Visiting Medical Officer (VMO) Claims Management

GUIDELINE

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1 BACKGROUND

1.1 About this document

The purpose of this Guideline is to notify arrangements that will facilitate more effective scrutiny of VMO claims to ensure that they are appropriate to be paid.

1.2 Key definitions

"Area Health Service" is sometimes referred to in older documents. This should be read as Local Health District.

"Call-back" means called to attend a hospital, whether or not rostered on-call, at a time when the VMO would not otherwise have attended the hospital, in response to a request from the relevant hospital or public health organisation (PHO) to attend for the purpose of providing services.

"Emergency after-hours medical services" means services initiated by or on behalf of non-chargeable patients whose medical conditions require immediate treatment and which take place on a public holiday, on a weekend, or at any time other than between 8.00 am and 6.00 pm on a weekday, not being a public holiday.

"Immediate treatment" refers to emergency medical attention given to patients which requires immediate cessation of all other activities and immediate attendance by the doctor. It includes those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious deterioration of the patient's health.

"Fee-for-service contract" means a fee-for-service contract as defined in the *Health Services Act 1997*.

"On-call" means rostered to be available to attend public patients pursuant to an on-call roster prepared by a public health organisation in consultation with the relevant clinical department;

"Regional visiting medical officer**"** means a VMO:

(i) who is appointed for a continuous period of at least 12 months under one or more service contracts in respect of one or more regional hospitals listed in Schedule1 to the Determinations; and
(ii) who is engaged under standard contract arrangements approved by the NSW Ministry of Health.

1.3 Legal framework

Rural Doctors' Settlement Package Hospitals

- RDA Schedule of Fees

VMO Model Service Contracts

- Model sessional service contract
- Model sessional service contract - practice company
- Model fee-for-service service contract

- Model fee-for-service service contract - practice company
- Fee-For-Service VMO Practice Company - Rural Doctors Package Hospitals
- Fee-For-Service - Rural Doctors Package Hospitals

Determinations

- Public Hospitals (Visiting Medical Officers Fee-For-Service Contacts) Determination 2007
- Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2007

Medicare Benefit Schedule (MBS)

2 VMO GENERAL INFORMATION

2.1 Submission of VMO Claims

VMOs, or those who make claims on their behalf (e.g. practice managers), should submit their on line claims to the relevant hospital department on a monthly basis, consistent with the relevant Determination or the terms of the Rural Doctors Settlement Package (RDSP). Compliance with the relevant Determination or the Package is mandatory.

It is recommended that the claims submitted after the 15th of the month be processed and notification of the requirement to submit the claims in accordance with the Determinations or RDSP be issued to the VMO.

The VMO must be notified that a separate claim needs to be submitted for each month and for each facility where the services were provided.

A VMO will maintain a record, in the form prescribed, of services rendered by the VMO under the sessional contract. This record will indicate, in respect of each of the services so rendered:

a) the date, commencing and finishing times, full name and/or medical record number of the patient and nature of service;
b) particulars of on-call periods;
c) for call-backs, the name and/or designation of the person requesting the call-back, and appropriate entry by the VMO in the medical record of the relevant attendance and/or treatment;
d) particulars of teaching, training and committee work;
e) particulars of any leave of absence.

The record referred to will be maintained for each calendar month during which services are provided by a VMO, and it shall be submitted to the PHO as part of the claim. Note that the VMO Determinations provide that where a public health organisation and a visiting medical officer agree that sufficient information is otherwise available to the public health organisation from the medical records or the visiting medical officer's personal records, then so long as such information continues to be available there is no requirement for the visiting medical officer to provide the full name and/or medical record number of patients.

2.2 Reports to be used when checking claims

Relevant reports and resources should be used to check the validity of the claims. VMOs must have made an appropriate notation identifying services to be paid in the Medical Record. It is acceptable for the notation to have been made by a member of the junior medical staff on behalf of the VMO, but it must identify with sufficient precision the date and nature of the service provided.

Relevant records, that can authenticate VMO claims include:

- eMR (Electronic Medical Record);
- PAS (Patient Administration system);
- PMI (Patient Master Index);
- Approved Committee lists, attendance records, minutes and action lists;
- Records of Non-Standard Arrangements approved by the Ministry of Health;
- Applicable Service Plans;
- Call Back Registers;
- VMoney Web;
- Surginet; and/or
- rosters.

2.3 Checking VMO claims

VMoney Web is programmed to request particulars for each aspect of a claim. This should enable checkers to assess all lines of the claim against existing records. PHOs should give consideration to the following:

- Review whether enough information has been provided or is otherwise available to enable the claim to be validated. If not, refer the claim back to the VMO by rejecting the line/s for more information or identify your concern in the comment field before claims are escalated to the approver.
- Claims identified as being inconsistent with the rules are marked with an orange or red flag. Claims marked with red flags cannot be approved. Claim lines with orange flag that are forwarded for approval should have further information entered by the checker with an explanation of why the claim should be approved.
- All claims under the Miscellaneous tab must be reviewed by the PHO.
- Checkers should ensure that the correct cost centre is provided and seek authorisation to make changes where required.
- PHOs will need to maintain an up-to-date list of any approved non-standard arrangements in place with the VMO. **Where a non-approved non-standard arrangement is being claimed, Directors of Medical Services should contact the Workplace Relations Branch at NSW Ministry of Health if confirmation is required that arrangements have been properly approved.**

2.4 Meeting claims

VMOs are entitled to claim payment for attendance at meetings under the terms and conditions of the Determinations and the Rural Doctors Settlement Package.

