Information Bulletin

Rural Doctors' Settlement Package Clarifications Reference Guide

Summary The Rural Doctors' Settlement Package Clarifications Reference Guide (Revised 2023) has been published and provides the correct billing by Fee for Service for Visiting Medical Officers (VMOs) at Rural Doctors' Settlement Package (RDSP) Hospitals.

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NSW Health

INFORMATION BULLETIN

Rural Doctors' Settlement Package Clarifications Reference Guide

PURPOSE

This Information Bulletin informs of the publication of the updated *Rural Doctors' Settlement Package Clarifications Reference Guide* (Revised 2023).

The *Rural Doctors' Settlement Package Clarifications Reference Guide* has been updated to include item number 1011, Supervision, and provide further clarification on item number 1005, timeframes for completion of discharge summaries.

KEY INFORMATION

The *Rural Doctors' Settlement Package Clarifications Reference Guide* clarifies the correct billing by Fee for Service Visiting Medical Officers (VMOs) at Rural Doctors' Settlement Package (RDSP) Hospitals.

The RDSP applies to Specialist General Practitioners (and to Specialists who have elected to be remunerated under this Package) at designated RDSP Hospitals.

ATTACHMENTS

1. Rural Doctors' Settlement Package Clarifications Reference Guide

RDA NSW
Rural Doctors' Association
Caring for the Country

NSW GOVERNMENT | Health

RURAL DOCTORS' SETTLEMENT PACKAGE

CLARIFICATIONS REFERENCE GUIDE

REVISED 2023

INDEX

INTRODUCTION

The Rural Doctors' Settlement Package

For Fee for Service Payments at specified NSW Country Hospitals (see Annexure 1).

This document is a compilation that brings together all of the information that makes up the RDA Settlement Package.

Preface:
The RDA Remuneration Package is acknowledged as a major factor in supporting rural doctors in their VMO roles in rural NSW.

Every Item on every page has been agreed by the Rural Doctors' Association and the NSW Ministry of Health Liaison Committee and is binding on both Hospitals and Doctors.

Explanatory Note

The RDA package consists of 3 types of item number:

- items specifically created for the package (such as consultation items)
- commonly used items from the 1987 Medical Benefits Schedule (item descriptions can be found in the current Ministry of Health Information Bulletin and further detail is available in the 1987 MBS)
- for other items, use the current MBS, and it will be indexed appropriately

The item numbers in the RDA package that were specifically created for the package and the commonly used item items from the 1987 Medical Benefits Schedule will be indexed on 1st August each year according to a formula based on changes in average weekly earnings of Australian full time workforce, from average changes of CPI and Motor Vehicles CPI.

RDSP ITEM NUMBER SUMMARY

(see the current RDA Settlement Package Information Bulletin for the full listing and current fees)

CONSULTATIONS - DURING A WARD ROUND

IN HOURS

Inpatient, one only seen	1002
Inpatient, more than one seen	1004
Non-inpatients any number	1010

SUNDAY AND PUBLIC HOLIDAYS

In and Non-inpatients any number	1016

ALL OTHERS, including Holidays (This Item discourages ward rounds before 7am & after 6pm)

In and Non-inpatients any number	1018

CONSULTATIONS - NOT DURING A WARD ROUND

IN HOURS

Inpatient, one only seen	1002
Inpatient, more than one seen	1004
Non-Inpatients any number	1010
Non-Emergency but not Routine	1012

AFTER HOURS (WEEKDAY)

First patient per visit	1024
Subsequent patients at same visit	1026

AFTER HOURS (WEEKEND)

First three patients per visit	1031
Subsequent patients at same visit	1034

LATE NIGHT HOURS

First patient per visit	1039
Subsequent patients at same visit	1042

ANTI SOCIAL HOURS

First patient per visit	1046
Subsequent patients at same visit	1050

CONSULTATIONS - EMERGENCY

Anti-Social Hour & first patient seen	1054
All Other Emergency attendances (regardless of time or ward round)	1056

TIMES REFERRED TO IN SCHEDULE

IN HOURS:	Monday to Friday 0700 to 1800 (7am to 6pm) Saturday 0700 to 1200 (7am to Midday)
AFTER HOURS:	Monday to Friday 1800 to 2200 (6pm to 10pm) Saturday 1200 to 2200 (Midday to 10pm) Sunday & Holidays 0700 to 2200 (7am to 10pm)
LATE NIGHT HOURS:	Any day 2200 to 2400 (10pm to midnight)
ANTI SOCIAL HOURS:	Any day 2400 to 0700 (midnight to 7am)

