# Northern Territory Health Services fees and charges manual

29/06/2018

Version: 1.0

# Contents

# Introduction

## Purpose

The NT Health Services **Fees and charges manual** (this Manual) provides a reference for NT Health staff and consumers on applicable fees and charges for treatment, accommodation, transport and products required by patients and delivered by Northern Territory public Health Services.

This Manual does not replace statutory law and should not be regarded as a legal document, however it does make reference to legislation.

## Version control

This Manual is a live document to which amendments will be made regularly. Notification of amendments is by Circular sent by email to relevant staff and available on the intranet. If you wish to receive Circular information contact Financial Services on 89858008 or email healthservicescharges.doh@nt.gov.au.

It is the responsibility of each user of the Manual to ensure that they are using the current version. The current version is:

| | |
|---|---|
| **Fees and Charges Manual** | July 2018 |
| **Changes to latest version** | Clarification of application of fees, new rates and fees |
| **Gazetted fee schedules** | 1 July 2017 |
| **Prostheses list** | February 2018 |

## Intranet/Internet

This Manual is available via the Northern Territory Department of Health:

**Intranet** site at:

*http://internal.health.nt.gov.au/divisions/ac/feescharges/Pages/default.aspx*

**Internet** site at:

*https://nt.gov.au/wellbeing/hospitals-health-services/hospital-fees-and-charges*

## Calendar of updates

The fees and charges in this Manual are updated regularly throughout the year as follows:

| Annual review dates | Reason for update |
|---|---|
| February | Australian government prostheses list updated |
| 20 March | Australian government nursing home type patient fee indexation |
| 1 July | Australian government private patient fee indexation and nt government annual general fees indexation |
| August | Australian government prostheses list updated |
| 20 September | Australian government nursing home type patient fee indexation |
| Miscellaneous updates may also occur throughout the year to reflect any ad-hoc fee changes, policy amendments or clarification of information in the Manual. | |

## Icons

For your convenience this Manual has the following icons:

There is a ***form*** related to this information.

There is a ***weblink*** with more detail.

There is more ***information*** within this Manual in the named section or table reference.

| Table 1.2<br>**Private patient** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Overnight stay (includes long stay acute) | $350 | 1 July 2017 | S43 2017 | 1 July 2018 |

## Supporting Documents

### NT Government Gazette

Pursuant to section 6(2) (b) of the *Medical Services Act* and with reference to section 43 of the *Interpretation Act*, the Minister can amend the determination of charges for medical services. These charges are set by notice in the Northern Territory Government Gazette.

The Gazette is available at:

www.nt.gov.au/ntg/gazette.shtml

The Medical Services Act available at:

www.austlii.edu.au/au/legis/nt/consol_act/msa153/

### Private Health Insurance Circulars

The Private Health Insurance Branch of the Australian Government Department of Health produces Private Health Insurance (PHI) circulars. The circulars contain important information related to Australian Commonwealth Government legislation which governs the operation of private health insurance. These circulars announce changes to private patient band rates and nursing home type patient rates.

Private Health Insurance Circulars available at:

www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars.htm

# Contacts

If you have any questions about the application of fees and charges, you may wish to contact one of the resources below for specialised assistance:

| Need | Expert source | Contact details |
|---|---|---|
| Australian Defence eligibility | **Garrison Health Solutions** | 1300 126 420 |
| Medicare Benefits Schedule eligibility details and rules | **Medicare** | 132 011 (General Enquires)<br><br>132 150 or **askMBS@humanservices.gov.au** (MBS schedule interpretation) |
| Motor Accidents Compensation (MAC) Scheme in the Northern Territory | **Territory Insurance Office** | 1300 493 506 or **macnct@tiofi.com.au** |
| Nursing home type patient deductions from Centrelink payments | **Centrelink** | 1800 044 063 |
| Pharmaceutical Benefits Scheme rules | **PBS** | 1800 020 613 (PBS Information Line) |
| Veterans Affairs eligibility | **Department of Veterans Affairs** | 1800 550 457 |
| Workers compensation rights and responsibilities in the Northern Territory | **NT Worksafe** | 1800 250 713 |

| | | |
|---|---|---|
| Internal policy advice on the application of fees and charges in this Manual | **Revenue Unit, Department of Health** | Phone (08) 898 58008 or email **healthservicescharges.doh@nt.gov.au** |

# 1 Admitted patient fees

## 1.1 Public

A public patient is an individual, eligible for Medicare, who on admission to a public hospital elects to be treated as a public patient. A public patient will be treated by doctors nominated by the hospital and cannot choose a specific doctor to provide their care. All patients need to complete the ***Patient election form HR372 (a) -7/13***, at the time of admission or as soon as practical after this. Patients should be classified as public until such a time a valid election can be made.

Where a Medicare eligible patient is entitled to claim from a third party (eg workers compensation or motor accident compensation), they need to submit a claim. For more information go to ***1.3 Compensable***. If the claim is rejected, then they are able to be public or elect to be private.

Public patients are entitled to receive care and treatment without charge (this excludes accommodation for maintenance type care such as nursing home type care, prosthetics, orthotics and accommodation at the Lorraine Brennan Centre – RDH Only). They may be admitted as an overnight stay or same day patient. After 35 days of continuous hospitalisation they may be reclassified as either a long stay acute or long stay nursing home type patient.

Charges should be raised for public patients classified as a long stay nursing home type patient. For more information go to ***11.1 Nursing home type patients (NHTP)***.

| Table 1.2<br>**Public patient** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Nursing home type patient | $57.85 | 20 March 2016 | S20 2016 | 20 September 2018 |

After 35 days where a nursing home type patient takes **approved leave**, any approved leave period will **not** be charged (i.e. greater than 1 day will not be charged, less than 1 day will still be charged).

If after 35 days a nursing home type patient takes **unapproved leave** (i.e. without notice or informed decision), the patient ***will*** be charged according to the admission and discharge data recorded in the hospitals patient management system.

Residents of countries with which Australia has a Reciprocal Health Care Agreement (RHCA) ***may*** be eligible for treatment as a public patient at no charge. For more information go to ***9.2 Reciprocal Health Care Agreements (RHCA)***.

## 1.2 Private

A private patient is a person who is eligible for Medicare, who on admission to a public hospital, or as soon as possible thereafter, ***elects*** to be treated as a private patient. Private patients are entitled to be treated by a doctor of their choice (provided that doctor has the right of private practice at that hospital). **Patients should be advised that this election will remain for the patient's total hospital stay unless there are unforeseen circumstances**. (Refer to ***11.8 Change of election*** for further information). Private patients need to complete the ***Patient election form HR372 (a) -7/13*** as well as the ***National private patient hospital claim form.***

The hospital will raise an account for accommodation, doctors' fees for medical services including diagnostic services and surgically implanted prostheses, directly to the patient's insurer and Medicare for settlement, where it is has been delivered by the Health Services. The hospital will accept the health fund payment as full payment with no additional costs to the patient for hospital services, such as gap expenses, excess or co-payments. A patient who elects to be private, but is **not covered** by insurance is responsible for the payment of all fees.

Where a service is provided by a third party (e.g. radiology imaging) to a patient who elects to be private, the third party may invoice that patient directly and normal private health insurance claim processes may apply.

Private patients may be admitted as an overnight stay or same day patient. After 35 days of continuous hospitalisation they may be reclassified as either a long stay acute or long stay nursing home type patient. For more information go to ***11.1 Nursing home type patients (NHTP).***

| Table 1.2 **Private patient** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Overnight stay (includes long stay acute) | $357 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same day band 1 | $259 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same day band 2 | $297 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same day band 3 | $343 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same day band 4 | $357 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Nursing home type patient contribution (from patient) | $57.85 | 20 March 2016 | S20 2016 | 20 Sept 2018 |
| Nursing home type patient default benefit (from insurer) | $90.69 | 20 March 2016 | S20 2016 | 20 Sept 2018 |

*Admitted patients*

Hospital fees

| Table 1.2<br>**Private patient** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| * *Note: Private long stay nursing home type patients are to be charged both the Patient Contribution and the Patient Default Benefits amounts for each overnight stay.* | | | | |
| Specialist fees (including surgery) | 100% MBS | | | |
| Diagnostics* (pathology and radiology including MRI, CT, nuclear medicine) | 100% MBS | | | |
| Surgically implanted prostheses | As per Private insurance - prostheses list - See ***5 Surgically implanted prostheses fees*** | | | |

* *fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

Medical procedures carried out in a public hospital on a same day patient who elects to be private will attract a fee for accommodation, maintenance and care (excluding medical fees (MBS) and surgically implanted prostheses) based on the type of procedure undertaken. The Australian Government has four Bands within which patient treatment will fall:

- Band 1 – gastrointestinal endoscopies, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic.
- Band 2 – procedures (other than Band 1) carried out under local anaesthetic, no sedation.
- Band 3 – procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour.
- Band 4 - procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.

A definitive list of procedures for Band 1 has been issued with no flexibility for reclassification. With respect to Band 2, Bands 3 and Band 4, theatre time and anaesthetic type should be determined by the attending doctor.

In an effort to limit hospitals claiming same day benefits for procedures traditionally undertaken on a non-admitted basis, the Type C Exclusion list has been developed. However if the medical practitioner believes that a patient warrants admission, the completion of the Same Day Certificate component of the ***National private patient hospital claim form*** must be completed.

