 days	410
	15 + days	215
Surgical/Obstetric:	1 - 14 days	375
	15 + days	215
Other (Medical):	1 - 14 days	375
	15 + days	215
Psychiatric*	1 - 42 days	240
	43 -65 days	215
	66 + days	195
Rehabilitation*	1 - 49 days	350
	50 - 65 days	215
	66 + days	160
Geriatric**		215
Nursing Home Patient		125
Same Day Patient***		300

*Fees only apply for patients admitted to rehabilitation and psychiatric programs/units designated by the Department of Human Services.

**Geriatric fee can only be charged for patients treated in State Geriatric Centres.

*****Hospitals are required to strictly comply with the definition of "Admission" in the 1993 Medicare Agreement which prescribes the minimum criteria which must be met before a patient can be admitted. The minimum criteria for admission are defined in the *PRS/2 Manual, Version 7.0, July 1996.***

(See section on Patient Classifications for the definitions of advanced surgical, surgical and medical patients).

Date of effect: 1 May 1997

Reference: Circular No. 7/1997