RURAL
DOCTORS
ASSOCIATION
(NSW) INC.

The Rural Doctors' Settlement Package.

The Rural Doctors' Settlement Package.

For Fee for Service Payments at specified NSW Country Hospitals

Preface:

The RDA Remuneration Package is acknowledged as a major factor in reducing the migration of experienced country Doctors from smaller Hospitals requiring constant On Call with minimal if any local Specialist backup to the cities or major towns where work is less demanding.

To remain successful, and prevent some of the disputes which we know are now erupting as Hospitals try to save money, it has been found necessary to again publish the original Agreements, together with all alterations to the Package since 1/1/1989.

Every Item on every page has been agreed by the Liaison Committee and is binding on both Hospitals and Doctors.

Contents:

Indexation figures

1/8/88: 6.385 %	1/8/89: 6.22 %	1/8/90: 6.06 %
1/8/91: 6.00 %	1/8/92: 3.54 %	1/8/93: 2.49 %
1/8/94: 2.67 %	1/8/95: 3.93 %	

From 7/3/96, the RDA Indexation Formula, using Australian Bureau Stastistics figures, replaced ACT Indexation speeding the process considerably. The August 1995 RDA Schedule will be published shortly.

ORIGINAL AGREEMENT

SCHEDULE OF FEES FOR GENERAL PRACTITIONER MODIFIED FEE FOR SERVICE HOSPITAL PATIENTS PAYMENTS IN N.S.W. COUNTRY PUBLIC HOSPITALS - AS FROM 1 AUGUST, 1988 *

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* The fees shown are at 1987/88 levels and will be adjusted in line with the A.C.T. indexation formula on 1 August 1988.

SERVICE		FEE ($)
<u>On call</u>		2.50 per hour
<u>Attendances</u>		
- Nursing home type patients		As at previous rates
- In hours (Mon - Frid, 7.00 a.m. - 6.00 p.m.; Saturday, 7.00 a.m. - Midday)		
Inpatients:		
Where only one in-patient is seen		22.10
Where two or more in-patients are seen on the one occasion		15.00 each
Out-patients:		
All in-hours out-patients, regardless of duration of consultation		15.00 each
- After hours (Mon-Frid, 6.00 p.m. - 10.00 p.m.; Saturday, 12.00 Midday - 10.00 p.m.; Sunday, 7.00 a.m. - 10.00 p.m.)		
After hours ward round	Sunday only	20.00 each
	All other	15.00 each
After hours consultations (inpatient and outpatient) not in the course of a ward round, all days except Saturdays, Sundays and public holidays.		
	First patient	34.53
	Subsequent patients	25.00 each
After hours consultations (inpatient and outpatient) not in the course of a ward round, Saturdays, Sundays and public holidays		
	First three patients seen on the one occasion	34.53 each
	Subsequent patients	25.00 each
- Late night consultation (All days, 10.00 p.m. - Midnight)		
	First patient	60.00
	Subsequent patients	34.53 each
- Anti social hours consultation (All days, 12.00 Midnight - 7.00 a.m.)		
	First patient	75.00
	Subsequent patients	34.53 each

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- Emergency consultation fee (as defined)		60.00
- Prolonged emergency attendance	Item 160	59.50
	Item 161	96.90
	Item 162	134.30
	Item 163	174.25
	Item 164	208.25
- Ambulance escort for severely ill patients:		87.00 per hour + reasonable return journey & out of pocket expenses

Procedures

- Obstetrics	
Antenatal care attendance	15.00
Confinement only, including two well baby checks	100.00
Caesarean section, including two well baby checks	150.00
All post natal attendances to be paid at the standard consultation rate (This includes attendances following an incomplete confinement (Item 201 - $55.25) and attendances on a sick neonate where a referral would be made to a paediatrician, were one available).	15.00
- Agreed procedures	
Intravenous infusion, performed by the practitioner	17.75
Intravenous infusion by open exposure	29.35
ECG Tracing only	11.75
ECG tracing and report	23.90
- Other services	85% M.B.S.
- Attendance at recognised committee meetings:	Previously agreed formula

ORIGINAL AGREEMENT

RURAL G.P. FEE FOR SERVICE SCHEDULE CONDITIONS

15 JULY 1988

The Fee Schedule herewith and Conditions below have been prepared by the Rural Doctors Association/N.S.W. Department of Health Joint Working Party in recognition of the circumstances particular to rural fee-for-service general practitioners at affected hospitals.

ON CALL

Number on call

The maximum number of G.P.s on call at any hospital will be three. The number of G.P.s on call at each hospital (the approved level) to be determined initially by the Joint Working Party.

Thereafter, any variations to the determined levels to be subject to decision by a Liaison Committee Review Panel having equal representation (two members each) from the Rural Doctors Association and the New South Wales Department of Health.

On call rate

The daily on call rate to be $60.00 ($2.50 per hour).

Other conditions of on call

Conditions of on call to be as set out in the Secretary's Circular of 4-5-88, i.e.:

1. On-call payment can only be received by a practitioner from one hospital at the one time.

2. Each hospital should draw up, in consultation with its Medical Staff Council, an on-call roster showing dates and times each doctor is on-call within the level approved by the Department (having been determined by the Joint Working Party). This should be done monthly in advance and the roster displayed.

3. Rosters should reflect the needs of the hospital for essential cover. The number required on call should reflect the services provided by the hospital and the skills of available doctors - this may be a dynamic situation.