SUMMARY OF OTHER SPECIAL ITEMS

FEE PER FIFTEEN MINUTES: Prolonged professional attendance not less than one hour – ventilated patient awaiting transfer. 165

ON CALL ALLOWANCE (per hour) 1000
ON CALL ALLOWANCE (per hour) After Hours 1001

IN HOURS ATTENDANCE for the first patient seen, neither routine nor emergency (as defined), where the VMO is requested, or determines there is a definite clinical need following contact from the hospital, to return to the hospital primarily for this attendance. 1012

NONBOOKED ANAESTHETIC/ SURGEON CALLBACK

First in Anti-Social Hours	1054
All others	1056

AMBULANCE ESCORT (per hour) 1058

CONFINEMENT and ROUTINE POST NATAL CARE

Vaginal Delivery	1062
Caesarean Delivery	1064
Delivery of neonate at high risk	1066 (see below for full details)
Referred Caesarean Delivery	210

INTRAVENOUS INFUSION

Ordinary	1072
Open 'cutdown'	1074

COMMITTEE MEETINGS 1076 Fee / hour
(to nearest 15 min)

1076 Fee per hour: the committee meeting fee (item 1076) is an hourly rate payable to the nearest 15 minutes.
A fee equivalent to a one hour meeting is payable if the meeting is cancelled by the LHD with

less than 24 hours' notice.

COMMITTEE TRAVEL > 25km each way, local ** 1077 Fee / hour

1077 Travelling time to eligible [for Item 1076] meetings, providing travel is over 25 km each way-see Section 14.5 for more details.

EXPLANATORY NOTES

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 Specialist General Practitioners (and to Specialists who have elected to be remunerated under this Package) in identified Hospitals (see Annexure 1). However, some VMOs appointed, as General Practitioners are also qualified as 'non-GP 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'.

1.2 This document is to be read in conjunction with the August 1987 Medical Benefits Schedule.

1.3 A Liaison Committee has been established for ongoing consultation between rural doctors and the Ministry. Where a disagreement between parties (a rural doctor or doctors on the one hand and the Ministry of Health 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 Ministry and the President of the NSW Branch of the Australian Medical Association shall appoint an independent person to determine the matter.

1.4 There shall be no change to any of the fees herein described, other than by indexation, without full discussion between and mutual consent of the Rural Doctors' Association and the NSW Ministry of Health.

2. THE ORIGINAL SCHEDULE

2.1 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 e.g. 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 e.g. Coronary Angioplasty.

2.2 All instances where a description OR base fee has been altered from this Schedule are listed as Items 1000 to 1999 in the 'Information Bulletin - Rural Doctors' Settlement Package Hospitals Indexation of Fees - Visiting Medical Officers' published annually and known as the 'Rural Doctors' Settlement Package Hospital Indexation of Fees'.

3. NEW SERVICES

3.1 Where a NEW service has become available since 1987, e.g. 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

4. SERVICES RESTRICTED TO NON-GP SPECIALISTS

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

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

4.3 Items applicable only to non-GP Specialists treating referred patients are included in the RDSP Hospitals Indexation of Fees – VMOs Information Bulletin. These have been in use in some Districts for some time and are identified by ^ in the Specialist Item column.

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

4.5 In cases where a RDSP non-GP Specialist is called in an emergency instead of or in place of a general practitioner, the non-GP Specialist is to receive the GP's Emergency fee, providing that:

4.5.1 The option of the sessional payment method has not been offered and accepted at the hospital;

4.5.2 The non-GP specialist is called by the on call general practitioner to assist in the case of an emergency as defined in the rural GP's Indicative List of Emergencies.

5. ON CALL (ITEMS 1000 to PHOL)

Number on call

The maximum number of GPs on call at any hospital will be approved by the Liaison Committee.

Any variations to the determined levels are to be subject to decision by a Liaison Committee having equal representation (three members each) from the Rural Doctors' Association and the New South Wales Ministry of Health.

5.1 A practitioner cannot claim an on-call payment from more than one hospital at the one time.

5.2 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 Ministry of Health (having been determined by the Liaison Committee). This should be done monthly in advance and the roster displayed.

5.3 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.

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

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

6. DISCHARGE SUMMARY (ITEM 1005)

6.1 A fee will be payable to GP VMOs upon completion of a discharge summary for an admitted patient. On each occasion they will receive a payment. Only one fee is paid per patient.