VMOs with Sessional contracts

"4(7) A visiting medical officer shall participate in committees expressly established or authorised by the public health organisation to which the officer is appointed where reasonably required by the public health organisation for the proper and efficient functioning of the hospital or hospitals concerned."

"5(2) In establishing the annual ordinary hours….regard shall be had to:

(a) the services to public patients…, taking into account ….. committees to which the officer is appointed under clause 4(7);"

VMOs with Fee For Service contracts – reference IB2007_044

"4(7) A visiting medical officer shall participate in committees expressly established or authorised by the public health organisation where reasonably required by the public health organisation for the proper and efficient functioning of the hospital or hospitals concerned."

"5(5) A visiting medical officer shall be remunerated for his or her time spent participating in ……committees (as required under subclause 4(7)) in accordance with the hourly remuneration rates applying at that time under sessional contracts."

VMOs with Fee for Service Rural Doctor Package Hospital contracts

The VMO shall participate in committees expressly established or authorised by the Board of the PHO and to which the VMO is appointed where here reasonably required by the Area Health Service for the proper and efficient functioning of the hospital concerned. The VMO will be remunerated for such participation in accordance with the Rural Doctors Settlement Package.

Note that time spent travelling to and from committee meetings are to be paid if the meeting is more than 25 km from the rural health facility where the VMO has his or her primary appointment.

The fee is payable for meetings concerned with hospital patient management, peer review, clinical privileges, credentialing, clinical planning and Quality Assurance where meetings are of a type approved by the PHO Chief Executive or delegate. Approved meetings do not include meetings of the Medical Staff Council or Local/Health Service Boards.

PHOs should reimburse VMOs where their attendance and clinical input into the meetings is requested by the PHO. For those meetings for which reimbursement is approved, the PHO should receive a positive output to improve services / processes (eg Minutes, recommendations etc).

Discussions regarding reimbursement for meetings, and VMO involvement, should be approached in a co-operative manner. This could include discussion of the budget for meetings and the number of VMOs required to attend.

Committees that have VMOs as members should have defined the VMO members(s) of the Committee by name and /or position held.

The following information is extracted from the RDSP and maybe considered for implementation by PHOs under the arrangements for Sessional contracts and FFS contracts.

Meetings for which payments will be available include:

- PHO based administrative meetings where VMO assistance is required or requested (e.g. Medical and Dental Appointments Advisory Committee, Credentials Committee, "Clinical Stream" meetings, Clinical Council, Chronic and Complex Care, Aged Care, etc).
- Hospital administrative meetings where VMO assistance is required or requested (e.g. infection control meetings, operating theatre management committees, Morbidity and Mortality Committees, Patient Care Committees, Perinatal Committee, etc). **Note:** there needs to be an output from the committee eg recommendations and the detail of the attendance record reflected in formal Minutes of the meetings.
- Ad hoc meetings where a VMO presence is requested by a hospital manager or LHD Executive (eg planning meetings, meetings with consultants etc).
- In accordance with the VMO Determination, Hospital General Managers are to submit to the Chief Executive, for authorisation, Committees for which VMO payment is to be made.

Examples of meetings for which payments will not be available:

- Medical Staff Council Meetings;
- Education meetings for the benefit of the medical officer;
- Public relations type meetings where VMO may be invited and attends by their own choice (e.g. opening ceremonies, meetings with dignitaries); and
- Any non-approved meetings.

Note: Where claims are submitted for attendance at meetings, checkers should ensure that the meeting for which reimbursement is being sought has been approved by checking with the relevant Director Medical Services/Health Service Manager, and meeting Minutes must be checked for attendance before payment is made.

2.5 Cancelled Theatre Sessions

The VMO is entitled to be paid for that portion of the cancelled time that is reasonably estimated would have involved the treatment of non-chargeable patients at the hourly rates, on the condition that the VMO attends the PHO to provide services for the relevant period in lieu of the cancelled theatre session, unless excused from such attendance by the PHO.

The payment should only apply in circumstances where:

A VMO has a pre-arranged operating theatre session cancelled by the PHO:

- less than 28 day notice of such cancellation was provided to the anaesthetists;
- less than 14 day notice of such cancellation was provided to a regional VMO who is not an anaesthetist;
- less than 7 day notice of such cancellation was provided to other VMOs.

For payment to be made, the following activities should be undertaken as requested by the PHO:

- undertaking training and education activities specified by the PHO;
- undertaking clinics or procedures within the scope of the VMO's clinical privileges;
- undertaking quality assurance or review activities specified by the PHO.

Where a VMO cancels a pre-arranged operating theatre session, and the cancellation is not due to illness, the VMO is required to make up the cancelled time over the ensuing 14 day period at time/s of mutual convenience to the VMO and the PHO. If such mutually convenient time is unavailable, the VMO will cooperate with the PHO in examining the feasibility of alternate arrangements with another medical practitioner for the performance of operations or procedures upon non-chargeable patients affected by such cancellation.