4. Medical staff on call must be both accessible and available to attend the hospital for the period they are rostered.

5. Doctors should make monthly claims for their on call payments in the same way as they claim fee-for-service payments.

ORIGINAL AGREEMENT

ATTENDANCES

In hours

Mon - Frid,	7.00 am - 6.00 p.m.
Saturday	7.00 a.m. - 12.00 Midday

For in-hours in-patients:

where only one in-patient is seen - $22.10,
where two or more in-patients are seen on the one occasion - $15.00 each patient.

All outpatient in-hours consultations to be charged at a flat fee of $15.00 per patient, regardless of duration of consultation.

Nursing home type patient fees as at previous rates.

After hours

Mon - Frid,	6.00 p.m. - 10.00 p.m.
Saturday,	12.00 Midday - 10.00 p.m.
Sunday,	7.00 a.m. - 10.00 p.m.

After-hours ward rounds

Sunday ward rounds: - $20.00 per patient
Other after-hours ward rounds: - as at the in-hours rate.

After hours outpatient consultations and inpatient call backs

For inpatients and outpatients, irrespective of which is seen first, on the one hospital visit, not in the course of a ward round:

On Saturdays, Sundays and public holidays -

First three patients:	$34.53
Subsequent patients:	$25.00

Other days -

First patient:	$34.53
Subsequent patients:	$25.00

Late night outpatient consultations and inpatient call backs

All days, 10.00 p.m. - 12.00 Midnight.

For inpatients and outpatients, irrespective of which is seen first:

First patient:	$60.00
Subsequent patients:	$34.53

ORIGINAL AGREEMENT

Anti-social hours outpatient consultations and inpatient call backs

All days, 12.00 Midnight to 7.00 a.m..

For inpatients and outpatients, irrespective of which is seen first:

First patient: $75.00
Subsequent patients: $34.53

EMERGENCIES

Definition:

An emergency attendance occurs where the hospital requires the visiting medical practitioner's immediate and urgent attendance.

In an emergency, as defined, the Emergency Consultation fee will be $60.00, except between the hours of 12.00 Midnight - 7.00 a.m. when it will be $75.00.

An indicative, but not exhaustive, list of emergency situations is attached for guidance.

For prolonged emergency attendances on a single patient, Items 160-164 may be charged instead (see below).

The Emergency Consultation fee will be payable in an emergency, as defined, whether the practitioner is on call or is called in to assist an on call practitioner. The fee will be paid whether or not the VMO is in the hospital at the time of the call.

The fee will be payable for all G.P. anaesthetist attendances between the hours of 10.00 p.m. and 7.00 a.m. in cases where the G.P. surgeon has received the Emergency Consultation fee.

Multiple Emergencies

Where more than one Emergency patient requires attendance simultaneously (eg., bus crash), each Emergency patient to attract the Emergency Consultation fee. Each patient attracting the Emergency Consultation fee must fulfil the definition of `Emergency' in their own right.

Prolonged Emergency Attendance

Items 160-164 (prolonged emergency attendance on a single patient), which are normally available only to specialists, to apply to rural G.P.s.

Ambulance Escort

No change.

ORIGINAL AGREEMENT

PROCEDURES

Obstetrics

Confinement and postnatal care fees to be separated: no combined fees

a) Antenatal care - no change

b) Confinement only, including two well baby checks, - $100. No payment if practitioner does not attend.

c) Caesarean section, including two well baby checks - $150.

d) Postnatal care - $15 per attendance.

e) Incomplete confinement Item 201 - postnatal care to be billed separately.

f) Separate consultation fee for sick neonate where referral to a paediatrician would occur if one were available.

E.C.G.

No change.

I.V. Drip

Restore to anaesthetics items, but must be performed by the medical practitioner.

Other procedures

No change.

IMPLEMENTATION

1. Agreed conditions to be implemented from 1 August 1988.
2. A Liaison Committee will be established for ongoing consultation between rural G.P.s and the Department. Where a disagreement between parties (a rural doctor or doctors on the one hand and the Department or its officers on the other hand) arises over interpretation of the terms or definitions of this agreement the matter will be referred to the Liaison Committee, which may call on outside expert advice if necessary. In the event that the Liaison Committee is unable to achieve agreement, the Secretary of the Department and the President of the N.S.W. Branch of the A.M.A. shall appoint an independent person to determine the matter.
3. There shall be no change to any of the fees herein described, other than by Clause 4 (Indexation Formula) without full discussion between and mutual consent of the Rural Doctors Association and the N.S.W. Department of Health.
4. Levels of all fees herein and in the Medical Benefits Schedule to be adjusted according to the ACT indexation formula (as previously agreed) from 1 August 1988 and each August 1st thereafter.

ORIGINAL INDICATIVE LIST OF EMERGENCIES

JOINT WORKING PARTY: RURAL G.P.s
INDICATIVE LIST OF EMERGENCIES

1. Respiratory

Acute, severe respiratory distress due to asthma, croup, pneumonia or pneumothorax, requiring immediate attention.

2. Cardiovascular

Cardiac arrest.

Chest pain requiring admission for investigation as a possible myocardial infarction.

Acute respiratory distress due to cardiac failure.

Acute Thrombosis in a major artery.

3. Central Nervous System Disease

Coma.

Fitting.

Suspected meningitis.

Head injury associated with vomiting or deterioration of consciousness.

Severe headache requiring immediate assessment, admission and/or observation for an extended period.

Acute paralysis.

4. GIT Disease

Acute severe gastro-enteritis in children or infants requiring admission, intravenous therapy or transfer.

Acute severe abdominal pain requiring admission.

Significant haematemesis and melaena.

5. Genito-urinary, acute renal colic, acute urinary retention

Gynaecological or obstetrics emergencies involving significant blood loss requiring admission and intravenous therapy.