Type C exclusions list and further information is contained in the Australian Government Private Health Insurance (Benefit Requirements) Rules 2011 available from: www.comlaw.gov.au/Details/F2018C00141

*Admitted patients*

## 1.3 Compensable (excluding TIO Motor Accident Compensation Patients)

A compensable patient is a person receiving services from a public hospital that is, or may be entitled under law that is or was in force in a State or Territory of the Australian Government, to the payment of damages or other benefits in respect of the injury, illness or disease for which they are receiving care and treatment. Compensable patients need to complete the ***Patient election form HR372 (a) -7/13***. Should their compensation claim not be successful, patients will be asked to elect if they wish to be private or public.

Under the *Health Insurance Act 1973*, patients to whom compensation has been made are not eligible for Medicare Benefits. Where there is reasonable evidence that a person would be entitled to claim for compensation or damages in respect to an injury, illness or disease e.g. Interstate Motor Vehicle, Public Liability, Workers Compensation, that person should be classified as "compensable' and accounts raised. **A hospital must not amend charges to compensable patients on the grounds that the patient voluntarily waives any rights to compensation. This does not constitute the failure of a claim.** In this instance the financial category remains the same and the invoices are sent to the patient.

**Compensable status takes precedence over all other financial categories *except* Medicare ineligible.** Where a Medicare ineligible patient is able to claim from a third party, the Medicare ineligible patient will be responsible for the fees until such time as evidence is provided to the hospital that the claim is accepted. Once a claim number has been received and the third party has accepted liability, the Medicare ineligible patient may be reclassified as a compensable patient.

Hospitals shall not raise charges for treatment of a person entitled to compensation under the *Motor Accidents Compensation Act 1979 (MACA)* administered by TIO, unless the patient is Medicare ineligible. Where a Medicare ineligible patient receives services as a result of motor vehicle accident, they are responsible for paying for those services unless a guarantee of payment has been received from an appropriate insurer. If the Medicare ineligible patient does not have insurance, they may submit a claim under MACA. For more information on MACA refer to ***1.3 Motor Accident Compensation Act (MACA)***.

| Table 1.3A **Compensable patient** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| ICU*, SCN**, CCU*** | $5,460 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Acute care overnight | $2,185 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Acute care same day | $1,440 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Hospital in the home (HITH) | $1,230 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Specialist fees | 120% MBS | | | |

* ICU – Intensive Care Unit
** SCN – Special Care Nursery
*** CCU – Coronary Care Unit

*Admitted patients*

| Table 1.3B **Compensable patient** | **Fee** | | **Date effective** |
|---|---|---|---|
| Diagnostics (pathology and radiology including MRI, CT, nuclear medicine)* | 120% MBS | | |
| Surgically implanted prostheses | As per Private insurance - prostheses list. See ***5 Surgically implanted prostheses fees*** | | |
| Medical transport | See ***7 Medical transport fees*** | S95 2015 | 1 October 2015 |

* *fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

## 1.4 Medicare ineligible

Medicare ineligible patients are persons who usually live outside Australia (overseas visitors and temporary visa holders) who are not citizens or permanent resident visa holders of any of the countries with which Australia has Reciprocal Health Care Agreements. Refer to ***9.2 Reciprocal health care agreements (RHCA)*** for information on RHCA. Medicare ineligible patients are not entitled to free medical treatment at public hospitals. Medicare ineligible patients need to complete the ***Patient election form – overseas patient HR372 (b) -7/13.***

Where a Medicare ineligible person does not provide a written guarantee of payment or an eligible insurance policy at the point of arrival, they will be required to:

- either **pre pay** or provide **credit card authorisation** for their emergency treatment
- either **pre pay** or establish a **payment plan** for their hospital admission
- **pre pay** for their specialist outpatient appointments

For those persons on student and work visas it is a condition of their visa that they obtain and maintain adequate insurance whilst in Australia. Refer to ***9.3 Overseas students*** for more information on overseas students. The Department of Immigration and Border Protection recommends overseas visitors seeking tourist visas should take out health insurance prior to entry to Australia as it would be in their best interest.

Children born in Australia to overseas visitors on or after 20 August 1986 are not eligible for Medicare unless one parent is an Australian citizen or a permanent resident at the time of the child's birth.

No charges are raised for babies born to Medicare ineligible parents until such time that babies become qualified. Refer to ***11.12 New born babies*** for information on new-born qualification status.

Medicare ineligible patients, regardless of whether their medical treatment is in connection to a compensable event, will be recorded and invoiced as a Medical Ineligible patient until such time a claim/liability is accepted.

*Admitted patients*

Immigration detainees and illegal foreign fishers are charged under agreement with the Commonwealth Department of Home Affairs. See ***1.5 Immigration detainees (Royal Darwin Hospital ONLY)***

| Table 1.4A **Medicare ineligible patient** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| ICU*, SCN** and CCU*** | $5,460 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Acute care overnight | $2,185 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Acute care same day | $1,440 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Hospital in the home (HITH) | $1,230 | 1 July 2018 | S49 2018 | 1 July 2019 |

* ICU – Intensive Care Unit
** SCN – Special Care Nursery
*** CCU – Coronary Care Unit

| Table 1.4B **Medicare ineligible patient** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Dialysis | $780 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Specialist fees | 120% MBS | | | |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |
| Surgically implanted prostheses | As per Private Insurance - Prostheses List<br>See ***5 Surgically implanted Prostheses Fees*** | | | |
| Medical transport | See ***7 Medical transport fees*** | 1 July 2018 | S49 2018 | 1 July 2019 |

* *fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

Medicare ineligible patients admitted in a public hospital with approved leave for 24 hours or more, with their bed available to be used for other patients, will not be charged accommodation fees for this period. If the approved leave is for less than 24 hours then, normal accommodation charges will apply. In circumstances where leave is unapproved, accommodation will be charged as if the patient was in hospital for the duration of the leave period. If the Medicare ineligible patient has taken leave against medical advice and is not readmitted within seven days, then the patient is deemed to have been discharged and charges will apply for the episode up to the discharge date recorded in the hospital system.

*Admitted patients*

Some travel insurers will not pay for a patient's leave days. If leave is determined to be chargeable, then the patient will be personally financially liable for that portion of the stay not covered by their insurer.

Where a Medicare ineligible person does not provide a written guarantee of payment at the point of arrival, they are required to either **pre pay** or establish a **payment plan** for their hospital admission.

## 1.5 Immigration detainees (Royal Darwin Hospital only)

Immigration detainees are Medicare ineligible, but whose charges for care and treatment will be met by the Australian Government Department of Immigration and Border Protection under an agreement with the Northern Territory Department of Health. Immigration detainees include asylum seekers and illegal foreign fishers and need to complete the ***Patient election form – overseas patient HR372 (b)-7/13.***

Under the current agreement, effective 1 January 2016, individual invoices are raised for each patient by the hospital and directed to the relevant immigration detention centre.

## 1.6 Australian Defence Force (ADF)

ADF personnel are eligible persons under Medicare, but whose charges for care and treatment will be met by the ADF. Garrison Health Services, part of Medibank Health Solutions, has been appointed by the Australian Government Department of Defence to co-ordinate the provision of health services to service personnel and active reservists within the ADF. ADF personnel may elect to be treated as a public or private patient. ADF patients need to complete the ***Patient election form HR372 (a) -7/13.*** ADF Personnel will be asked to elect if they wish to be private or public should the ADF decline responsibility.

Dependants of ADF personnel are not covered by the Department of Defence but may be covered by one of the Defence Force Health Funds, which are Private Health Funds.

| Table 1.6 **Australian Defence Force personnel** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Overnight Stay (includes long stay acute) | $357 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same Day Band 1 | $259 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same Day Band 2 | $297 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same Day Band 3 | $343 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Same Day Band 4 | $357 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Specialist Fees | 120% MBS | | | |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

*Admitted patients*

| Table 1.6 **Australian Defence Force personnel** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Surgically Implanted Prostheses | *As per Private Insurance - Prostheses List*<br>*See **5 Surgically implanted Prostheses Fees*** | | | |
| Medical Transport | *See **7 Medical transport fees*** | 1 July 2018 | S49<br>2018 | 1 July 2019 |

* *fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

## 1.7 Department of Veterans Affairs (DVA)

The Repatriation Commission, Military Rehabilitation and Compensation Commission, the Australian Government and the Northern Territory Government have an agreement for providing hospital services to entitled veterans (entitled persons). Under the agreement, entitled DVA patients are to be admitted to public hospitals as Veterans Affairs patients. Eligible veterans need to complete the ***Patient election form HR372 (a) -7/13.***

Patients entitled to treatment through DVA have been issued with a treatment entitlement card indicating their eligibility status. Occasionally a patient may only have a written authorisation from DVA. Those veterans issued with a *Repatriation Health card – for all Conditions* (a gold card) have full entitlement to treatment. Holders of a *Repatriation Health Card – For Specific Conditions* (a white card) are only eligible for treatment for specific injuries or diseases for which DVA has accepted financial responsibility.

Entitled Persons will ***not*** be covered under this Arrangement if they:

a) ***elect to be public patients*** under the National Health Reform Agreement 2011 (NHRA);
b) are ***compensable*** Patients; or
c) ***elect to be admitted under their private health insurance*** fund arrangements.

Hospitals are not to raise charges against DVA for patient accommodation except for a patient contribution for nursing home type patients (except for ex-Prisoners of War or Victoria Cross recipients). DVA reimburses the Department of Health for the treatment of entitled veterans under the agreement.