2.5.1 Checking the Claims Arising from Cancelled Theatre Sessions

The checker must:

- check claims that relate to theatre session cancellations for provision of alternative services;
- check any memos or other notifications provided to staff of planned theatre session cancellation. Where sufficient notice has been provided the claim should be rejected.
- where it is identified that a theatre session has been cancelled and a claim is still made for rostered hours, review contractual or other arrangements in place for that VMO or department. Unless the VMO has been excused from attendance by the PHO, check that sufficient information about how the time was spent has been included in the claim. Refer the claim back to the VMO for more information where needed.
- check Theatre Lists to assess whether the claim relates to the portion of the cancelled time reasonably estimated would have been involved in the treatment of non-chargeable patients.

Note that the Determination applies to cancelled theatre sessions. There is no provision for payment for individual theatre cases cancelled within a theatre session.

Before escalating a claim for approval that includes a claim for rostered hours where a theatre session has been cancelled, include notes in the checkers comments section in VMoney Web of a sufficient nature to allow the approver to know to review the claim closely prior to approving. Comments should identify that the claim is for hours where the theatre session has been cancelled with insufficient notice provided by the PHO, any specific contractual or other arrangements in place or any other issue that may need to be taken into consideration when approving the claim.

VMoney Web will flag where there is a claim made for other work at the same time as a claim for hours under this provision.

2.6 Professional Support Grants for Regional Visiting Medical Officers (RVMOs)

The following eligibility criteria apply:

As at 1 January each year, a RVMO needs to:

1. have held an appointment continuously for the immediately preceding 12 months, and
2. reside within a 50 kilometre radius of the regional hospital where services are provided.

In addition to meeting criteria 1 and 2, eligibility for the **$10,000** grant is further conditional on the RVMO:

- having provided at least 450 ordinary and/or call-back hours of services over the preceding 12 months at one or more regional hospitals (sessional); **or**
- having provided services (including planned services and emergency after hours medical services) involving fees of at least $100,000 in total over the preceding 12 months at one or more regional hospitals (fee-for-service)

In addition to meeting criteria 1 and 2 above, eligibility for the **$5,000** grant is further conditional on the RVMO;

- having participated on a 1:4 or more frequent basis in an on call emergency after-hours medical services roster applying in at least one regional hospital over the preceding 12 months.

A RVMO may be eligible for one or both grants.

Professional support grants **are not payable** for services provided by VMOs remunerated under the Rural Doctor Settlement Package. Where a VMO holds appointments at both Regional and RDSP hospitals, services provided by VMOs, when remunerated under the Rural Doctor Settlement Package, are not included when calculating VMOs service under the eligibility criteria 3, 4 and 5 above.

2.6.1 VMOs remunerated under both Sessional and FFS arrangements

In relation to the $10,000 grant, RVMOs who are remunerated under both sessional and FFS arrangements eg Obstetricians & Gynaecologists, may not satisfy the criteria under either sessional or FFS but might meet the requirements if both were combined.

It is appropriate in these circumstances, to consider the whole contribution of the VMO. For example if sessional hours total 270 (270/450 = 60%) and FFS payments $70,000 (70,000/100,000 = 70%), the VMO's total commitment equates to 130% thereby qualifying for the $10,000 grant.

There is no provision for a proportionate entitlement if minimum criteria are not satisfied i.e. if appointment is less than 12 months in the previous calendar year, or the VMO has not worked minimum specified sessional hours, or FFS payments were less than $100,000 in previous calendar year. Each calendar year stands alone.

2.6.2 Eligibility commences on 1 January each year

Eligibility for claims in the current calendar year is based on criteria met in the previous calendar year (referred to as accrual year in the Claim Form). A RVMO who has met the criteria in the previous calendar year is entitled to access the full amount of the professional support grant from 1 January in the current calendar year.

2.6.3 Cumulative Grants

Separate professional support grants of $10,000 and/or $5,000 annually, accrue for up to two years, provided the VMO continues over that two year period to satisfy the eligibility criteria. The two years is from 1 January until 31 December the following year. For example a RVMO meets the criteria in calendar year 2012 and becomes eligible for professional support grant from 1 January 2013. The RVMO has until 31 December 2014 to use the grant before any unused funds expire and are removed from the RVMOs balance.

If a VMO ceases to meet the eligibility criteria but has an accrued balance from previous years, the RVMO can continue to access the balance until it has been fully claimed or the 2 year accrual period has expired, whichever comes first, provided the VMO continues to meet eligibility criteria 1 and 2 outlined above in section 3.6.

2.6.4 Services at more than one Regional Hospital

Services at more than one 'regional hospital' shall be considered for determining eligibility for these grants. However a RVMO is not eligible to receive grants from more than one Local Health District per calendar year. The Local Health District at which the RVMO has the greatest service commitment shall be responsible for payment of the grant.

2.6.5 RVMO resignation or end of contract

If a RVMO resigns or their contract expires, professional support grant payments are not to be made for a conference or course occurring after the end of the VMO's contract or resignation date.

2.6.6 Reimbursements in Advance of a Conference

Payments made in advance for conference/course registrations, air fares and accommodation, and supported by original invoices and receipts, may be reimbursed prior to attendance on the understanding that if attendance at the conference/course does not proceed the amount advanced is to be repaid to the PHO within 14 days of the non-attendance becoming known.

Such advance reimbursements are to be treated as payment of the entitlement for the year in which the entitlement falls due after having established that such entitlements have accrued in the previous calendar year/s, eg payments reimbursed in December 2012 for a conference in January 2013 is debited against the entitlement for 2013 (which may also include the balance of entitlements left over from 2012).