Suspected ruptured ectopic pregnancy.

Accidental haemorrhage, foetal distress, premature labour in patients less than 36 weeks gestation.

Eclampsia.

ORIGINAL INDICATIVE LIST OF EMERGENCIES

6. Trauma

Acute fractures or dislocations where there is gross deformity, suspected neurovascular damage. (eg., not Colles' or clavicle).

Penetrating wounds of the chest, abdomen or head.

Suspected intra-abdominal, intra-thoracic, or intra-cranial injuries. Lacerations involving severe haemorrhages or risk to life or limb.

Burns greater than five per cent body surface area and greater than superficial depth.

7. Acute poisonings by dangerous substances

Potentially fatal bites.

Anaphylactic reactions requiring intravenous therapy and admission.

8. Ophthalmic

Penetrating eye injuries.

Acute glaucoma.

Acute loss of vision.

9. Psychiatric

Acutely disturbed or intoxicated patients requiring immediate sedation, crisis counselling or scheduling.

Patients presenting immediate risk to themselves or the health of others.

10. Where a hospital demands the immediate attendance of a VMO and no alternative arrangements are acceptable in spite of the due consideration of a VMO that a true medical emergency does not exist.

It is not intended that this list be exclusive but to act as a guide.

CLARIFICATIONS 89

N.S.W. DEPARTMENT OF HEALTH

C5747

ALL REGIONAL DIRECTORS

PAYMENT OF GENERAL PRACTITIONERS IN COUNTRY AREAS

On 1 August 1988 I issued a set of documents comprising the package agreed by the Rural Doctors Association - NSW. Department of Helath Joint Working Party which addressed concerns from the 1987 Country G.P.'s dispute.

Further to that information, I now wish to advise you of the following:

(a) The indexation rate applicable to the fee package from 1 August 1988 and;

(b) Points of resolution which have been agreed by the Rural Doctors Association - NSW Department of Health Liaison Committee established for ongonig consultation between rural G.P.'s and the Department. These points became effective from 1 February 1989.

Details of the advice are attached.

The fees and conditions of the package and of the current amendments apply only at the affected Hospitals included in the list issued 1 August 1988.

Signature
Michael Rosser,
Secretary.
Dated 31 Jan 1989

CLARIFICATIONS 89

N.S.W. DEPARTMENT OF HEALTH

C5747

PAYMENT OF GENERAL PRACTITIONERS IN COUNTRY AREAS

The advice below amends and clarifies the fees and conditions contained in the Rural Doctors Association - N.S.W. Department of Health Joint Working Party agreed package issued by the Secretary on 1 August 1988. The variations have been agreed by the Country G.P.s Liaison Committee.

The fees and conditions of the package and of the current amendments apply only at the affected hospitals, i.e., those included on the list issued on 1 August 1988.

The indexation rates apply from 1 August 1988. Other conditions are effective from 1 February 1988. (1989 intended)

1. INDEXATION

In settlement of the 1987/88 N.S.W. country doctors dispute, a Rural Doctors Association - N.S.W. Department of Health Joint Working Party agreed to a new schedule of fees, approved by the Minister, effective from 1 August 1988. The Schedule listed fees peculiar to N.S.W., with all other items of service to be paid at 85% of the 1 August 1987 Medicare Benefits Schedule fees.

The settlement included an agreement that fees would be adjusted according to the Australian Capital Territory indexation formula from 1 August 1988. The ACT has now advised of its indexation rates.

The outcome is that an increase of 6.385% backdated to 1 August 1988 to apply to fee for service payments to general practitioners at affected hospitals. The increase of 6.385% applies to all the specific items listed on the Schedule issued on 1 August 1988 and to items in the category `Other Services', i.e., items previously paid at 85% of the 1 August 1987 Medicare Benefits Schedule fees.

Please note that the Medicare Benefits Schedule item descriptions and fees of 1 August 1988 do not apply and have no relevance to the payment of fee for service general practitioners services at affected hospitals.

The Rural Doctors Association has agreed that, for ease of administration, it is acceptable for accounts to be calculated on the basis of existing fees and the total multiplied by 1.06385 to determine the amount paid. This method should be used both for calculation of back payment to 1 August 1988 and to determining payment of monthly accounts to 1 August 1989.

2. NURSING HOME AND LONG STAY PATIENTS

Emergency attendances (as defined) on nursing home type and long stay patients are to attract the relevant emergency item fees.

3. I.V. FEE

The I.V. fees is not to be paid unless infusion is involved, e.g., the fee is not to be paid for bolus cytotoxic drugs through a butterfly needle injection.

4. INDICATIVE LIST OF EMERGENCIES

The following item should be added within the `Trauma.' section to the Indicative List of Emergencies included in the settlement package:

"Acute (not chronic or recurrent) shoulder dislocation."

5. G.P. SPECIALISTS

Where a G.P. Specialist practitioner is:

a) eligible for the specialist rate under Medicare; and

b) performing as a specialist in the practice of his or her specialty where the patient is referred to him or her

payment should be at the specialist rate.

Of course, services provided by specialists must fall within the hospital's delineated role.

6. PAYMENT OF EMERGENCY ATTENDANCE FEES TO A FEE FOR SERVICE SPECIALIST INSTEAD OF A G.P. AT AFFECTED COUNTRY HOSPITALS

The 1st August 1988 Joint Working Party package included the provision for payment of an Emergency Consultation fee of $60.00 ($75.00 between the hours of 12 Midnight and 7.00a.m.) to be paid to a general practitioner called in to assist the on call practitioner in an emergency (as defined) at an affected hospital.