6.2 The discharging GP VMO must ensure that all required information is documented in the format/system prescribed by the LHD and as per GL2022_005: Patient Discharge Documentation.

6.3 A copy of the discharge summary should be provided to the patient/carer where possible, unless the VMO determines that the content of the discharge summary is sensitive in nature and not appropriate to be provided directly to the patient. Where the patient has not been provided a discharge summary, this reason needs to be documented in the patient's medical records.

6.4 All discharge summaries must be written as soon as possible or within 48 hours of discharge as per NSW Health Information Bulletin 2020-21 KPI and Improvement Measure Data Supplement (IB2020_040).

6.5 Information must be accurate, relevant, appropriate, avoid duplication, ensure use of accepted terminology and avoid the use of abbreviations.

6.6 A GP VMO must have completed the discharge summary in order to claim this item number. When a discharge summary is substantially completed by another practitioner, such as a doctor in training, a GP VMO will not be eligible to claim this item.

7. MEDICATION RECONCILIATION (ITEMS 1006 & 1007)

7.1 A fee will be payable to GP VMOs upon completion of a medication reconciliation, both for admission and discharge of the patient. On each occasion they will receive a payment, payable by

Item number 1006 for medication reconciliation on Admission or Item 1007 for medication reconciliation on Discharge.

7.2 The medication reconciliation process must include obtaining, verifying and documenting an accurate list of a patient's current medications and performing a reconciliation using a second source of information (such as GP or pharmacy lists) for inpatient medication administration. On discharge the medication reconciliation must document changes to regular medications for communication to the patient/pharmacy/GP (dependent on what is appropriate for the patient).

7.3 The process includes the completion of medication charting, writing prescriptions on discharge, and ensuring these changes are documented in the discharge summary.

7.4 The documenting of information must be in the format/system prescribed by the LHD.

7.5 A GP VMO must have completed the medication reconciliation in order to claim this item number. When a medication reconciliation is substantially completed by another practitioner, such as a doctor in training, a GP VMO will not be eligible to claim these items.

8. SUPERVISION (ITEMS 1008, 1009 and 1011)

8.1 VMOs can be appointed to act as supervisors for Doctors in training (DiT) by NSW Health.

8.2 A fee will be payable when a VMO Supervisor, or a rostered alternative, is called in for an emergency to attend to a patient, or patients at the request of a DiT or other hospital staff.

8.3 Item 1008 is payable when a VMO Supervisor, or a rostered alternative, provides emergency supervision between 7:01am to 11:59pm, or Item 1009 is payable when a VMO Supervisor, or a rostered alternative, provides supervision in Anti-Social hours (Midnight to 7am), as requested by DiT or other hospital staff in Section 8.2.

8.4 The fee for Supervisors, or a rostered alternative, to be called in the assist a trainee is at the same monetary value as the Emergency Consultation or Emergency Consultation Anti-Social fee based on when the supervision is provided.

8.5 Items 1008 & 1009 can only be claimed where there is no other medical supervisor rostered and available on site.

8.6 Items 1008 & 1009 cannot be claimed if the GP VMO is claiming an emergency consultation FFS item number or sessional rate for any services during the period of attendance.

8.7 The Supervising VMO, or a rostered alternative, may also claim other procedural fees associated with their attendance.

8.8 Item 1011 can only be claimed by one supervisor at any one time, and the one payment is made regardless of the number of junior doctors being supervised at the one time.

8.9 No additional payments can be made for fee for service items or sessional payments for patient care whilst supervising junior doctors under Item 1011.

8.10 Clinical supervision paid under Item 1011 will be as agreed to by the medical staff and relevant LHD management in advance. Supervision activities include all aspects of clinical supervision, which may be required by NSW Health or training colleges, and may include clinical areas such as the operating theatre, ward rounds and emergency department, as well as other areas.

9. EMERGENCIES (ITEMS 1054 and 1056)

9.1 GENERAL

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

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

9.1.3 For prolonged emergency attendances on a patient, Items 160 - 164 may be charged instead of 1054 or 1056. Conditions apply - see Section 9.4.

9.1.4 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 e.g. a clearly separate visit to the hospital to do a pre anaesthetic examination.

9.1.5 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. The fee will be paid whether or not the VMO is in the hospital at the time of the call.

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

RURAL GPs 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 hematemesis 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.

6. Trauma

Acute fractures or dislocations where there is gross deformity, suspected neurovascular damage. (e.g. 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.