2.6.7 Notes

Professional support expenses are costs incurred by a RVMO for their own professional development. Expenses incurred by family, friends or other medical practitioners are not included.

Prior approval to incur professional support expenses is not necessary. However, RVMOs are advised to consult with the Director Medical Services (DMS) in the first instance in respect of costs for “other items” not anticipated in the examples of such expenditure set out below. To provide consistency DMSs are advised to seek clarification from the District DMS.

In respect of “costs of locum cover” this means the net cost of engaging locum cover in private rooms while attending conferences and courses associated with continuing education. For example if a locum costs $1500 per day but generates $1000 per day in income then the net cost of $500 per day could be claimed as a professional support expense. The locum’s travel and accommodation costs, not meals, could also be claimed. These costs would only be applicable for the time required for the VMO to travel to and from and attend the conference, not for any associated extra leave the VMO might take.

In respect of “other items” this includes expenditure on such items as listed below. It must not include items associated with the “business” of conducting a private practice.

2.6.8 Allowable expenses

The following are allowable expenses:

- registration fee for a course/conference;
- return travel to and from the course/conference. Travel does not need to be approved in advance by the PHO. There is no need to book flights through the Government contractor. Reimbursement is limited to Business class or lesser airfares. First class airfares will not be reimbursed;
- travel insurance;
- airport transfers, taxis, airport parking, car hire and fuel costs for the RVMO to attend a course / conference;
- fuel costs or travel claim at the transport rate set out in the relevant Information Bulletin, currently 37.5 cents per km, when the RVMO drives to the course/conference;
- accommodation expenses while attending a course/conference. Only the costs of accommodation directly related to the course/conference (i.e. night before, up until and including last night) can be claimed. Any additional days holiday accommodation are at the expense of the RVMO. Accommodation will only be paid for a single or double room, and not an apartment of 2 or more bedrooms;
- locum expenses as per ‘notes’ above;
- laptop including hard drive/memory upgrade and warranty, or ultrabook, or netbook, or iPad or Tablet up to the cost of $5,000 on the basis of one item every two years. Equipment remains the property of the PHO;
- printer up to the cost of $500 on basis of one every two years. Medical texts, CDs, DVDs and subscriptions for professional journals;
- medical education programs;
- tertiary education course fees relevant to the specialty area; and
- registration for webinar, Up-to-Date, on-line conference participation and associated reading material.

2.6. 9 Expenses not approved include:

The following expenses are not approved:

- desktop personal computer;
- printer consumables such as ink, paper etc;
- laptop carry case;
- hard drive back up;
- smart phone purchases and monthly mobile phone plans;
- telephone and internet connection and monthly accounts;
- anti-viral protection software, general software and business related programs;
- medical / clinical equipment;
- DVD players / recorders etc;
- payment for frequent flyer points used in travel booking;
- excursion flights/trips from conference venue;
- meals and beverages, eg restaurant meals, take away meals, supermarket receipts café snacks and beverages, hotel room meals and snacks etc;
- hotel room internet connection and movie hire;
- per diem meals, incidentals and accommodation allowance as per Staff Specialist entitlements;
- AMA and Specialty College/Professional Association fees;
- Medical Staff Council membership; and
- hospital library contribution.

2.6.10 Checking claims

1. Claims should not include costs which are reimbursed by other organisations.
2. Claims are to be substantiated by **ORIGINAL TAX INVOICES & RECEIPTS,** or other appropriate evidence, in the case of locum expenses. Invoices and receipts for approved claims will not be returned to the RVMO.
3. Claims must be adjusted to exclude fares, accommodation, etc of family members accompanying the RVMO to conferences or direct costs relating to holidays taken in conjunction with attendance at the conference.
4. Claims will be returned if “unsigned”, if expenses have not been adjusted to exclude family members or are without original invoices/receipts.
5. Amounts reimbursed will be included as part of Miscellaneous payments in the VMoney system and will be reflected accordingly in the annual Statement of Earnings.

2.6.11 Auditing of claims

At the commencement of each **calendar year** a schedule of RVMOs who satisfy conditions for RVMO (at a Regional Hospital) and eligibility for the professional support grants should be prepared and maintained by each Medical Administration Unit for audit purposes.

The Schedule, which will also serve to identify RVMOs qualifying for a special loading for "call back/emergency after hour services" in the calendar year going forward, should be made available to HealthShare VMoney Supervisor for updating of VMoney records for qualifying VMOs.

When calculating eligibility for the $10,000 grant, the sessional fees of at least $100,000 in the calendar year represent the fees for services provided in the calendar year, not the payments made in the calendar year. Some of the services provided may not be billed until the following year. GST is included in amount billed therefore is to be included in the amounts to make up the sessional payments towards the $100,000 criteria. These factors need to be taken into consideration when determining VMO eligibility, particularly for the VMOs who are close to the $100,000 amount.