In cases where a country fee for service specialist is called in these circumstances instead of or in place of a general practitioner, the specialist is to receive the G.P.'s Emergency fee, providing that:

a) The option of the sessional payment method has not been offered at the hospital.

(b) The specialist is called by the on call general practitioner to assist in the case of an emergency as defined in the rural G.P.s Indicative List of Emergencies.

7. USE OF ITEM NUMBERS/ITEM DESCRIPTIONS IN ACCOUNTS

It is recognised that the basis for payment stated in the Commonwealth Medicare Benefits Schedule book is the item description. However, practitioners should include item numbers to facilitate payment of accounts to N.S.W. public hospitals. Additional, local conditions may also apply.

8. ADJUSTMENTS TO PRACTITIONERS' ACCOUNTS

Hospitals should itemise where any adjustment has been made to a G.P.'s fee statement, in addition to showing the total payment.

Advice to be provided to Finance Branch

Regions and Areas are to advise Finance Branch by 28 February, 1989 of the additional 1988/89 and per annum requirements of increasing G.P. rates by 6.385%. Such advice is to specify the base upon which the calculation is determined and is to be delineated from

Sessional payments
Fee for Service payments (non G.P.'s)
Contract Payments

with figures to be provided for all 4 categories as reconciled to the existing V.M.O. budget as at end of period 7 (12 January, 1989).

Upon receipt of the above advice, budgets will be supplemented.

CLARIFICATIONS 95

PREPARED BY THE NSW HEALTH DEPARTMENT & RDA(NSW) Inc for inclusion in the RDA Fee Schedule.

CONTENTS:

1 GENERAL

1.1 This document is to clarify the correct billing by RDA Fee for Service Visiting Medical Officers (VMOs) at RDA Package Hospitals.

The Rural Doctors Settlement Package applies to General Practitioners (and to Specialists who have elected to be remunerated under this Package) in identified Hospitals. However some VMOs appointed as General Practitioners are also qualified as 'Specialist' Medical Practitioners. These VMOs are entitled to the 'Specialist' fee levels in their Specialty for referred cases where the 1987 Medical Benefits Schedule provides a differential. This document sets out these cases in detail, when referring to 'Specialist'.

All clarifications to the Package since 31/1/1989 are included below. Changed or new Items are so designated.

1.1.1 This document is to be read in conjunction with the following:

1.1.1.1 The August 1987 Medical Benefits Schedule (not attached)
1.1.1.2 The original Agreement of 31/7/1988
1.1.1.3 Points of Resolution to the Agreement dated 31/1/1989
1.1.1.4 The 'Rural GP's Indicative List of Emergencies'

All of the above, or copies, are to be kept accessible at each RDA Package Hospital for the use of Staff and VMOs whose Surgery does not have them. (New Item)

2 THE ORIGINAL SCHEDULE

2.1 Fees have been indexed each August 1st since July 1988, but guidelines, descriptions and restrictions are unaltered from the August 1987 Medical Benefits Schedule. This is used because:

2.1.1 The Items it contains are more suitable to Rural Practice.

2.1.2 It is simpler with fewer options eg fractured pelvis.

2.1.3 Item numbers or descriptions are not constantly changing, an important consideration given the many procedures a Rural Practitioner is likely to perform.

2.1.4 It contains items applicable to rural General practice which are no longer present in the current Schedule.

2.1.5 It is not complicated by new items from the current Schedule which are not normally applicable to current Rural Practice eg Coronary Angioplasty.

3 ALTERATIONS FROM THE ORIGINAL MBS SCHEDULE

3.1 All instances where a description OR base fee has been altered from this Schedule are listed as Items 1000 to 1999 in the Ready Reckoner published annually and known as the RDA Schedule.

4 NEW SERVICES

4.1 Where a NEW service has become available since 1987, eg laparoscopic cholecystectomy, it may be allocated a number between 1000 and 1999, as above, by the Liaison Committee and a base fee set. If a number has not yet been allocated, then a mutually agreed fee may be used. A figure of 94.55% (RATE 4/1 - rate for 1994/5 Schedule) (New Item) of current 100% MBS for the Surgeon is suggested as this is the current ratio between RDA package fees and current 100% MBS fees.

5 SERVICES RESTRICTED TO SPECIALISTS

5.1 Item numbers in the 1987 Schedule which are specifically restricted to Specialists practising in their Specialty on referred patients remain so restricted.

5.2 The referring Doctor is to be identified on the account submitted by the Specialist, in accordance with MBS guidelines published in the 1987 Schedule.

5.3 From 1995, Items applicable only to Specialists treating referred patients will be included in the RDA Schedule/Ready Reckoner. (New Item) These have been in use in some Districts for some time and are identified by ^ after the coded description.

5.4 These Item numbers are not to be used by GPs or Specialists treating non-referred patients.

6 EMERGENCIES

6.1 GENERAL

6.1.1 The term EMERGENCY FEE includes the term CALL BACK FEE and EMERGENCY CONSULTATIVE FEE.

6.1.2 An emergency attendance occurs when the Hospital requires the visiting medical practitioner's immediate and urgent attendance.

6.1.3 For prolonged emergency attendances on a patient, Items 160 - 164 may be charged instead of 1054 or 1056. Conditions apply - see Section 6.4

6.1.4 The Emergency fee includes any associated consultation provided at the same visit to the hospital. It does not include a medically reasonable consultation provided earlier or later in the day eg a clearly separate visit to the hospital to do a pre anaesthetic examination.

6.1.5 The Emergency Consultation fee will be payable in an emergency, as defined, whether the practitioner is on-call or is called in to assist an on-call practitioner or is called by the hospital.