Acute (not chronic or recurrent) shoulder dislocation

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.

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

9.1.8 Each patient attracting the Emergency Consultation fee must fulfil the definition of 'Emergency' in their 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.

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

9.1.10 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 Call-back/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. Failure of the Nurse to document is not a valid reason to withhold payment if the Call-back/Emergency Consultation actually took place.

9.1.11 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.

9.2 NON-GP SPECIALISTS and EMERGENCY ATTENDANCES

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

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

9.2.3 For a non-GP 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 non-GP Specialist has been called in the case of an emergency as defined above.

9.2.4 For a non-GP specialist not participating in the GP On-call roster treating a referred patient, normal RDA package GP or RDA package non-GP 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 non-GP Specialist has been called by the hospital, e.g. the On- Call VMO, to assist in the case of an emergency as defined above.

9.3 ASSOCIATED CONSULTATIONS

9.3.1 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.

9.4 PROLONGED EMERGENCY ATTENDANCES (ITEMS 160 to 164)

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

9.4.1.1 The patient must be in imminent danger of death;

9.4.1.2 The patient must require continuous life-saving emergency treatment (not being treatment of a counselling nature);

9.4.1.3 The VMO must be present for the entire period claimed;

9.4.1.4 No other patients may be treated during the period claimed;

9.4.1.5 In exceptional circumstances, e.g. 2 severely burnt patients both awaiting retrieval, Condition 9.4.1.4 may be waived at the discretion of Hospital Management.

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

9.4.3 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.

9.5 CALLBACK FEE – SURGERY (ITEMS 1054 and 1056)

9.5.1 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 (i.e. general or local) entitles the GP/Surgeon to the equivalent of the emergency fee.

9.5.2 The Call-back fee includes any associated consultation performed during that visit to the hospital but a fee for the procedure/s is also payable.

9.6 CALLBACK FEE – ANAESTHETICS (ITEM 1054 and 1056)

9.6.1 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 (i.e. general or local) entitles the GP anaesthetist to the equivalent of the emergency fee in the same way as the GP surgeon.

9.6.2 The Call-back fee includes any associated consultation performed during that visit to the hospital but a fee for the anaesthetic/s is also payable.

9.7 PAYMENT OF EMERGENCY CONSULTATION FEE – OBSTETRICS (ITEMS 1054 and 1056)

9.7.1 Non-GP 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 i.e. 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, e.g. 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 i.e. not just obstetrics.

10. ANAESTHETICS

10.1 GP/NON-GP SPECIALIST ANAESTHETIC FEE DIFFERENTIAL

10.1.1 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.

10.2 PREOPERATIVE EXAMINATION (ITEM 82)

10.2.1 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.

10.2.2 If the Anaesthetist has claimed the Emergency or Call-back 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.

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

10.2.4 Item 82 is payable when the VMO does an examination in preparation for an anesthetic in a place other than an operation theatre or an anesthetic induction room.

10.3 MULTIPLE ANAESTHETIC RULE

10.3.1 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.

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

10.4 ANAESTHETIC TIME

10.4.1 An anaesthetic time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel.

10.4.2 The time taken should be recorded by the anaesthetist and where appropriate other staff within the patient's record. Theatre time should only be used as a guide to identify potential discrepancies, noting it will not detail post theatre activity.

NB: Please refer to Clarification '95 when reading this.

See: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=TN.10.3&qt=noteID

11. CONSULTATION AND A PROCEDURE

11.1 Where the 1987 Medicare Benefits Schedule states that a procedure is included with the associated consultation, e.g. 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.

11.2 It is not expected that a consultation fee will be charged on every occasion a procedure is performed e.g. if the procedure was pre-planned or booked.

12 OBSTETRICS

12.1 ANTE-NATAL CARE

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

12.2 POST-NATAL CARE

12.2.1 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 postnatal care.

12.3 REFERRED PATIENTS (ITEM 210)

12.3.1 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.

12.4 AFTER CARE by A DIFFERENT VMO

12.4.1 See Section 20 ("aftercare" provisions") for policy where post-natal care is undertaken by a VMO other than the VMO who attended during confinement.

12.5 OBSTETRICS ALLOWANCE and GLOBAL FEE (ITEMS 1062 & 1064)

12.5.1 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.

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

12.6 CARDIOTOCOGRAPHY (CTG ITEM 290)

Antenatal Cardiotocograph

12.6.1 Item 290 is not chargeable when a patient is already in labour.

12.6.2 A definition of high-risk pregnancy should assist in the use of this item as item 290 is only claimable for the management of high-risk pregnancy.