As a minimum the Schedule should indicate, in relation to each VMO that the VMO:

i) has held continuous appointment during all of previous calendar year - (Yes/No);
ii) resides within 50 km radius of regional hospital where VMO provides services – (Yes/No);
iii) is engaged under standard contract arrangements approved by the NSW Ministry of Health – (Yes/No);
iv) ordinary and call-back hours – previous calendar (accrual) year;
v) FFS payments - previous calendar (accrual) year;
vi) On Call commitment – previous calendar year eg 1:3, 1:5;
vii) Eligible for additional % loading for emergency call backs - Yes/No;
viii) Eligible for defined service $10,000 grant – Yes/No;
ix) Eligible for onerous on-call $5,000 grant – Yes/No;

Checkers processing claims should note that eligibility for claims in the **current calendar year** is based on criteria met in the **previous calendar year** (referred to as **accrual year** in the Claim Form). Note that entitlements accrue for two calendar years.

The Claim Form is intended to also serve as an on-going record of entitlements, claims paid, and balance of grants available. Therefore copies of processed Claims Forms should be maintained for each eligible RVMO as an ongoing record. This is not intended to prevent hospitals maintaining other additional records.

Reimbursement of professional support expenses includes reimbursement of the GST paid by the RVMO.

3 SESSIONAL VMO GENERAL INFORMATION

The sessional payment system is based on time providing services to non-chargeable, public patients. A sessional VMO is paid an hourly rate of remuneration for each ordinary hour (and on a proportionate basis to the nearest quarter hour) specified in a sessional contract for services provided to public type patients, consistent with the clinical privileges granted to the VMO. The ordinary hours during which a VMO is to provide services will be as agreed between the VMO and the PHO on an annual basis. Rate increases for sessional contracts are applied in July of each year and are set out in the current NSW Ministry of Health Policy Directive.

In respect of remuneration for ordinary hours of service, one of the following options apply to sessional VMOs as set out at clause 5(3) of the sessional Determination:

Option 1 – Budgeted actual hours remuneration;
Option 2 – Specified procedures remuneration;
Option 3 – Agreed hours remuneration.

Number of ordinary hours may be varied at any time by written agreement between the VMO and the PHO.

3.1 Review of Monthly VMO Claims

Subject to 14(2) of the Determination, PHOs, must ensure that all claims submitted by sessional VMOs are checked. Checking should confirm that the named patient was an in/out patient of the hospital on the dates claimed and ensure that times involved in providing services to all chargeable patients have been deducted.

Where claims for non-standard arrangements have been submitted, checkers should ensure that approval was given by the Ministry of Health for such arrangements to apply.

3.2 Checking of Claims

The following principles are to apply to the checking of the sessional claims:

- review each daily hour claimed to ensure that the correct hours are claimed;
- ensure that times for all chargeable patients on the doctor's claim have been deducted;
- ordinary hour sessions should be "rounded off" to the **nearest** ¼ hour for each occasion of service;
- checkers should be made aware that Emergency Department (ED) patients are not classified until admitted. Once admitted if the patient is classified other than private, delete from the relevant lines / item numbers from the VMOs claim, for the dates of the admission. All patients seen in the Emergency Department are considered non-chargeable patients, once admitted, as a chargeable patient, no further payment should be made by the PHO.
- some patients may be unclassified on admission or may have changed their classification after a visit by the Patient Liaison Officer; other systems should be used to identify the correct classification;
- query sessional hours greatly in excess of contracted hours and advise the hospital management; and
- some O & G doctors submit both Sessional and FFS claims as per their contracts. These claims need to be dealt with independently, i.e., one under sessional rules and one under FFS rules.

3.3 Call Back

Where a sessional VMO is called back to duty to provide immediate treatment after being release from duty, whether notified before or after leaving the employer's premises, the VMO shall be remunerated as follows:

- the minimum payment for any one call back, including travelling time, shall be one hour at the VMOs ordinary hourly rate of remuneration plus the appropriate loading;

- as to services provided during a call back within the hours of 8.00am to 6.00pm Monday to Friday inclusive – at the VMOs ordinary hourly rate of remuneration plus a loading of 10 percent, except as to a call back on a public holiday when t he loading shall be 50 percent;
- as to services provided during a call back outside the hours of 8.00 am to 6.00 pm Monday to Friday inclusive – at the VMOs ordinary hourly rate of remuneration plus a loading of 25 percent, except as to a call back on a public holiday when the loading shall be 50 percent;
- the duration of a call back shall include the actual travelling time from the place of contact to the hospital concerned and return, subject to a maximum of 20 minutes travel each way. PHO must check that travelling time is reasonable and does not exceed 20 minutes each way.

Call backs claimed can only be for non-chargeable patients and remunerated at the Determination rate. 100% of all call backs are to be checked against patient records.

Checking the claim – Call back hours

- call backs specify the start and finish time for each patient and include the patients' record;
- entries against reports are checked to ensure date and times match;
- no payment is to be made if no documentation is provided;
- call back claims for excessive before and after time compared to actual operation time and deduct as appropriate;
- no entitlement to travel unless the doctor has actually left the hospital and returned;
- the name and position of the staff member requesting the call back has been provided; and
- if a VMO is claiming for a chargeable patient, the call back claim is adjusted accordingly to reduce the hours claimed. The time claimed should be prorated according to the number of patient claimed, e.g. Total hours claimed is 1 ½ and the number of patients is 3 and 1 was verified as a chargeable type, then the Total Hours should be only 1 hour.