6.1.6 It is emphasised that the Rural GPs' List of Emergencies is indicative only, is not exhaustive and is to be used as a guide only.

6.1.7 Where more than one Emergency patient requires attendance simultaneously (eg. bus crash), each Emergency patient is to attract the Emergency Consultation fee.

6.1.8 Each patient attracting the Emergency Consultation fee must fulfil the definition of 'Emergency' in his/her own right. However, where the hospital calls a VMO in for an emergency consultation which later proves not to be an emergency, the emergency consultation fee is still payable.

6.1.9 An emergency consultation fee (as defined) only or a consultation fee only is allowable before a procedure fee.

6.1.10 It is expected that, in normal circumstances, a notation will be made by the Senior Nurse on duty in the patient's medical record that the Callback/Emergency Consultation took place and the reasons. A separate book may be used for this purpose in lieu of the notation in the medical record to expedite auditing. (New Item) Failure of the Nurse to document is not a valid reason to withhold payment if the Callback/Emergency Consultation actually took place.

6.2 SPECIALISTS and EMERGENCY ATTENDANCES

6.2.1 For a specialist participating in the GP On-call roster treating non-referred patients, normal RDA package GP rates apply including the Emergency Fee. The VMO is acting as a GP.

6.2.2 For a specialist participating in the GP On-call roster treating a referred patient, normal RDA package GP or RDA package Specialist rates may apply including the Emergency Fee but only if sessional payment has not been accepted.

6.2.3 For a specialist not participating in the GP On-call roster treating a non-referred patient, normal RDA package GP rates may apply including the Emergency Fee, only if the sessional payment method has not been offered and accepted at the hospital AND the specialist has been called in the case of an emergency as defined above.

6.2.4 For a specialist not participating in the GP On-call roster treating a referred patient, normal RDA package GP or RDA package Specialist rates may apply including the Emergency Fee, only if the sessional payment method has not been offered and accepted at the hospital AND the specialist has been called by the hospital, eg the On-Call GP/Specialist, to assist in the case of an emergency as defined above.

6.3 ASSOCIATED CONSULTATIONS

6.3.1 Payment for any associated consultation at the same visit to the hospital is included in the Emergency Fee. If a consultation fee has already been charged then only the difference between the two remains payable.

6.4 PROLONGED EMERGENCY ATTENDANCES (Items 160 to 164)

6.4.1 The only conditions to be met before services covered by items 160-164 are used are:

6.4.1.1 The patient must be in imminent danger of death;
6.4.1.2 The patient must require continuous life-saving emergency treatment (not being treatment of a counselling nature);
6.4.1.3 The VMO must be present for the entire period claimed;
6.4.1.4 No other patients may be treated during the period claimed.
6.4.1.5 In exceptional circumstances, eg 2 severely burnt patients both awaiting retrieval, Condition 6.4.1.4 may be waived at the discretion of Hospital Management. (New Item)

6.4.2 A prolonged emergency attendance fee may be paid instead of the emergency fee or instead of the standard consultation fee on each attendance.

6.4.3 Each separate attendance is to be treated on an individual basis with fees only payable if the separate attendance is medically reasonable and conforms to the criteria for the type of consultation claimed.

6.5 CALLBACK FEE - SURGERY

6.5.1 A call to administer an un-scheduled, non-booked (non-booked means called in with less than 24 hours warning and not attached to an existing routine operating list) procedure requiring an anaesthetist (ie general or local) entitles the GP-surgeon to the equivalent of the emergency fee.

6.5.2 The Callback fee includes any associated consultation performed during that visit to the hospital but a fee for the procedure/s is also payable.

6.6 CALLBACK FEE - ANAESTHETICS

6.6.1 A call to administer an unscheduled, non-booked (non-booked means called in with less than 24 hours warning and not attached to an existing routine operating list) anaesthetic (ie general or local) entitles the GP-anaesthetist to the equivalent of the emergency fee in the same way as the GP surgeon.

6.6.2 The Callback fee includes any associated consultation performed during that visit to the hospital but a fee for the anaesthetic/s is also payable.

7 ANAESTHETICS

7.1 GP/SPECIALIST ANAESTHETIC FEE DIFFERENTIAL

7.1.1 As the RDA Schedule is now disassociated from the current Commonwealth Schedule of Fees, the abolition of the General/Specialist differential by the Commonwealth does not apply except for private patients.

7.2 PREOPERATIVE EXAMINATION (ITEM 82)

7.2.1 The fee for anaesthetics includes the pre-operative examination of the patient in preparation for administration of the anaesthetic except where such examination entails an attendance other than that at which the anaesthetic is administered. Where a separate attendance has occurred then Item 82, 1987 MBS is applicable.

7.2.2 If the Anaesthetist has claimed the Emergency or Callback fee for performing an unbooked anaesthetic then any PRE-OPERATIVE examination or consultation performed during the same visit to the hospital, even if a separate attendance, is not payable. If this occurred on a separate visit to the Hospital on the same day then it is payable.

7.2.3 Premedication of the patient in preparation for anaesthetic is deemed to form part of the administration of the anaesthetic.

7.3 MULTIPLE ANAESTHETIC RULE

7.3.1 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.

7.3.2 The resultant fee is to be rounded to the nearest 10 cents.

8 CONSULTATION AND A PROCEDURE

8.1 Where the 1987 Medicare Benefits Schedule states that a procedure is included with the associated consultation, eg item 3012 dressing burns, the one fee is paid, but where the schedule is silent and the procedure is not elective both a consultation and a procedure fee may be paid.