DVA will pay medical practitioners separately to this arrangement through Medicare Australia for admitted patient's medical specialist consultation's, including diagnostic and imaging services, at MBS rates. Hospitals may raise charges on behalf of medical practitioners under their Right of Private Practice (ROPP) agreement. For more information on ROPP see ***12.5 Right of private practice.***

| Table 1.7 **Department of Veterans Affairs** | **Fee per day** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Nursing home type patient contribution | $57.85 | 20 March 2016 | G50 2018 | 20 Sept 2016 |
| Specialist fees | 120% MBS | | | |
| Surgically implanted prostheses | As per Private Insurance - Prostheses List<br>See *5 Surgically implanted prostheses fees* | | | |

## 1.8 Motor Accident Compensation Act (MACA)

In 1979 the Northern Territory Government established a no fault motor vehicle accident compensation scheme administered by the Territory Insurance Office (TIO). From 1 July 2014, the scheme covers everyone injured or killed in a motor vehicle accident in the Territory, except where the motor vehicle is unregistered or unregister-able (though passengers and pedestrians will be covered) or used in a motorsport event or high speed time trial (includes drivers and passengers). Certain exclusions may apply. All types of road users are protected by the scheme, including pedestrians, drivers, passengers, motorcyclists and cyclists. The Motor Accidents scheme is funded by motor vehicle owners through compulsory contributions paid when registering vehicles in the NT. MACA patients need to complete the *Patient election form HR372 (a) -7/13.* Patients will be asked to elect if they wish to be private or public should their claim not be successful.

The Motor Accidents Compensation ACT is available from:

*www.austlii.edu.au/au/legis/nt/consol_act/maa298*

Hospitals may not raise charges for admitted care to people entitled to benefits under the MACA. TIO has an agreement with the Department of Health for reimbursement of the cost of hospital treatment.

If however a **patient voluntarily waives any rights to compensation. This does not constitute the failure of a claim.** In this instance the financial category remains the same and the invoices are sent to the patient at the compensable rate.

Where applicable, the Health Services should invoice TIO the difference between travel insurance claims and the current TIO MAC bed Days agreement, where amounts recoverable under MACA are greater than that accepted under the patients travel insurance

Where a Medicare ineligible patient with an approved Motor Accidents Compensation (MAC) claim has an Emergency Department (ED ) consultation only and is not admitted as an inpatient immediately after, TIO will be financially liable for the ED episode at the Medicare ineligible rate (see table T34.4.4A).

*Admitted patients*

In instances where MACA patients are transferred interstate, TIO is liable for the transport costs and hospitals should raise charges as outlined in *7 Medical transport fees*. This does ***not*** include intra-territory transfer costs.

| Table 1.7 **Motor Accident Compensation Act** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Medical Transport | See *7 Medical transport fees* | 1 July 2018 | S49 2018 | 1 July 2019 |

*Admitted patients*

# 2 Non-admitted patient fees

## 2.1 Public

### Emergency department

Under the National Health Reform Agreement, any person who is Medicare eligible is to receive Emergency Department services at no charge.

Refer to ***11.6 s19(2) Exemptions initiative*** for variations to this arrangement that apply at Gove District Hospital and Tennant Creek Hospital.

### Outpatients

A public outpatient is a person who receives health care from public hospital staff or receives health care at a public hospital without being admitted, or after discharge. Treatment may be provided by health professionals, such as a medical practitioner, allied health professional or nurse.

Public patients are entitled to receive non-admitted patient services at no charge, with the following exceptions for which charges can be raised:

- Dental Services;
- Spectacles and hearing aids;
- Surgical supplies;
- Prosthetics (see ***6 Prosthetic & orthotic fees***);
- External breast prostheses funded by the National External Breast Prostheses Reimbursement Program; and
- Aids, appliances and home modifications (see ***6 Prosthetic & orthotic fees***).

## 2.2 Private

### Emergency department

Under the National Health Care Agreement, any person who is eligible for Medicare is to receive Emergency Department services at no charge. This includes patients who would elect to be treated as private if admitted.

Refer to ***11.6 s19 (2) Exemptions initiative*** for variations to this arrangement that apply at Gove District Hospital and Tennant Creek Hospital.

### Outpatients

A Medicare eligible person who is referred to a specialist medical practitioner by name from a general practitioner, district medical officer or an appropriate clinician is able to be treated as a private outpatient under Medicare in a public hospital. Referrals must also contain the name and either practice address or provider number of the referring

practitioner, date of referral and period of referral (where greater than 12 months). See *11.4 Primary care referred* for further details.

A Primary Care referred patient will be Medicare bulk-billed 85% of the MBS schedule fee as per Table 2.2 below (with no patient contribution required) for non-admitted consultations, radiology and pathology services where the service provider is a public Northern Territory Health Service.

| Table 2.2<br>**Primary care referred patient (private)*** | **Fee** |
|---|---|
| Medical consultation | 85% MBS |
| Radiology | 85% MBS |
| Pathology | 85% MBS |

* *all services bulk-billed directly to Medicare Australia*

Private non-admitted patients who receive medical supplies, orthotics and other items of this nature, will be charged. See *6 Prosthetic and orthotic fees* for further details.

## 2.3 Compensable (excluding MACA)

Services for compensable patients (defined in *1.3 Compensable*) will be charged at the non-admitted rates below:

| Table 2.3A<br>**Compensable patient - Emergency department services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Resuscitation | $2,175 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Emergency | $1,195 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Urgent | $860 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Semi-urgent | $510 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Non-urgent | $340 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

| Table 2.3B **Compensable patient - non-admitted services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Medical Practitioner | $635 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Telehealth - Medical Practitioner** | $952 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Allied Health or Nurse | $320 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Telehealth - Allied Health or Nurse** | $480 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Hyperbaric unit | $2,645 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Minor operations | $1,000 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Chemotherapy | $1,200 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

** *fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

*** *for the purpose of applying the telehealth fee, the consulting practitioner is deemed to be the clinician at the opposite end to the patient. This means if the consulting practitioner is a Medical Practitioner then the single telehealth fee is 150% of $635 or $952. If the consulting practitioner is an Allied Health professional or Nurse then the single telehealth fee is 150% of $320 or $480. This single fee reflects that services are required at both the patient and practitioner ends of the telehealth consultation, and is significantly less than the time and cost of travel and accommodation if telehealth were not available.*

*Non-admitted patients*

## 2.4 Medicare ineligible

Services for Medicare ineligible patients (defined in ***1.4 Medicare Ineligible***) will be charged at the non-admitted rates below:

| Table 2.4A<br><br>**Ineligible patient - Emergency department services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Resuscitation | $2,175 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Emergency | $1,195 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Urgent | $860 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Semi-urgent | $510 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Non urgent | $340 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

**Emergency treatment of Medicare ineligible persons should *not* be delayed because of financial considerations.**

| Table 2.4B<br><br>**Ineligible patient – Non-admitted services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Medical Practitioner | $635 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Telehealth - Medical Practitioner** | $952 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Allied Health or Nurse | $320 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Telehealth - Allied Health or Nurse** | $480 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Hyperbaric unit | $2,645 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Minor operations | $1,000 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Chemotherapy | $1,200 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

*Non-admitted patients*

* fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.

** for the purpose of applying the telehealth fee, the consulting practitioner is deemed to be the clinician at the opposite end to the patient. This means if the consulting practitioner is a Medical Practitioner then the single telehealth fee is 150% of $635 or $952. If the consulting practitioner is an Allied Health professional or Nurse then the single telehealth fee is 150% of $320 or $480. This single fee reflects that services are required at both the patient and practitioner ends of the telehealth consultation, and is significantly less than the time and cost of travel and accommodation if telehealth were not available.

Where a Medicare ineligible person does not provide a written guarantee of payment at the point of arrival, they need to either **pre pay** or provide **credit card authorisation** for their emergency treatment or **pre pay** for their specialist outpatient appointments.

## 2.5 Immigration detainees (Royal Darwin Hospital only)

The Agreement with the Department of Home Affairs sets out the non-admitted rates.

## 2.6 Australia Defence Force Personnel (ADF)

Garrison Health Services have agreed to the following rates for non-admitted services until such time as NT Hospitals having the capacity to bill all services based on MBS item numbers.

| Table 2.6A<br><br>**Australian Defence Force personnel - Emergency department services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Resuscitation | $2,175 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Emergency | $1,195 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Urgent | $860 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Semi-urgent | $510 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Non urgent | $340 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

| Table 2.6B<br><br>**Australian Defence Force personnel – Non-admitted services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Medical Practitioner | $635 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Telehealth - Medical Practitioner** | $952 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Allied Health or Nurse | $320 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Telehealth - Allied Health or Nurse** | $480 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Hyperbaric unit | $2,645 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Minor operations | $1,000 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Chemotherapy | $1200 | 1 July 2018 | S49 2018 | 1 July 2019 |
| Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)* | 120% MBS | | | |

* *fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

** *for the purpose of applying the telehealth fee, the consulting practitioner is deemed to be the clinician at the opposite end to the patient. This means if the consulting practitioner is a Medical Practitioner then the single telehealth fee is 150% of $635 or $952.50. If the consulting practitioner is an Allied Health professional or Nurse then the single telehealth fee is 150% of $320 or $480. This single fee reflects that services are required at both the patient and practitioner ends of the telehealth consultation, and is significantly less than the time and cost of travel and accommodation if telehealth were not available.*

## 2.7 Department of Veterans Affairs (DVA)

The Agreement between the Repatriation Commission, Military Rehabilitation and Compensation Commission, the Australian Government and the Northern Territory Government provides eligible Veterans and war widows' (entitled persons) access to the full range of outpatient services at public hospitals.

Entitled Persons will ***not*** be covered under this Arrangement if they:

(a) ***elect to be public patients*** under the National Health Reform Agreement 2011 (NHRA);

(b) are ***compensable*** Patients; or

(c) ***elect to be admitted under their private health insurance*** fund arrangements.