3.4 Deducting Chargeable patient claims

In relation to check chargeable patient claims:

- PHOs should ensure that all chargeable patients on the claim are deducted;
- A patient is considered non chargeable while in the ED even if he/she has private cover, but once the patient elects to be admitted as a private patient, or is otherwise classified as a chargeable patient, then deduct if the doctor has claimed;
- If the doctor has deducted hours for chargeable patients – check that these deducted hours match with the hospital records, and
- The classifications for chargeable patients include (this is not an exhaustive list):
  - MAA;
  - Overseas;
  - Workers compensation;
  - DVA (Veteran affairs); and
  - Private.

3.5 On-Call

All on-call should be checked against the relevant on-call roster for each VMO at the hospital. If any discrepancies are found, the VMO is to be contacted to confirm the accuracy of the date(s) and or time(s) claimed. Only one payment is to be made to a VMO who is rostered to be on-call to more than one hospital. Payment should be made by the hospital to which the VMO has the greatest on-call commitment.

Where a VMO is rostered to be on-call to more than one hospital within NSW Health at the same time the VMO shall be entitled to receive an on-call allowance only from that hospital to which the officer has the greatest on-call commitment, or where the on-call commitments are equal the VMO shall receive an on-call allowance only from one hospital.

3.6 Teaching and Training of Post Graduate Medical Officers

VMOs who personally delivered teaching and training to postgraduate and prevocational medical officers shall be remunerated for their time. Attendance at an activity in which teaching and training is provided is not sufficient to justify a claim. The VMO must deliver a lecture or tutorial, convene and chair a session etc. The contractual context for payment of VMOs for teaching and training is detailed below. Reference to Area Health Services should now be read as Local Health Districts.

VMOs with Sessional contracts – reference IB2007_044

"4(6) A visiting medical officer shall participate in the teaching and training of postgraduate medical officers as may reasonably be required by the public health organisation."

"5(2) In establishing the annual ordinary hours….regard shall be had to:
(a) the services to public patients…, taking into account ….. postgraduate teaching….;"

VMOs with Fee For Service contracts – reference IB2007_044

"4(6) A visiting medical officer shall participate in the teaching and training of postgraduate medical officers as may reasonably be required by the public health organisation."

"5(5) A visiting medical officer shall be remunerated for his or her time spent participating in teaching and training (as required under subclause 4(6)) ….in accordance with the hourly remuneration rates applying at that time under sessional contracts."

VMOs with Fee for Service Rural Doctor Package Hospital contracts

The VMO may participate in the teaching and training of postgraduate medical officers where reasonably required and remunerated by the Area Health Service in accordance with the hourly rate determined by the NSW Department of Health.

PHO must ensure that a list of approved teaching and training activities maintained and the name of attendees at these activities.

4 FEE FOR SERVICE (FFS) VMO

The fee for service payment system is based in the MBS. PHOs must ensure that all claims submitted by Fee for Service VMOs are checked. Checking should confirm that the named patient was an in/out patient of the facility on the dates claimed and verify from the Medical Record that the consultation/procedure claimed took place for the patient concerned. Where it is not possible for all claims to be checked, a rotation system of VMO claims should be applied which will ensure each VMO will have at least one monthly claim form thoroughly checked every three months.

Except as provided for below, the rate for remuneration for the provision of a medical service under a FFS contract is 100% of the MBS. The multiple procedure rules must also be taken into consideration when approving claims.

The rate for remuneration for the provision of a medical service under a fee-for-service contract where the medical service is provided in a hospital which has no Resident Medical Officer, Registrar or Career Medical Officer available as medical practitioner of first contact on a 24 hour a day 7 days a week basis, is 110% of the relevant MBS fee. For the avoidance of doubt, the availability of the medical officer of first contact is at hospital level, not an individual specialty or department

The rate for remuneration under a fee-for-service contract for the provision of an emergency after hour's medical service (as defined in this Guideline) is 110% of the relevant MBS fee.

The rate for remuneration payable to a RVMO:

- Who provides an emergency after hours service at a regional hospital; and
- Whose usual place of residence is within a 50 kilometre radius of the regional hospital where the service is provided;
  Is 120% of the relevant Commonwealth Medical Benefits Schedule fee in respect of that occasion of service.

4.1 Checking the Fee for Service claim

The following checks must be conducted on every claim:

- all FFS line items must have the correct item number;
- dates on claim are checked, if any are for prior months ensure they have not been paid previously;
- check the patient's name and/or MRN has been provided and that the patient is a non-chargeable patient;
- all claims must include the correct patient MRN where one exists;
- claims must be checked against emergency after-hours roster, and
- the name and position of the staff member requesting the emergency after-hours medical services has been provided.
- A VMO undertaking the surgery can claim 100% for the item with the greatest Schedule fee, 50% for the item with the next greatest Schedule fee and 25% for third and subsequent items.

4.2 Fee For Service 2015 ECG Clarification (Items 11700-11702)

An ECG report must include a statement of its interpretability, the rhythm and rate present, and any changes present in the ECG suggesting pathology, and a conclusion as to the most likely cause or causes of any abnormalities or, in the absence of any abnormalities, a statement to that effect.

The VMO will assist the public hospital(s) to which s/he is appointed in establishing consistent quality assurance procedures for the data acquisition.

The VMO will ensure the data acquisition and hence the ECG is of good quality prior to making any assessment and writing the report.