8.2 It is not expected that a consultation fee will be charged on every occasion a procedure is performed eg if the procedure was preplanned or booked.

9 OBSTETRICS

9.1 ANTE-NATAL CARE

9.1.1 Attendances are payable until confinement commences (confinement commences when "labour" begins). Labour is interpreted as regular contractions with a 2-3cm effaced cervix. (New Item)

9.2 POST-NATAL CARE

9.2.1 Routine post-natal care is now included in the Fee for a confinement whether it be by vaginal delivery (1062) or by caesarean section (1064), with both items attracting the same fee. Item numbers 1062 and 1064 are inclusive and cover all non-Emergency attendances for confinement once labour has commenced and 9 days normal post natal care.

9.3 REFERRED PATIENTS

9.3.1 Where the patient is referred by another practitioner for Caesarean Section, the fee for item 210 applies, which already includes 9 days post-natal care.

9.4 AFTER CARE by A DIFFERENT VMO

9.4.1 See Section 17 ("after-care" provisions) for policy where post-natal care is undertaken by a VMO other than the VMO who attended during confinement.

9.5 OBSTETRICS ALLOWANCE and GLOBAL FEE

9.5.1 The special "Obstetrics Allowance" is to be paid in all instances where a confinement fee is paid, excepting Item 210 above. It is included in the calculation of the current fee for Items 1062 and 1064.

9.5.2 The global fee is for a confinement comprising 1st, 2nd and 3rd stages and 9 days of routine post natal care. It is expected that every effort be made by the practitioner to attend the confinement.

9.6 CARDIOTOCOGRAPHY

9.6.1 Item 290, antenatal CTG is not applicable during labour, as defined, and only applies to high risk pregnancies.

9.7 PAYMENT OF EMERGENCY CONSULTATION FEE - OBSTETRICS

9.7.1 Specialists who are not "Fee for service" are not eligible for the Emergency Fee.

9.7.2 For those not initially involved, a confinement may be regarded as a procedure for the purposes of the payment of an emergency fee ie an emergency consultation fee is payable to the practitioner called in when:

9.7.2.1 attending an abnormal delivery or Caesarean section on patients admitted under the practitioner "called-in" in the first instance;

9.7.2.2 attending an abnormal delivery or Caesarean section on patients admitted under a general practitioner and called in to do such by the general practitioner;

9.7.2.3 attending an abnormal delivery or Caesarean section on patients who present for admission not under any practitioner, eg. visitors to the area;

9.7.2.4 when called in by the treating VMO to resuscitate a neonate;

9.7.2.5 to perform an anaesthetic if not the original treating VMO;

9.7.2.6 to perform an epidural block in labour at the request of the mother and treating VMO;

9.7.2.7 to assist at a caesarean section if not the treating VMO;

9.7.2.8 An Emergency attendance not considered part of a normal confinement;

9.7.3 For those who are initially involved, an Emergency Fee is payable if the treating VMO is called by the Hospital to urgently assess the patient outside the normal routine assessments in Labour. This would be expected to occur infrequently and at the request of the Hospital.

9.7.4 If called in to perform a confinement on an unassessed (by the VMO) patient, an Emergency Fee is payable in addition to the normal confinement fee.

9.7.5 NOTE: The reason for initiation of a call should be used as the basis of payment, not the final diagnosis. This applies to all emergency calls ie not just obstetrics.

10 NON-INPATIENTS

10.1 NON-INPATIENT ATTENDANCE FEE AND PATIENT SUBSEQUENTLY ADMITTED AS A PRIVATE / CHARGEABLE PATIENT

10.1.1 A patient is not to be admitted under a VMO without the VMO's prior knowledge and consent. (New Item)

10.1.2 A Non-Inpatient attendance fee is payable when the patient presents at the Hospital without any prior arrangement with the VMO and is registered as a Non-Inpatient. A prior arrangement is one where the VMO and patient have together arranged this particular attendance, or admission, after the patient has been physically attended by the VMO at a place other than the Hospital and the same VMO is attending the patient as a non-inpatient.

10.1.3 The Health Insurance status of the patient is of no bearing on whether a non-in-patient fee is chargeable or not by the VMO nor is whether the patient is Third Party, Workers' Compensation or Veteran Affairs.

10.1.4 A fee is payable by the hospital to the fee for service VMO for non-in-patient services provided to the patient prior to the patient being admitted.

10.1.5 However, where a VMO claims a fee for a non-in-patient consultation and then a second consultation fee following the patient's admission to hospital, the second fee cannot be charged unless there is medical justification for the additional services. The emergency fee is to be regarded as a consultation for these purposes.

10.2 NON-INPATIENTS: COMPENSABLE

10.2.1 VMO's should be paid by hospitals for services relating to compensable non-in-patients. VMO's are not to lodge claims on insurance companies etc. or patients.

11 COMMITTEES

11.1 There is now a fixed fee for VMOs required to attend certain meetings, regardless of the duration of such attendances. For a meeting to be eligible for such payment, the meeting must:

11.1.1 have been established by the Board of Directors or General Manager.

11.1.2 the Board/General Manager must request the attendance of the VMO at the meeting.

11.1.3 The meeting must require clinical input from the VMO eg QA, Clinical Privileges, Peer Review and Credentialling type meetings.

11.1.4 The payment is not to be made to a VMO for attendance at Area/District Board meetings.

11.2 A transport allowance may in some circumstances also be claimed, at the Transport Allowance rate detailed in Circular 91/47. This is 30.3 cents/km (RATE 11/2A) for vehicles with engines over 1600cc and 25.4 cents/km (RATE 11/2B) under 1600cc at present. (RATES 11/2A & 11/2B are the 1994/5 rates).