*Non-admitted patients*

## 2.8 Motor Accident Compensation Act (MACA)

The Agreement with the Territory Insurance Office sets out the non-admitted fees and rates applicable.

# 3 Rehabilitation fees (non-admitted)

## 3.1 Rehabilitation services

Rehabilitation services provided to non-admitted patients are charged at the gazetted rate for Allied Health or a Clinical Nurse. See ***2.3 Medicare ineligible***, ***2.4 Compensable*** and ***2.6 Australian Defence Force personnel***.

Classes and education sessions may be provided to an individual or a group. The fee is applied per patient regardless of the number of people in the class or education session.

| Table 3.1<br><br>**Ineligible & compensable – non-admitted services** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Classes (including hydrotherapy)/ Education Sessions | $50 | 1 July 2018 | S49 2018 | 1 July 2019 |

# 4 Dialysis fees

## 4.1 Dialysis

The following charges apply to overseas visitors and compensable patients requiring renal dialysis in Northern Territory Health Service facilities.

| Table 4.1<br><br>**Ineligible and compensable patients** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Dialysis | $780 | 1 July 2018 | S49 2018 | 1 July 2019 |

Acute dialysis required as part of the treatment of an urgent medical condition is part of medically necessary treatment under the RHCA.

Maintenance renal dialysis may be made available free of charge to patients from countries which include maintenance dialysis in their RHCA with Australia.

Access to maintenance dialysis will depend on the availability of resources in the treating hospital and meeting the conditions below:

- arrangements directly between the overseas health authority and the Health Services must be made in advance of arriving in the NT and agreed to by the service provider's General Manager or equivalent delegation level; and
- no more than 10 treatments are required during one visit to Australia.

Where arrangements are not made in advance or the number of treatments exceeds 10 services, treatment should be charged at the ineligible dialysis rate above.

For up to date RHCA information, go to:
*www.humanservices.gov.au/individuals/services/medicare/reciprocal-health-care-agreements*

# 5 Surgically implanted prostheses fees

## 5.1 Prostheses

On 31 October 2005 the *National Health Amendment (Prostheses) Act 2005* came into effect, re-regulating the benefit levels health funds are required to pay for all prostheses provided to their members associated with an MBS procedure. The relevant benefit amounts are determined by the Australian Government Minister for Health. These are contained on a Prostheses List that is updated in February and August each year.

The Prostheses List ('the List') is the schedule to the *Private Health Insurance (Prostheses) Rules* and is divided in three parts: Part A (Prostheses), Part B (Human Tissue) and Part C (Other Prostheses – Cardiac Event Recorders and External Infusion Pumps).

The Prostheses List is available from:

www.health.gov.au/internet/main/publishing.nsf/content/prostheses-list-pdf.htm

**The rates contained in the Prostheses List are used for all chargeable patients.**

| **Current prostheses list** | February 2018 |
|---|---|

Under the legislation there are two categories that can be provided to private patients – **no-gap prostheses** (where the health fund will meet 100% of the cost) and **gap permitted prostheses** (where a private patient will have a gap amount to pay in addition to the health fund rebate). For no-gap prostheses, the Prostheses List contains only a minimum amount, and for gap permitted the list contains both a minimum and maximum benefit amount.

As the Northern Territory Department of Health has a no-gap policy for private patients in its public hospitals, the minimum will be charged, for which only the private health insurers are required to pay. This is unless the relevant health fund pays a level above the minimum. All other financial categories will be charged at the maximum benefit rate for gap prostheses as per Table 6.1A below:

| Table %.1A<br>**Chargeable patient** | **No-gap prostheses** | **Gap prostheses** | **Not listed** |
|---|---|---|---|
| Private | Minimum benefit | Minimum benefit | Prior agreement required |
| DVA | | | |
| Ineligible | Minimum benefit | Maximum benefit | Full cost recovery |
| Compensable | | | |
| ADF personnel | | | |
| Immigration detainees | | | |

*Prostheses*

Under Australian Government legislation, health funds are only required to pay benefits for items on the Prostheses List. This means if any hospital (public or private) uses prostheses on a private patient and it is not on the Prostheses List, then the health fund is not compelled to pay **any** benefit.

To reflect further arrangements negotiated between the States, Territories and Health Funds, a discount will be applicable for any Cardiothoracic or Ophthalmic item. This removes the need to provide supplier invoices to the health fund to obtain a benefit.

| Table 5.1B<br><br>**Private patients** | **Health insurer rebate** | **Discount** | **Details** |
|---|---|---|---|
| All items on the Prostheses List (excluding Cardiothoracic and Ophthalmic items) | Minimum Benefit | Not Applicable | No Invoice required |
| Cardiothoracic items | | 7.5% | |
| Ophthalmic items | | 20% | |

Benefit amounts are to be calculated using the current minimum benefit on the Prostheses List for the item and then taking off the relevant percentage discount listed above.

If the cost of purchasing a cardiothoracic or ophthalmic item is above the calculated benefit a health fund will pay, hospitals may provide supplier invoices to the health fund for these items. In this instance health funds will reimburse the cost of the prostheses up to, but not exceeding, the minimum benefit level.

Where possible, and clinically appropriate, hospitals should source prostheses which are on the prostheses list or able to be fully funded by health funds so that patients have no out-of-pocket expenses.

# 6 Prosthetic and orthotic fees

## 6.1 Prosthetics

An external prosthesis is an artificial device that replaces a missing body part for functional and/or cosmetic reasons. This includes artificial limbs and digits. External prosthetics can consist of components, such as feet and knee components, but do not include surgically implanted prostheses.

Charges for Prosthetic services apply to:

| Table 6.1<br>**Prosthetic services** | **Admitted** | **Non-admitted** |
|---|---|---|
| Public (eligible*) | No charge | No charge |
| Public | Chargeable | Chargeable |
| Private | | |
| DVA | Chargeable (except when required for discharge) | Chargeable |
| MACA | Chargeable | Chargeable |
| Ineligible | | |
| **Prosthetic fee schedule: see Attachment A** | | |

* *Admitted or non-admitted public patients that hold a valid Pensioner Concession Card (PCC) or Health Care Card (HCC) or for paediatric patients 18 years old and under.*

## 6.2 Orthotics

An orthosis is a brace or splint used to support, align, prevent or correct musculoskeletal irregularities to improve function.

Charges for Orthotic services apply to:

| Table 6.1<br>**Prosthetic services** | **Admitted** | **Non-admitted** |
|---|---|---|
| Public (eligible*) | No charge | No charge |
| Public | Chargeable | Chargeable |
| Private | | |
| DVA | Chargeable (except when required for discharge) | Chargeable |
| MACA | | |
| Ineligible | | |
| Compensable | | |
| ADF personnel | | |
| Immigration detainees | | |
| **Orthotic fee schedule: see Attachment B** | | |

* *Admitted or non-admitted public patients that hold a valid Pensioner Concession Card (PCC) or Health Care Card (HCC) or for paediatric patients 18 years old and under.*

# 7 Medical transport

## 7.1 Medical Transport

No charge is raised when a public or private patient is retrieved from a rural or remote area, transferred between hospitals either within the Northern Territory or interstate for medical reasons. These patients are covered by the Patient Assistance Travel Scheme (PATS).

Further information for patients about PATS is available from:

https://nt.gov.au/wellbeing/health-subsidies-support-and-home-visits/patient-assistance-travel-scheme/introduction

All other patient financial categories are to be charged for transport in accordance with Tables 7.1A (dedicated aeromedical service), 7.1B (commercial transport) and 7.1C (ground based ambulatory services provided by public Health Services).

| Table 7.1A<br><br>**Aeromedical transport (dedicated aeromedical service)** | **Fee** | **Date effective** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Full aero-medical transport | $40<br>per aero nautical mile* per flight | 1 July 2018 | S49 2018 | 1 July 2019 |
| Shared medical transport (separate payors) | $26.90<br>per aero nautical mile per patient | 1 July 2018 | S49 2018 | 1 July 2019 |

* *Fees are calculated from the place of dispatch and return to the dispatch location.*

| Table 7.1B<br><br>**Commercial transport** | **Fee** | **Date effective** | **Last gazetted change** |
|---|---|---|---|
| Aeroplane, bus, etc. | Full cost recovery** | 27 November 2013 | G48 2013 |

** *Full cost recovery – as per third party service provider's invoice.*

Note, where a public or private patient is required to be transferred to an interstate hospital, the Health Service will generally transport the patient to Adelaide. If the patient nominates a facility/institution in another state or territory, the Health Service will fund the equivalent of the commercial Adelaide return fare. Any difference in transport costs are the patient's responsibility. If, however, a public or private patient must be evacuated to another interstate facility/institution for particular medical reasons then there is no charge to the patient.

*Medical transport*

All other patient financial categories are to be charged.

Ground based ambulatory retrieval and transfer services provided by either Top End or Central Australia Health Services are charged at the rates detailed in Table 7.1C below:

| Table 7.1C<br>**Ground based ambulatory retrieval/transport services provided Health Services** | | **Fee** | **Date effective** | **Last gazetted change** |
|---|---|---|---|---|
| **Retrieval** (site of accident to clinic) | 0-24 km | $400 | 1 July 2018 | S49 2018 |
| | 25-49 km | $450 | 1 July 2018 | S49 2018 |
| | 50-99 km | $600 | 1 July 2018 | S49 2018 |
| | 100-149 km | $700 | 1 July 2018 | S49 2018 |
| | 150-199 km | $800 | 1 July 2018 | S49 2018 |
| | 200+ km | $900 | 1 July 2018 | S49 2018 |
| **Transport** (clinic to aerodrome) | | $250 | 1 July 2018 | S49 2018 |

## 7.2 Cost sharing

Where more than one patient is transported via a dedicated aeromedical transport service in a single trip, cost sharing is able to be applied in certain circumstances.