Local Health Districts retain the right to conduct clinical audit(s) on the quality of assessment and written reports of the ECG by the VMO. Where such an audit reveals deficiencies on the quality of assessment and/or written report of the ECG, Local Health Districts reserve their rights not to pay the relevant claims for items 11700, 11701 and 11702.

A maximum of 4 of item 11700-11702 for an individual patient will be paid in any 24-hour period. An ECG with an algorithm report that is not separately and individually reported will not be paid.

Definitions:

Item 11700. Twelve-lead electrocardiography: an ECG that is reported within one hour of being performed and used in making acute management decisions by a VMO who is on site.

Item 11701. All ECG reports not covered in Item 11700.

5 RURAL FEE FOR SERVICE VISITING MEDICAL OFFICER CLAIMS

The Rural Doctors Settlement Package (RDSP) fees are applicable to VMO general practitioners, locally resident VMO specialists who have elected to be remunerated under the RDSP, and non-resident VMO specialists with the agreement of the relevant LHD, who provide services at facilities to which the RDSP applies.

Non-resident specialist VMOs, and those who provide services at an RDSP facility as part of an outreach service from a tertiary, regional or base hospital, do not have an automatic right to elect to be remunerated under the RDSP, but can only do so with the agreement of the relevant LHD that RDSP arrangements will apply.

A specialist VMO is locally resident, for this purpose, if his or her usual place of residence is within a 50 kilometre radius of the RDSP facility and that RDSP facility is the closest public hospital to that place of residence.

Rural VMOs are remunerated in accordance with the August 1987 MBS. Fees under the RDSP are indexed from 1 August each year according to an agreed formula.

Any items not listed in the schedule are to be paid at the rate of 140% of the current MBS fee.

GP Registrars are appointed as VMOs at a Rural Local Health District in accordance with NSW Ministry of Health Policy 2011_074. They are provided with RDA VMO contracts, and are entitled under the Policy to bill under the RDSP schedule. GP Registrars and GP VMOs should not claim for attendance for the same patient on the same day, as a standard practice.

5.1 RDSP Obstetric and anaesthetic grants

The grants are limited to GPs with VMO status, including obstetric and anaesthetic privileges at a Hospital covered by the RDSP who have held an appointment for the whole three months in order to receive a grant following the end of those three months.

VMOs not participating in the On Call Rosters, GP Registrars and locums are not eligible. 'Area of Need' GPs, who have a reasonable expectation of being present for more than 3 months, are eligible for Incentive Payments.

The incentive payments are paid to the VMOs who appear on the original list from the Ministry of Health. The amount allocated yearly is a set amount. If a VMO leaves and no eligible VMO is appointed, then the allocated amount can be divided amongst the remaining eligible Obstetric recipients.

If a new VMO meets the criteria to receive a share of the grant after completing the whole three months, then the amount is divided evenly amongst the VMOs for the facility where they are working.

These payments are not to be made until the release of the list from the NSW Ministry of Health.

5.2 GP VMO sessional arrangements in Emergency Departments at RDSP facilities

It is possible, with the agreement of both the relevant local Health District and a GP VMO, that where a GP VMO is required to provide a continuous on-site presence at a facility covered by the RDSP, sessional remuneration arrangements can apply. A GP VMO can be provided with both RDSP fee-for-service rates and also receive sessional rates for shift work at the applicable sessional VMO remuneration rate including background practice costs as applicable from time to time.

For sessional rates to apply, it is a requirement that a GP VMO must be present at the hospital during the entire duration of a shift, and that all work carried out during that shift (including inpatient rounds) will be covered by the sessional payments. Where the shift is of four hours or more duration, inpatient rounds must be completed.

5.3 Checking an RDSP Fee for Service claim

The checking of RDSP claims should include, but not be limited to the following:

- verifying that on-call claims against the roster and corresponding days/hours are correct;
- checking inpatients election status and hospitalisation period to ensure dates claimed by the VMO coincide;
- confirming the VMO has notated the patient medical record. The VMO must record attendance;

- for after-hours item numbers, times of attendance are to be recorded on claim;
- checking the frequency of attendance of Nursing Home Type patients comply with the RDSP;
- checking any claims for attendances at Outpatients and subsequent admission comply with the RDSP. If the VMO has seen the patient in outpatients and a subsequent admission occurs the VMO should not claim a second fee unless there is a medical justification for the additional service. The non-inpatient fee is to be regarded as a consultation for these purposes;
- ward rounds occur once per day at any reasonable hour where a VMO will see most or all inpatients under their care. A VMO is entitled to claim one ward round visit per day per acute patient;
- items not listed in the schedule are to be paid at the rate of 140% of the current Medicare Benefits Schedule fee;
- all multiple services such as Surgical, Fracture and Suture item numbers to ensure that they are paid at 100 percent (1st item), 50 percent (2nd item), and 25 percent (3rd and subsequent items);
- Check all multiple anaesthetic items to ensure the first item is paid at 100 per cent and subsequent items are paid at 20% (2nd) and 10% (3rd and following items)
- ECGs – as a general rule Item 1908 would apply where the complete procedure was provided by the one VMO. And Item 1909 applies where the tracing and report are provided by different VMOs; and
- all assistant at operation numbers.