11.2.1 To be claimable, the following criteria must be fulfilled:

11.2.1.1 The meeting must meet all of the criteria in 11.1 above.

11.2.1.2 The meeting must be at a place where the VMO does not have his/her primary appointment. It is not to be paid for attending meetings at a hospital at which the VMO has his/her primary appointment.

11.2.1.3 The one way distance from the hospital of primary appointment to the site where the meeting is held must be 25 kilometres or more.

11.2.1.4 Journeys made by the VMO to provide other Services under his/her contract are not eligible for the Transport Allowance under this clause.

11.2.2 The transport allowance when claimable applies to all mileage travelled.

11.2.3 Other benefits/requirements are detailed in Circular 94/118 eg the vehicle must be comprehensively insured.

12 AMBULANCE CALL OUT

12.1 The Ambulance Service may request, through the Hospital, attendance of a VMO. The most senior VMO On-Call for the Hospital will make the decision on whether to attend themselves or which VMO to send. Payment to the VMO, or the VMO delegated, would be under the normal 'Call Out' provision of the Rural Doctors' Package.

13 INTRAVENOUS INFUSIONS

13.1 A normal intravenous infusion is payable by Item 1072 or 1074.

13.2 An intravenous infusion set up during an anaesthetic is only payable, by the same item numbers, if there was a reasonable indication for its use. This is in addition to the anaesthetic fee.

13.3 A blood transfusion attracts a different fee (Item 944). It is not expected that item 1072 would also be payable if the sole reason for the IVI was for blood transfusion.

13.4 Injections, intravenous or otherwise, are considered part of the consultation covered by the consultation fee. There is therefore no separate item number/description and no fee additional to the consultation fee.

13.5 Injection/infusion of a radio opaque medium (Item 2937) is chargeable eg for IVP, as is the infusion of a cytotoxic agent (Item 932). However, a consultation fee would not normally be payable unless a full and bona fide consultation involving a history and examination actually took place.

14 NURSING HOME TYPE and LONG STAY PATIENTS

14.1 Other than for Emergency Calls or for clinical need, VMOs are permitted to claim, at most, one attendance per week per patient in this category. By mutual agreement between VMOs and management, this period may be extended to greater than one week. (New Item)

14.2 A routine visit to a Nursing Home Inpatient attracts Item 1002 where 1 Inpatient (including acute Inpatients) is seen.

14.3 A routine visit to a Nursing Home Inpatient attracts Item 32 where 2 Inpatients (including acute Inpatients) are seen.

14.4 A routine visit to a Nursing Home Inpatient attracts Item 34 where 3 or more Inpatients (including acute Inpatients) are seen.

14.5 `Non-routine' acute Special Visits, including Emergency attendances, on Nursing Home type and long stay patients attract the relevant acute Inpatient, including Emergency, Consultation Fees. Acute Special visits are to be based on clinical need (see Section 15.3.2 about inappropriate visits and charges).

15 NON-EMERGENCY FOLLOW-UP AND WARD ROUND CONSULTATIONS

15.1 IN-PATIENT VISITS

15.1.1 There must be a distinction made between `ward round' consultations and `In-patient Special Visits' ie `non-ward round/follow-up' consultations.

15.2 WARD-ROUNDS

15.2.1 A ward-round will occur only once per day at any reasonable hour where a VMO will see most or all In-patients under his care, [usually excluding those recently admitted from the A & E / Emergency Department / Outpatient area, unless a clearcut clinical indication exists]. A VMO is entitled to claim only one ward-round visit per day per acute in-patient.

15.3 SPECIAL VISITS

15.3.1 A special visit, by the responsible physician, may occur at any hour, other than during a ward-round, without any request necessarily being made by the hospital, the only indication being based on clinical need.

15.3.2 If any visits are seen as inappropriate by the hospital clinical administration, it would be reasonable for the matter to be raised at a medical Quality Assurance meeting with the VMO concerned being given the opportunity of presenting his/her case/s to her/his peers for assessment. The Quality Assurance meeting should assess whether the VMO has incurred a justifiable attendance fee. Further, it should be noted that the term `peers' is not restricted only to VMOs from the town concerned.

16 X-RAY CONSULTATION

16.1 Where a VMO has claimed a consultation fee or emergency fee and is required to wait to read the X-Ray only one consultation fee is payable. A second consultation fee is payable only if additional examination of the patient is necessary.

17 AFTER-CARE

17.1 As a general rule, the fee specified for each of the operations listed in the 1987 MBS contains a component for routine post operative care unless otherwise indicated.

17.2 After-care is deemed to include all normal post - operative treatment rendered by the VMO's and need not necessarily be limited to treatment given by the surgeon or to treatment given by any one VMO.

17.3 Where after-care is undertaken by a VMO (delegated) other than the attending surgeon at the same hospital where the procedure (operation) was undertaken, the full fee (including after-care) is to be paid to the surgeon VMO with no fees being paid to the after-care VMO for routine after-care. Other fees may apply eg assistance fees. The sharing of the after-care is a private arrangement between the surgeon and the attending VMO who undertakes the after-care. A suggested split is 75%/25% respectively but it is emphasised that this is a private arrangement. The hospital is not to pay the after-care VMO any fee for routine after-care. (New Item)

17.4 For the purposes of after-care, a confinement is to be considered a procedure, with these rules therefore applying.

17.5 Where after-care is undertaken by a VMO, other than the surgeon who undertook the procedure, at a hospital other than at the hospital where the procedure was undertaken, the attending after-care VMO is paid normal consultation fees for attendances.