In the case of a medical retrieval where there are **multiple patients** being transported (either from a single location or multiple locations within a single retrieval), cost sharing will only apply where there is a **single payor** responsible. This means, if there are two patients being transported as a result of a single motor vehicle accident where TIO is the insurer, then this will result in a single transport charge to TIO provided there is an accepted claim. If there are two patients being transported as a result of two separate motor vehicle accidents where TIO is the insurer, then this will again result in a single transport charge to TIO provided they both have their claims accepted.

Where there are **multiple patients** with **separate multiple payors** responsible for individual patients who have been transported on a single flight, then the cost of the flight will be applied singularly at the separate payor-rate to each payor (as per Table 8.1A for aeromedical transport only).

# 8 Medical reports, copies of medical records and imaging

## 8.1 When charges should be raised

*Circumstances under which charges **should** be raised are for:*

- a search for a medical record (unless it cannot be found).
- copies of a patient's medical record is requested by and provided directly to the patient.
- copies of medical images to CD are requested by and provided directly to the patient.
- replacements of medical certificates and Centrelink forms when required to be rewritten.
- requests for medical reports or copies of medical records by solicitors, insurers and other third parties, for legal or employment purposes, subject to written consent being given by the patient (this excludes requests from Gallagher Bassett in relation to workers compensation claims by a DoH staff-member).
- copies of medical images to CD are requested by an insurer, solicitor or other third party, subject to written consent being given by the patient.
- requests for information from interstate health authorities or other employers in respect to the eligibility of candidates for appointment.
- requests for information by solicitors acting on behalf of a victim of crime.
- requests to provide evidence or an assessment for circumstances not outlined below in ***8.2 – When charges should not be raised***.

## 8.2 When charges should not be raised

*Circumstances under which charges should **not** be raised are:*

- when a copy of the discharge summary is requested by and provided directly to the patient.
- when requests are made for copies of a patient's discharge summary, operation findings and other relevant letters between health professionals, by a health professional concerned only with the patient's continued treatment or care, e.g. the patient's General Practitioner.
- when completing medical certificates and Centrelink forms at the time of consultation.
- requests from Gallagher Bassett in relation to workers compensation claims by a DoH/Health Services staff-member.
- requests by a body responsible for regulating the activities of health professionals, eg. a professional registration board investigating the conduct of a professional or a Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing.
- requests from Territory Families or the police, required in the conduct of investigating claims into suspected maltreatment of children.

- requests from Community Corrections for reports in relation to matters of sentencing, parole and supervision of court orders.
- when a single request is made for a medical report and photocopied information from a medical record, no Search Fee is applied. This is included in the Medical Report Charge.

| Table 8.2A<br>**Patient request** | **Calculated** | **Fee (GST exempt)** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Search fee | Per search | $38 | S49 2018 | 1 July 2019 |
| Copy of medical records | Per page | $0.25 | S49 2018 | 1 July 2019 |
| Copy of discharge summary | Free | | S49 2018 | 1 July 2019 |
| Replacement medical certificate | Per certificate | $38 | S49 2018 | 1 July 2019 |
| Medical/allied health report (max 2 pages) | Per report | $315 | S49 2018 | 1 July 2019 |
| Medical report<br>(additional pages) | Per page | $160 | S49 2018 | 1 July 2019 |
| Medical images to CD | 1 study | $13 | S49 2018 | 1 July 2019 |
| | 2 studies | $20 | | |
| | More than 2 Studies | $30 | | |

| Table 8.2B<br>**Third party request** | **Calculated** | **Fee (GST inclusive)** | **Last gazetted change** | **Review date** |
|---|---|---|---|---|
| Search fee | per search | $40 | S49 2018 | 1 July 2019 |
| Copies of medical records | per page | $1 | S49 2018 | 1 July 2019 |
| Medical/ allied health report (max 2 pages) | per report | $350 | S49 2018 | 1 July 2019 |
| Medical report (additional pages) | per page | $175 | S49 2018 | 1 July 2019 |
| Medical images to CD | 1 Study | $22 | S49 2018 | 1 July 2019 |
| | 2 Studies | $30 | | |
| | More than 2 Studies | $40 | | |

*Medical reports, records and imaging*

Hospital fees

Specialist medical assessments are calculated at the specialist hourly rate including salary on-costs (superannuation and category allowance). Travel time is charged where travel required by the specialist to provide or perform an assessment.

Procedures for safeguarding the privacy of Medical Records are set out in the *Hospital Network: Patient Information Privacy Policy* available from:

*http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/726/3/Privacy%20Policy.pdf*

# 9 Other patient categories

## 9.1 Prisoners

Australian prisoners are Medical eligible but Medicare benefits cannot be accessed whist incarcerated. While in custody any heath serviced provided to a prisoner are considered the responsibility of the state/territory. Prisoners need to complete the ***Patient election form HR372 (a) -7/1.***

***Prisoners from correctional facilities outside the Northern Territory will be charged at a rate equivalent to that of a Medicare ineligible patient*** under the *Health Insurance Act 1973*, the same eligibility criterion applies to prisoners and those in police custody, as for any other patient presenting for treatment. A prisoner who is an Australian citizen or is an eligible overseas person and no compensation case is involved then the patient is eligible for treatment as a public patient in a public hospital at no charge. These patients also have the right to election for private or public treatment. In the event the patient elects to be private they will not be entitled to the 75% Medicare Rebate and the patient is responsible for the payment of the resultant fees.

## 9.2 Reciprocal health care agreements (RHCAS)

Australia has Reciprocal Health Care Agreements (RHCAs) with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. In general, the RHCAs provide for emergency department and ***immediately necessary*** outpatient and accommodation and treatment at no charge as an admitted public hospital patient to citizens of these countries. They do not cover any treatments as a private patient in any kind of hospital. Overseas visitors requesting to be admitted under a RHCA need to select appropriate box on the ***Patient election form HR372 (a) -7/1.***

Detailed information for staff is available to NT Health staff in the **Reciprocal patients policy directive** available in the Policy and Guideline Centre on the NT Health intranet site. An overview of entitlements is below:

| Country | Length of entitlement to RHCA |
|---|---|
| Belgium | Duration of stay |
| Finland | Duration of stay (excluding students on student visas) |
| Italy | First 6 months of visa |
| Malta | First 6 months of visa (excluding students on student visas) |
| Netherlands | Duration of stay |
| New Zealand | Duration of stay (excluding medically necessary care out of hospital) |
| Norway | Duration of stay (excluding students on student visas) |

Hospital fees

| Country | Length of entitlement to RHCA |
|---|---|
| Republic of Ireland | Duration of stay (excluding medically necessary care out of hospital and excluding students on student visas) |
| Slovenia | Duration of stay |
| Sweden | Duration of stay |
| United Kingdom | Duration of stay |

### Patients covered

**RHCAs are *not* designed to replace private travel health insurance**.

Under the RHCAs with Finland, Italy, Malta, the Netherlands, Norway, Sweden, Belgium, Slovenia and the United Kingdom, Australian public hospitals provide care at no charge to citizens from these countries as public patients, as well as subsidised out-of-hospital medical treatment under Medicare and subsidised medicines under the Pharmaceutical Benefits Scheme.

The RHCAs with New Zealand and Ireland provide care at no charge as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Visitors from Belgium, the Netherlands and Slovenia require their European Health Insurance card to enrol in Medicare. They are eligible for treatment in public hospitals until the expiry date indicated on the card, or to the length of their authorised stay in Australia if earlier.

Eligibility can be confirmed by the patient holding a Reciprocal Health Care Card issued by Medicare or by showing their passport of the country with which there is a RHCA. Hospital staff should check that the visa is valid.

### Services covered

**RHCAs only cover immediately necessary medical treatment as a public patient**. Immediately necessary treatment means any ill health or injury which occurs while the person is in Australia and requires treatment before the person leaves Australia. It does not include treatment prearranged before the person arrived in Australia or elective treatment.

Patients are eligible for air transfer services between public hospitals providing they meet the eligibility criteria.

'Not immediately necessary' is a term used for medical treatment that can be delayed as determined by an appropriately qualified medical professional.

*Other patient categories*

### Services Not Covered

Other services not covered under the RHCAs are:

- Ambulance Cover
- Dental care
- Optometry Services
- Medical evacuations intra or interstate
- Medical Evacuation to the visitor's home country
- Funerals
- Ambulance cover
- Elective treatment
- Funerals
- Treatment as a private patient in a public hospital
- Treatment that has been pre-arranged before arrival in Australia
- Treatment deemed by a medical professional to be not immediately necessary

Further information for patients about each agreement is available at:
*www.humanservices.gov.au/customer/services/medicare/reciprocal-health-care-agreements*

## 9.3 Overseas Students

Patients on student visas from the United Kingdom, Sweden, the Netherlands, Belgium, Slovenia, Italy or New Zealand, are covered by Medicare. Students from Norway, Finland, Malta and the Republic of Ireland are not covered by the RHCAs with those countries.

With the exception of students from Belgium, New Zealand, Norway and Sweden, it is a condition of their student visa that they take out Overseas Student Health Cover (OSHC). Overseas students are charged the same rates as other Medicare ineligible patients, see ***1.4 Medicare ineligible***, and are required to complete the ***Patient election form – overseas patient HR372 (b) -7/13***.