5.4 Emergency and Out of Hours items claimed

The definition for an emergency as per the Rural Doctors Settlement Package is as follows: “An emergency occurs where the hospital requires the visiting medical practitioner’s immediate and urgent attention.”(see Definitions in this Guideline).
Emergency must be requested by the hospital, and the medical records for all emergency claims for inpatients should be examined to verify that the emergency was initiated by the hospital. Emergency consultations for non-inpatients should also be recorded on the Non Inpatients Register.

5.5 Consultations

Claims pursuant to Item 1002 apply only where one inpatient has been seen on the one occasion. If more than one inpatient has been seen (on the one occasion), the rate for the Item 1004 should apply.

Attendance times to be recorded on VMO’s claims for out of hours items and verification clerk is to ensure these agree with times recorded on the Inpatient records and Non Inpatient Register. VMoney will verify inpatient classification and hospitalisation dates only.

Check that the correct items are claimed and that the frequency of attendances on Nursing Home Type patients and the rate of payment conform to RDSP rates and Ministry of Health policy.

5.6 Attendances at Outpatients and Subsequent Admission

Any instances of claiming both inpatient and outpatient attendances must comply with the RDSP rates and Departmental Policy.

5.7 ECG Clarification 2015

An ECG report must include a statement of its interpretability, the rhythm and rate present and any changes present in the ECG suggesting pathology and a conclusion as to the most likely cause or causes of any abnormalities or, in the absence of any abnormalities, a statement to that effect.

The VMO will assist the public hospital(s) to which s/he is appointed in establishing

consistent quality assurance procedures for the data acquisition.

The VMO will ensure the data acquisition and hence the ECG is of good quality prior to making any assessment and writing the report.

Local Health Districts retain the right to conduct clinical audit(s) on the quality of assessment and written reports of the ECG by the VMO. Where such an audit reveals deficiencies on the quality of assessment and/or written report of the ECG, Local Health Districts reserve their rights not to pay the relevant claims for item 1908 or 1909.

A maximum of 4 of item 1908/1909 for an individual patient will be paid in any 24-hour period. An ECG with an algorithm report that is not used for making specific management decisions will not be paid.

Item 1908. Twelve-lead electrocardiography: an ECG that is reported within one hour of being performed and used in making urgent management decisions (such as a decision whether to thrombolyse or not).

Item 1909. All ECGs not covered in Item 1908.

5.8 Multiple Operation Rule

In accordance with the MBS Book rule, a VMO undertaking the surgery can claim 100% for the item with the greatest Schedule fee, 50% for the item with the next greatest Schedule fee and 25% for third and subsequent items. The determination of the fee is based on rates specified in the RDSP schedule or as factored on the MBS book.

5.9 Multiple Anaesthetic Rule

The fee for an anaesthetic administered in connection with two or more operations performed on a patient on the one occasion is calculated by the following rule applied to the anaesthetic items for the individual operations:

- 100% for the item with the greatest anaesthetic fee plus 20% for the item with the next greatest anaesthetic fee plus 10% for each other item.

5.10 Aftercare

- Fees for some procedures automatically include an aftercare component; and
- Checks should be undertaken to ensure that payment is not made twice for aftercare (to both the VMO providing initial treatment and subsequent VMO claiming aftercare).

5.11 Discounting of delayed claims:

The fee payable under the RDSP is discounted where claims are delayed as follows:

- After 12 months from the date a service was provided, the fee payable can be discounted by 50%, subject to the public health organisation having provided a month's notice to the visiting medical officer that a discount of 50% will apply if a claim is not received; and
- After 24 months from the date a service was provided, no payment is owing in respect of the service, subject to the public health organisation having provided a month's notice to the visiting medical officer that no payment will be made if a claim is not received.

Applications to submit claims later than these time limits without any, or with a lesser, discount can be made in writing (including electronically) to the relevant public health organisation within 4 weeks from the date of receipt of discount notice if there are exceptional circumstances (such as serious illness of the visiting medical officer). The public health organisation has the discretion on how to deal with such applications. If a visiting medical officer is dissatisfied with the decision of the public health organisation, the dispute resolution procedure may be invoked.

Attachment A: Regional Professional Support Payment

Step 1	**Claim Form - EXAMPLE**
Identify accrual year and establishment entitlement from above-mentioned Schedule	Accrual Year ending December **2013** Resides < 50Kms from facility — Y Continuous appointment during accrual year — Y FFS of at least $100,000 or Sessional hours at least 450 — Y On Call 1:4 or more frequent in accrual year — N **(B)** Entitlement - **$10,000 and/or ~~$15,000~~** ? (strike out incorrect amount)
Step 2	**Claim Form - EXAMPLE**
Maintain on-going record of claims processed during calendar year	**Record of Claims** Balance bought forward from previous year — $ Nil Entitlement this year **(B)** — $10,000 $10,000 Previous Claims This Yr $3,500 This Claim **(A)** $4,000 — $7,500 Balance carried forward — $2,500
Step 3	**Claim Form - EXAMPLE**
i) VMO Claims Checking Officer to verify VMOs entitlement and correctness of claim	**VMO Claims Checking Officer** Verified Correct (Admin/VMO Clerk)…../…./………
ii) DMS or other delegated Manager to approve claim for reimbursement in accordance with provision of Determination	**Approved for Payment** Signature Delegated Officer………../……..…/………. (DMS_ Level 4) as per Delegation Manual
iii) Senior Admin Officer to ensure all prescribed checks and approvals necessary for payment	**Authorised for Payment** Signature Delegated Manager…./…../……..