17.6 Where an operation is undertaken by a VMO under sessional arrangements and the after care is undertaken by another VMO, the second VMO is to be paid normal consultation fees for attendances.

18 OPERATIONS

18.1 ASSISTANCE AT OPERATIONS

18.1.1 For any fee to be paid for assisting at an operation/s, at least one of the procedures must attract a Surgeon's fee greater than $162.30 (RATE 18/1/1 - rate for 1994/5 Schedule).

18.1.2 For an operation (or combination of operations) for which the Surgeon's fee does not exceed $265 (RATE 18/1/2 - rate for 1994/5 Schedule), the fee specified in item 2951 is payable.

18.1.3 Where the fee for the operation (or combination of operations) exceeds the $ limit specified in item 2951 (see item 2953 of RDA schedule), 20% of the Surgeon's fee as specified in the RDA Schedule is payable under Item 2953.

18.1.4 If the operation undertaken is not listed in the RDA Schedule then the greater of either 20% of the full fee from the 1987 MBS times the current adjustment figure, or Item 2951 is applicable. The current adjustment figure is 1.176512 (RATE 18/1/4 - rate for 1994/5 Schedule).

18.1.5 Benefit in respect of assisting at operations is not payable unless the assistance is rendered by a VMO other than the anaesthetist or assistant anaesthetist.

18.1.6 The amount of fee specified for assistance at an operation is the amount payable whether the assistance is rendered by one or more than one VMO.

18.2 MULTIPLE OPERATION RULE

18.2.1 The fees for two or more operations performed on a patient on the one occasion (other than listed hereunder) are calculated by the following rule:

100% for the item with the greatest Surgical fee plus
50% for the item with the next greatest Surgical fee plus
25% for each other Surgical item.

18.2.2 The resultant fee is to be rounded to the nearest 10 cents

18.2.3 Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

18.2.4 The multiple item rule only applies to procedures performed by the same surgeon. Where a different surgeon, even if he/she was initially the anaesthetist or the assistant, performs a procedure, the full fee from the RDA Schedule applies to that particular procedure.

18.2.5 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one (1) item and service in applying the multiple operation rule.

19 ECG TRACING AND REPORT

19.1 The description applicable to Item 1908 is `TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report` ie Item 908 from the 1987 MBS.

19.2 The description applicable to Item 1909 is `TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another Medical Practitioner, not associated with an attendance item, or twelve - lead ELECTROCARDIOGRAPHY, tracing only' ie Item 909 from the 1987 MBS.

19.3 New item numbers were allocated only because new fees were allocated.

19.4 As a general rule Item 1908 would apply where the complete procedure was provided by the one VMO. Item 1909 applies where the tracing and report are provided by different VMOs.

19.5 Item 1908 can be partially performed by another person on behalf of the VMO. That is performed in accordance with accepted medical practice, under the supervision of the VMO. While it is not necessary for the VMO to be present for the entire service, he or she must have direct involvement in at least part of the service.

19.6 For a VMO to be paid item 1908 when not in attendance at the taking of the ECG the VMO would have to have:

19.6.1 'established consistent quality assurance procedures for the data acquisition'. This means the ECGs must consistently be of good quality and the leads must be correctly placed.

and

19.6.2 personally analysed the data and written the report.

20 ACCOUNTS

20.1 These are to be presented to the Hospital only once each month.

20.2 The Hospital is entitled to be given details of:

20.2.1 The date of the Service

20.2.2 The time of the VMO's visit to the Hospital, except in the case of a Wardround when this should be particularly noted as WR or similar.

20.2.3 Sufficient detail to identify the patient. In most cases, the Initial and Surname together with the above date and time will be deemed sufficient. Where two or more patients seen on the same day have the same initial and surname then sufficient extra detail to identify each should be given. If readily available, the Medical Record Number of Inpatients should be shown if requested by the Hospital.

20.2.4 The appropriate Item Number claimed, together with a brief description of the nature of the Service performed. The abbreviated description from the RDA Schedule or similar will be deemed sufficient.

20.2.5 The fee claimed.

20.2.6 Where an anaesthetic fee is claimed, sufficient detail to identify the procedure/s performed eg the Item number or description.

20.2.7 Where Assistance at an operation is claimed, sufficient detail to identify the Surgeon eg his/her initials.

20.2.8 Where the claimant is a Specialist, practising in his/her Speciality, treating a referred patient, sufficient detail to identify the referring Doctor must be shown. In a small town, with few VMOs, his/her initials should suffice.

20.3 In all cases, including assisting, multiple item, derived fees and where the RDA Schedule does not show the fee, the final figure is to be rounded to the nearest 10 cents, where an even 5 cents becomes 10 cents in accordance with normal mathematical rules.

20.4 If the Service was performed by a suitably accredited VMO on a Public Patient, no other conditions may apply.

20.5 The VMO should normally receive payment within 2 weeks of the account being submitted. Complete, and individual, written explanations and details of all accounts not paid within 2 weeks of being received should be given to the VMO concerned and arrangements made to prevent a recurrence.

20.6 It is expected that in normal circumstances, VMO's accounts are rendered as soon as possible in the month following provision of the Service. Complete, and individual, written explanations and details of all accounts not submitted within 2 weeks of the next month should be given to the Hospital concerned and arrangements made to prevent a recurrence. It is acknowledged that in unusual circumstances eg a dubious Worker's Compensation claim, an account may not be able to be rendered until months/years later. These however remain payable.

LIAISON APPROVED	
For Dpt HEALTH	Colleen Doepel, General Manager, Corporate Services
For RDA(NSW)	Geoff White President RDA(NSW) Inc.
DATE	7/03/1996