# 10 Primary health fees

Top End and Central Australia Health Services deliver remote primary health through a network of clinics outside urban areas (Darwin, Palmerston, Alice Springs, Katherine, Gove and Tennant Creek) across the Northern Territory.

Staffing in these clinics vary based on the population size and clinical need in each location and may comprise of Medical, Nursing and Aboriginal Health Practitioners. These staff provide services on both an appointment and emergency basis. In circumstances where the patient is insured in respect of such charges for services provided, the fees in Table 10.1 can be applied.

| Table 10.1<br>**Primary health fees** | | **Fee** | **Equivalent MBS item number** | **Last gazetted change** |
|---|---|---|---|---|
| **General practitioner type consultations** | | | | |
| Standard consult | Less than 20 minutes | $90 | 23 | S49 018 |
| Long consult | More than 20 minutes | $140 | 36, 44 | S49 2018 |
| Health assessment for employment | Employee, pre-employment and other health screening* | $350 | Not applicable | S49 2018 |
| Nurse/ Aboriginal health practitioner consult/service | In-hours consultation for dressings and review at the premises | $111 | Not applicable | S49 2018 |
| **Emergency service presentations** | | | | |
| Medical officer attendance | Emergency attendance | $676 per hour | 160 | S49 2018 |
| Nurse attendance | Emergency attendance | $406 per hour | Not applicable | S49 2018 |

** excludes public health screening*

Where **both** a nurse and medical officer attend an emergency service presentation, only the fee for the medical officer will be applied. Patients will not be charged for more than one health professional per presentation.

# 11 Waiving of fees

## 11.1 Waiving fees

Waivers extinguish the Health Service's right to collect the debt at a future date. However prior to fees being waived, there should be every attempt to establish a payment plan. Please contact Patient Accounts with regards to payment plan options.

In particular cases, where it is established that that a person does not have the financial capacity to pay as it would involve personal financial hardship or where it is not in the public interest, charges can be waived. Examples include:

- Ineligible patients who are hospitalised for communicable diseases
- Financially disadvantaged pensioners
- Patients without any independent source of income, such as children of pensioners

The Chief Executive may waive or post-pone all or part of the charge up to $1,500 under the *Medical Services Act*. Waivers over $1,500 are to be referred to the Minister for Health for Approval. Medical Services Act available from:

*www.austlii.edu.au/au/legis/nt/consol_act/msa153/*

As soon as it is established that a person does not have the financial capacity to pay, a briefing showing the amounts owing and the reason why the charges should be waived shall be submitted to the Chief Executive through the Chief Finance Officer.

## 11.2 Credit memos

Credit memos of invoices should only be used where there has been an error in billing, i.e. services incorrectly charged in price or quantity. An example of this is the charging of a second emergency department consultation within a 24 hour period. A credit memo is to be used when the invoice has been finalised and issued.

# 12 Explanatory notes

## 12.1 Nursing home type patients (NHTP)

Public, private and DVA patients are reclassified as Nursing Home Type Patients (NHTP) if, after 35 days of continuous hospitalisation the patient no longer requires acute or sub-acute (rehabilitation or restorative) care and requires accommodation and maintenance care only. Charges are raised against all public, private and DVA Nursing Home Type patients (except ex Prisoner of War or Victoria Cross recipients). Acute Care Certificates are valid for a period up to 30 days, after which a new certificate will need to be issued.

The 35 day qualifying period may be accrued in a single or multiple hospitals either public or private. Transferring between hospitals does not effect on the qualifying period. The qualifying period is only broken if the patient is discharged from hospital and is not re-admitted within 7 days. In such cases a new 35 day period will commence from day one of the next admission, excluding statistical discharges. Periods of less than 7 days out of hospital do not break the qualifying period, though this period outside hospital care is not included in the count e.g. a patient who has accrued 20 days then takes three days of weekend leave will start day 21 when returning to the hospital.

The NHTP rate represents 87.5% of the Australian Government adult single rate pension plus rent assistance, excluding the GST compensation component and pharmaceutical allowance. Rates are adjusted in line with Consumer Price Index (CPI) by the Australian Government in March and September every year.

Private Nursing Home Type patients are to be charged both the Patient Contribution and the Basic Benefits amounts for each overnight stay.

Compensable or Medicare ineligible patients cannot be classified as Nursing Home Type Patients, regardless of the type care provided. Compensable and Medicare ineligible patients will be charged at the standard same day or overnight rate.

## 12.2 Newborn babies

All newborn babies are admitted patients. They are however further classified into unqualified or acute (qualified).

### Classification criteria

A newborn patient day is acute (qualified) if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care (ASH & RDH only)
- is admitted to, or remains in hospital without its mother

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

If a newly born baby is classified as acute (qualified), the parent or parents must elect whether the baby is to be treated as a public patient or a private patient; admission documentation must be completed as for any other patient. Should only the mother continue to require admitted patient care on the 10th day, the baby is classified as a boarder.

## 12.3 Acute care certificates

If after 35 days of continuous hospitalisation it is determined by the treating doctor that the patient requires continued acute care then the doctor is required to complete an Acute Care Certificate. The requirement under legislation for a section “3B certificate” to be issued for long stay acute patients no longer exists.

Despite this change it is however advised that a certificate still be completed if the patient is deemed to be acute. Certificates continue to be required by Veterans Affairs, TIO under the Motor Accident Compensation Act (MACA) agreement and workers compensation insurers. Should a dispute arise between a hospital and a third party whose is financially responsible for the patients treatment the acute care certificate will act as medical evidence.

Acute Care Certificates are valid for a period up to 30 days, after which a new certificate will need to be issued.

Work is currently underway nationally to develop a nationally consistent Acute Care Certificate.

## 12.4 Primary care referred

A Medicare eligible person who is referred to a specialist medical practitioner, by name, from a general practitioner (GP) or district medical officer (DMO) following provision of a primary care level service in the community for a consultation or a procedure, including radiology and pathology services.

Under ordinary circumstances (i.e. in the context in which the MBS rules have been designed) specialist consultants would receive GP type primary care level referrals in their private rooms and would Medicare bill for these services. In the Northern Territory there is insufficient critical mass of population for most specialist consultants to establish private rooms therefore Specialist Medical Consultants see private patients on hospital premises.

The important thing is that the services, which are Medicare billed, are provided within the following conditions:

- They are primary level services (i.e. community patients) and not related to a current hospital admission;
- They are referred by a GP or DMO to a named Specialist Medical Consultant;
- The Specialist Medical Consultant has the right of private practice. See ***12.5 Right of private practice***.

*Explanatory notes*

- The classification of Primary Care Referred is for non-admitted patients only.

A primary care referred patient will be Medicare bulk-billed 85% of the MBS schedule fee (no patient contribution) for non-admitted consultations, radiology and pathology services.

## 12.5 Right of private practice

The Department may grant a Staff Specialist Clinician, who is registered and credentialed to perform clinical duties for 75% of his/her employment with the Department, the ability to engage in private practice during employment time and within public hospitals.

Under such arrangements, eligible clinicians will elect to receive either Category A or Category B Private Practice Allowance in exchange for the undertaking to exercise their right to private practice to the fullest extent possible and paying over to the Department an agreed amount of the fees arising from such Private Practice work

## 12.6 S19(2) Exemptions initiative

To improve access to primary care in rural remote areas, the Australian Government will allow Medicare benefits to be claimed in respect of bulk-billed, non-admitted, non-referred professional services provided in emergency departments and outpatient clinics at some small rural hospitals. This includes nursing and allied health services.

This situation existed prior to the National Health Reform and the Australian Government continues to support the two exempt sites in the Northern Territory: Gove District Hospital and Tennant Creek Hospital.

It is important to note that these are public patient services that are claimed against the MBS under a 19(2) exemption. So whilst the public hospital employed doctor providing the service requires a valid provider number for MBS benefit purposes, they do not require engagement in private practice.

## 12.7 Multiple visits on the same day/ attendances during the same episode

The possibility exists that a person may attend, or be admitted to, and discharged from a hospital more than once in the same day.

Hospitals may charge for every outpatient attendance for chargeable patients. This means hospitals can charge for the following:

- Multiple same-day outpatient hospital attendance;
- Outpatient attendances when the patient is subsequently admitted.

Hospitals may also charge for an Emergency Department (ED) and an Outpatient attendance on the same day.

When a chargeable patient is attends ED multiple times in one day, only one emergency account is raised, being the first ED episode of the day.

*Explanatory notes*

When a chargeable day stay patient is admitted and discharged, and then subsequently readmitted and discharged within the period of one day (midnight to midnight) at the same hospital, only one day stay account is to be raised, being the first same-day inpatient episode of the day.

When a day stay patient is subsequently retained by the hospital (or if discharged and readmitted on the same day) beyond midnight on the day of admission, the patient is reclassified as an overnight stay and only charged the overnight fee.

## 12.8 Change of election

Patients should make an informed decision to be private or private at the time of admission, or as soon as possible after admission. The patient should be advised that this choice will remain for the total hospital stay unless there are unforeseen circumstances.

Unforeseen circumstances include, but are not limited to:

- A change in medical circumstances, for example where the patient is admitted for a particular procedure, but found to have complications requiring additional procedures.
- The length of stay is extended beyond that originally and reasonably planned by an appropriate health care professional.
- A change in social or financial circumstances while in hospital (eg. loss of job).

**Inadequate private health insurance cover is not sufficient reason to change an election.**

To make a change of election the patient must complete a new election form. The change is effective for the remainder of the admission and is not retrospective.

## 12.9 Telehealth and telemedicine

Charges for patients receiving services through telehealth will only be charged for the services in **one location**, i.e. location of the treating doctor, not where the patient is located. This applies to both inpatient and outpatient services delivered through telehealth. Telehealth rates can be found in the tables for non-admitted services in the applicable patient categories.

## 12.10 Private health insurance and compensation

Private Health Insurance cannot be utilised for treatment arising from compensable events.

## 12.11 No-gap policy

If a Medicare eligible patient elects to be private in a Northern Territory public Health Service, medical services provided by that public Health Service will be charged at the Medicare rate such that there are no out-of-pocket expenses for the Medicare eligible patient. Where the Medicare patient has a co-payment or excess on their private health insurance this is able to be discounted, provided all applicable waiting periods have been satisfied.

*Explanatory notes*

# Glossary

## Admission

The formal administrative process by which a patient commences a period of treatment, care and accommodation in a hospital.

## Admitted Patient

A patient who has undergone the formal hospital admission process.

## Allied health

This includes, but is not limited to, services provided by a physiotherapist, podiatrist, social worker, occupational therapist, orthoptist, dietician, audiologist or speech pathologist.

## Australian Defence Force (ADF)

Personnel serving in the Royal Australian Air Force, the Australian Army and the Royal Australian Navy.

## Australian Government

Commonwealth Government of Australia responsible for the private health insurance industry, Medicare Benefits Schedule and the Prostheses List.

## Boarder

A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. A boarder is thus defined as not admitted to the hospital. A hospital however may register a boarder.

METeOR (Metadata Online Registry)

## Compensable patient

A patient receiving hospital services who, is or may be, entitled to payment, or has received payment, by way of compensation in respect to the injury, illness or disease for which the patient is receiving those services.

## Coronary Care Unit (CCU)

A specialised ward dedicated to acute care services for patients with cardiac diseases.

METeOR (Metadata Online Registry)

## Day only or same day patient

A patient who is admitted and separated on the same day.

## Department of Veterans Affairs (DVA)

The Australian Government Department which arranges and/or pays for the health care of veterans and war widows according to their entitlement for certain services and their clinical need for those services.

## Discharge or separation

The formal administrative process by which an admitted patient ceases a period of treatment, care and accommodation in a hospital.

## Eligible person

A person who is eligible for Medicare as defined in the *Health Insurance Act 1973* as an Australian resident or eligible overseas representative. A person covered by a Reciprocal Health care Agreement is eligible for Medicare for immediately necessary medical treatment, if they elect to be a public patient. The *Health Insurance Act 1973* gives the Minister discretionary powers to either include or exclude certain persons or categories of persons for eligibility for Medicare. Eligible persons must enrol in Medicare before benefits can be paid.

## Emergency department (ED)

A purposely designed and equipped area with designated assessment, treatment and resuscitation areas. It has the ability to provide resuscitation, stabilisation and initial management of all emergencies. It utilises skills of medical staff, designated emergency department nursing staff and nursing unit manager, 24 hours per day, 7 days per week.

METeOR (Metadata Online Registry)

## Hospital

A health care institution that has an organised medical and other professional staff, inpatient facilities and delivers medical, nursing and related services 24 hours per day, 7 days per week.

WHO (World Health Organisation)

## Hospital-in-the-home (HITH)

Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

METeOR (Metadata Online Registry)

## Inpatient

See "**Admitted patient**"

## Intensive care unit (ICU)

A designated ward of a hospital, which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises skills of medical, nursing and other staff trained and experienced in the management of these problems.

METeOR (Metadata Online Registry)

## Leave

**Approved leave** may be provided to admitted patients. This may be granted up to a maximum of 7 days leave without being separated from a hospital.

**Non Approved Leave** is where the patient leaves the hospital without being officially discharged or without giving notice or has left with medical advice been given and understood by the patient (informed decision).

## Medicare Benefits Schedule (MBS)

The schedule of fees set by the Government for standard medical services, based on a fair price and how much Australia can afford to pay for the total health system. Whether you have private health insurance or you are a private patient paying for all your own costs, the Government provides a rebate on nearly all medical fees. This rebate is currently 75% of the MBS fee for in-hospital medical fees and 85% of the MBS fee for specialist medical fees incurred out of hospital. You can purchase health insurance to cover the remaining 25% of the MBS fee and gap cover for any potential additional fees.

## Motor Accident Compensation Act (MACA)

Northern Territory Act which establishes a no fault compensation scheme in respect of death or injury in or as a result of motor vehicle accidents, prescribes the rates of benefits to be paid under the scheme and abolishes certain common law rights in relation to motor vehicle accidents.

## Neonate

A live birth that is less than 28 days old.

METeOR (Metadata Online Registry)

## Newborn Qualification Status

Qualification status indicates whether a patient day within a newborn episode is either acute (qualified) or unqualified.

METeOR (Metadata Online Registry)

## Non-Admitted Patient

A patient who does not undergo a hospitals formal admission process. There are three categories of non-admitted patient:

- Emergency Department patient
- Outpatient
- Other non-admitted patient (treated by hospital employees off the hospital site – community/outreach services.

METeOR (Metadata Online Registry)

## Nursing home type patient (NHTP)

The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

## Outpatient

See "**Non-admitted patien**t"

## Overnight stay

Where a patient has been admitted into hospital and is accommodated in that hospital as at midnight (i.e. remains an admitted patient of the same hospital until a calendar day subsequent to the calendar day of their admission).

## Patient

A person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patients, admitted and non-admitted. Boarders are not patients.

METeOR (Metadata Online Registry)

## Primary care referred patient

A Medicare eligible person who is referred to a specialist medical practitioner by name from a general practitioner/district medical officer following a primary care level service in the community for a consultation or a procedure, including radiology and pathology services.

## Patient Assistance Travel Scheme (PATS)

PATS promotes equity of access to specialist medical services. To be eligible for PATS the patient must: be a Medicare eligible resident of the NT, reside more than a 200km radius from the specialist (offshore locations are exempt from this e.g. Bathurst Island and Groote Eylandt) and NOT entitled to compensation or other alternative funding for travel.

## Private patient

A private patient is a person who is eligible for Medicare, who on admission elects to be treated as a private patient. The patient receives medical or diagnostic services from a medical practitioner chosen by the patient.

## Prostheses (surgically implanted)

Surgically implanted prostheses, includes such things as hip replacements, artificial lenses and heart valves.

## The prostheses list

Under the *Private Health Insurance Act 2007*, private health insurers are required to pay mandatory benefits for a range of surgically implanted prostheses that are provided as part of an episode of hospital treatment (or hospital substitute treatment) where a Medicare benefit is payable for the associated professional service(surgery). There are more than 9,000 products on the Prostheses List. The List does not include; external legs, external breast prostheses, wigs and other such devices.

## Public hospital

A hospital funded by the Government. 'Recognised' public hospitals have access to the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and private health insurance arrangements.

## Public patient

A Medicare eligible patient who elects to be treated in a public hospital under Medicare, by a doctor appointed by the hospital.

## Right of private practice

The Department may grant a Staff Specialist Clinician the ability to engage in private practice during employment time within public hospitals.

## Same-day patient

A patient who is admitted and separated on the same date, and who meets one of the following minimum criteria:

1. that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (Commonwealth),
2. that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

METeOR (Metadata Online Registry)

## Special care nursery (SCN)

A hospital ward staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

METeOR (Metadata Online Registry)

## Telehealth

The use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

International Organisation for Standardisation

## Telemedicine

The use of advanced telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers.

International Organisation for Standardisation

# Attachment A - Prosthetic Fees

Please note that the fees set out in the table are only for Public Patients. Compensable and Ineligible patients will be charged on a case by case basis, at full cost recovery.

## Prosthetic Fee Schedule for Public Patients

| Code | Prosthetic Description | Fee |
|---|---|---|
| 1A | TR work prosthesis, socket, hook, cable, harness, lock, silicon liner | $3,935 |
| 1B | TR dress prosthesis (self-suspend), socket, cosmetic hand, glove, lock, silicon liner | $3,985 |
| 1C | TR dress prosthesis (harness suspend), socket, cosmetic hand, glove, cable, harness | $2,770 |
| 1D | PH prosthesis, socket, hand, glove | $1,610 |
| 2A | TH work prosthesis, socket, elbow unit, hook, cable, harness, lock, silicon liner | $4,915 |
| 2B | TH dress prosthesis, socket, elbow unit, cosmetic hand, glove, cable, harness, lock, silicon liner | $5,065 |
| 2C | TH dress prosthesis, socket, elbow unit, cosmetic hand, glove, cable, harness | $3,750 |
| 3A | SD, modular socket, shoulder, elbow, cosmetic hand, glove, cable, harness, soft cover, adaptors | $4,400 |
| 3B | SD prosthesis, standard, socket, shoulder unit, elbow unit, hook, cable and harness | $7,170 |
| 4A | Ankle Symes, socket, foot, socket adaptor | $2,920 |
| 4B | Partial foot, socket, tibial tubercle height, with toe filler | $2,570 |
| 5A | TT exoskeletal , socket, foot, ankle, shin, pelite liner | $3,070 |
| 5B | TT endoskeletal, socket, foot, adaptors, soft cover , lock, silicon liner | $4,850 |
| 5C | TT endoskeletal, socket, foot, adaptors, soft cover, PTB cuff, PTS | $3,120 |
| 6A | TT, exoskeletal, socket, joints, thigh lacer, ankle, shin, foot | $4,510 |
| 6B | TT, endoskeletal, socket, joints, thigh lacer, foot, soft cover, adaptors | $4,320 |
| 6C | TT exoskeletal, socket, joints, ischial bearing thigh section, shin, ankle, foot | $4,870 |
| 6D | TT endoskeletal, socket, joints, ischial bearing thigh section, foot, soft cover, adaptors. | $4,680 |

*Attachment A – Prosthetic fees*

| Code | Prosthetic Description | Fee |
|---|---|---|
| 7A | KD endoskeletal, socket, foot, knee unit, soft cover, adaptors. | $6,300 |
| 7B | KD exoskeletal , socket, external knee joints, ankle, shin, foot | $6,110 |
| 8A | TF exoskeletal , suction socket, knee unit, shin, ankle, foot, valve | $6,700 |
| 8B | TF endoskeletal , socket, foot, knee unit, adaptors, soft cover, lock, silicon liner | $7,790 |
| 8C | TF exoskeletal, socket, knee unit, ankle, shin, foot, waist band, hip joint, | $6,553 |
| 8D | TF endoskeletal, socket, knee unit, foot, waist band, hip joint, adaptors, soft cover. | $6,900 |
| 9A | HD Canadian type, exoskeletal , socket, hip joint, knee unit, shin, ankle, foot | $8,260 |
| 9B | HD Canadian type, endoskeletal, socket, hip joint, knee unit, foot, adaptors, soft cover. | $8,970 |
| 10A | Removable Rigid Dressing | $530 |

# Attachment B - Orthotic Fees

## Orthotic Fee Schedule

| Code | Orthotic Description | Fee |
|---|---|---|
| **Helmets** | | |
| HO1 | Prefabricated soft helmet | $160 |
| HO2 | Prefabricated hard helmet | $390 |
| HO3 | Custom made hard helmet | $1,550 |
| HO4 | Paediatric shaping helmet | $1,550 |
| **Spinal orthotics and supports** | | |
| SP01 | Patriot collar | $138 |
| SP02 | One piece collar | $138 |
| SP03 | The original Philadelphia collar | $144 |
| SP04 | Philadelphia tracheotomy collar | $143 |
| SP05 | Philadelphia stabilizer | $175 |
| SP06 | Atlas collar | $174 |
| SP07 | Miami j advanced cervical collar | $200 |
| SP08 | Miami j cervical collar | $238 |
| SP09 | Occian back | $248 |
| SP10 | Miami junior cervical collar | $210 |
| SP11 | Papoose | $385 |
| SP12 | Miami JTO thoracic extension | $475 |
| SP13 | Non-surgical halo | $720 |
| SP14 | Miami lumbar belt, LSO | $379 |
| SP15 | Miami lumbar TLSO | $495 |
| SP16 | Elastic sacro cinch brace | $160 |
| SP17 | Comfortmax chair back brace | $235 |

*Attachment B - Orthotics fee*

| Code | Orthotic Description | Fee |
|---|---|---|
| **Spinal orthotics and supports** (continued) | | |
| SP18 | Flat pack low Taylor/chair back | $255 |
| SP19 | Hyperextension brace | $349 |
| SP20 | CASH brace | $260 |
| SP21 | Flex hyperextension brace | $380 |
| **Abdominal binder** | | |
| AB01 | Soft, elastic abdominal binder | $150 |
| AB02 | Back cinch binder | $150 |
| AB03 | Maternity support belt | $155 |
| **Hip orthotics** | | |
| HIP01 | Custom made hip knee ankle foot orthotic, plastic and metal, knee and hip | $1,410 |
| HIP02 | Custom made hip abduction brace | $970 |
| HIP03 | Prefabricated hip abduction brace | $610 |
| **Trusses** | | |
| T01 | Custom made hernia truss | $170 |
| T02 | Prefabricated hernia truss scrotal | $150 |
| T03 | Prefabricated hernia truss inguinal | $150 |
| **Knee orthotics** | | |
| K01 | Post-operative knee extension brace | $150 |
| K02 | Knee sleeve neoprene | $135 |
| K03 | Patella femoral brace | $178 |
| K04 | Wrap around hinged knee support | $158 |
| K05 | Hinged knee support – pull on | $155 |
| K06 | Prefabricated knee ligament bracing | $815 |
| K07 | Custom made knee ligament bracing | $1,200 |

*Attachment B - Orthotics fee*

Hospital fees

| Code | Orthotic Description | Fee |
|---|---|---|
| **Knee orthotics** (continued) | | |
| K08 | Prefabricated knee osteoarthritis bracing | $905 |
| K09 | Custom made knee osteoarthritis bracing | $1,555 |
| K10 | Swedish knee cage | $408 |
| **Knee ankle foot orthotics** | | |
| KAFO1 | Custom made KAFO, spring loaded lockable knee, plastic, metal uprights | $2,770 |
| KAFO2 | Custom Made KAFO, Free Knee Joints, Metal and Leather | $2,770 |
| KAFO3 | Custom made advanced KAFO | $3,500 |
| KAFO4 | Prefabricated advanced KAFO | $3,620 |
| **Ankle foot orthotics** | | |
| AFO1 | Grenace ankle brace | $172 |
| AFO2 | Grenace all terrain ankle brace | $172 |
| AFO3 | Air stirrup ankle brace | $188 |
| AFO4 | Active Ankle Brace T1 and T2 | $172 |
| AFO5 | Positive lock night splint | $170 |
| AFO6 | Paediatric positive lock night splint | $180 |
| AFO7 | Prefabricated leaf spring AFO | $176 |
| AFO8 | Custom made leaf spring AFO | $530 |
| AFO9 | Custom made solid ankle AFO | $530 |
| AFO10 | Custom made jointed AFO - tamarack | $700 |
| AFO11 | Custom made jointed AFO - gillette | $700 |
| AFO12 | Prefabricated carbon fibre dynamic AFO | $545 |
| AFO13 | Prefabricated carbon AFO light | $595 |
| AFO14 | Foot up no shoe | $210 |
| AFO15 | Foot up with shoe | $174 |

*Attachment B - Orthotics fee*

Hospital fees

| Code | Orthotic Description | Fee |
|---|---|---|
| **Ankle foot orthotics (continued)** | | |
| AFO16 | Custom made GRAFO | $770 |
| AFO17 | Custom made PTB AFO | $890 |
| AFO18 | Custom made crow boot | $1,010 |
| AFO19 | Custom made single/double upright AFO with joint and ferrule | $580 |
| AFO20 | Total contact cast | $170 |
| AFO21 | Camwalker standard | $165 |
| **Foot Orthotics** | | |
| FO1 | Insoles PPT/pelite 3mm | $110 |
| FO2 | Insoles PPT/pelite 6mm | $110 |
| FO3 | Heel pads/wedge PPT/pelite | $110 |
| FO4 | Hallux valgus night splint | $148 |
| FO5 | Hallux valgus day splint | $127 |
| FO6 | Custom made medial arch supports/metatarsal dome/semi rigid (pair) | $410 |
| FO7 | Custom made medial arch supports/metatarsal dome/ rigid (pair) | $530 |
| FO8 | Custom made arch supports with heel cup (plastic) (pair) | $410 |
| FO9 | Custom made UCBL (pair) | $410 |
| F10 | Silicon toe spacer | $122 |
| F11 | Foam toe spacer | $122 |
| **Post-operative boots** | | |
| PO1 | OTS post-operative boots | $132 |
| PO2 | Triple post-operative boots | $145 |
| **Shoe modifications** | | |
| SBU1 | Shoe Build Up < 20mm | $170 |

*Attachment B - Orthotics fee*

| Code | Orthotic Description | Fee |
|---|---|---|
| **Shoe modifications** (continued) | | |
| SBU2 | Shoe Build Up > 20mm | $230 |
| SBU3 | Shoe build up > 40mm | $290 |
| SBU4 | Shoe build up > 60mm | $350 |
| CMF | Custom made footwear | $1,000 |
| SM01 | Shoe stiffener plastic | $110 |
| SM02 | Shoe stiffener steel/carbon fibre | $170 |
| SM03 | Custom made rocker sole | $170 |
| SM04 | Custom made shoe wedges | $170 |
| SM05 | Metatarsal bar | $110 |
| SM06 | T strap fitted to shoe | $170 |
| SM07 | Round ferrule fitted to shoe | $170 |
| SM08 | Square ferrule fitted to shoe | $170 |
| **Paediatric** | | |
| P01 | Parlick Harness G hips | $190 |
| P02 | Dennis brown CDH cuff and bar | $200 |
| **Wrist and hand orthotics** | | |
| W01 | Pre-fabricated neoprene wrist brace | $150 |
| W02 | Pre-fabricated neoprene wrist brace with extra supports | $155 |
| W03 | Pre-fabricated palmer wrist brace | $160 |
| W04 | Pre-fabricated resting hand splint | $168 |
| W05 | Pre-fabricated wrist brace with thumb abduction | $155 |
| W06 | Pre-fabricated ulnar deviation brace | $150 |
| W07 | Custom made wrist brace | $290 |
| W08 | Custom made finger brace | $170 |
| W09 | Pre-fabricated Finger Brace | $145 |

*Attachment B - Orthotics fee*

| Code | Orthotic Description | Fee |
|---|---|---|
| **Elbow orthotics** | | |
| E01 | Pre-fabricated elbow range of motion brace | $290 |
| **Shoulder orthotics** | | |
| SH01 | Pre-fabricated shoulder abduction sling | $170 |
| SH02 | Pre-fabricated shoulder sling | $150 |
| SH03 | Pre-fabricated ac sling | $165 |
| **Miscellaneous** | | |
| MIS01 | Mobility aid | To quote as needed |
| MIS02 | Special order aid/appliance | To quote as needed |