12.6.3 Item 290 is payable for a pregnancy complicated by maternal or foetal need for antenatal admission:

- Before 37 completed weeks of pregnancy (including preterm labour); or
- After 37 completed weeks for any maternal or foetal indication, where the patient is not in labour; or
- After 37 completed weeks for any maternal or foetal indication where the CTG is not performed as part of the routine preparation for a lower section Caesarean section or induction of labour.

12.7 MANAGEMENT OF LABOUR AND DELIVERY, OR DELIVERY ALONE (INCLUDING CAESAREAN SECTION) (ITEM 1066)

12.7.1 Management of labour and delivery, or delivery alone (including caesarean section, where in the course of antenatal supervision or intrapartum management one, or

more, of the following conditions is present, including postnatal care for 7 days:

- Multiple pregnancy;
- Recurrent antepartum haemorrhage from 20 weeks gestation;
- Grades 2, 3 or 4 placenta praevia;
- Baby with a birth weight less than or equal to 2500gm;
- Pre-existing diabetes mellitus dependent on medication or gestational diabetes requiring at least daily blood glucose monitoring;
- Trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery;
- Pre-existing hypertension requiring antihypertensive medication or pregnancy induced hypertension of at least 140/90mmHg associated with at least 1+ proteinuria on urinalysis;
- Prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress;
- Foetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; or
- Conditions that pose a significant risk of maternal death.

13. NON-INPATIENTS

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

13.1.1 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.

13.1.2 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 Veterans Affairs.

13.1.3 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.

13.1.4 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.

13.2 NON-INPATIENTS: COMPENSABLE

13.2.1 VMOs should be paid by hospitals for services relating to compensable non-in-patients. VMOs are not to lodge claims on insurance companies, etc. or patients.

14. COMMITTEE MEETINGS (ITEMS 1076, 1077 and 11.2A)

14.1 Principles:

14.1.1 Hospitals and Local Health Districts (LHDs) should reimburse Visiting Medical Officers (VMOs) where their clinical input into meetings about improvements of resources of the Hospital is sought by the LHD. Improved functioning of the hospitals/health services is of benefit to the hospital, to Visiting Medical Officers and to patients.

14.1.2 For those meetings for which reimbursement is approved, the hospital/health service

should receive a positive output to improve service/processes (e.g. minutes, recommendations etc).

14.1.3 VMOs receive a benefit in quality improvement activities, both in terms of improved

functioning of the hospital and for their own professional development or practice accreditation purposes, so VMOs should make a contribution to quality improvement activities and not receive payment for all of those activities. This concept would be best reflected by not paying VMOs to attend training and information sessions.

14.1.4 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.

14.2 Examples of meetings for which payments will be available:

14.2.1 District based administrative meetings where VMO assistance is required or requested (e.g. Medical and Dental Appointment Advisory Committee, Credentials Committee, Network

or District "stream" meetings, Quality Council, Chronic and Complex Care, Aged Care, etc)

14.2.2 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 e.g. recommendations and the detail of the attendance record reflected in formal minutes of the meetings.

14.2.3 Ad hoc meetings where VMO presence is requested by hospital manager or area executive (e.g. planning meetings, meetings with consultants etc).

14.3 Examples of meetings for which payments will not be available:

14.3.1 Board meetings

14.3.2 Medical staff council meetings

14.3.3 Peer review, morbidity and mortality meetings with no clear output for the hospital/health service to implement changes to services/processes.

14.3.4 Education meetings for the benefit of the medical officers.

14.3.5 Public relations type meetings where VMO may be invited but attends by their own choice (e.g. opening ceremonies, meetings with dignitaries).

14.4 A Transport Allowance may in some circumstances also be claimed, payable by Item 11.2A

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

14.4.1.1 The meeting must meet all of the criteria in 14.1-14.3.5 above;

14.4.1.2 The meeting must be at a place where the VMO does not have their primary appointment. It is not to be paid for attending meetings at a hospital at which the VMO has their primary appointment;

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

14.4.1.4 Journeys made by the VMO to provide other Services under their contract are not eligible for the Transport Allowance under this clause;

14.4.2 The transport allowance when claimable applies to all mileage travelled and is based on the current Australian Taxation Office "cents per kilometre method";

14.4.3 Other benefits/requirements are detailed in Circular 94/118 e.g. the vehicle must be comprehensively insured.

14.5 COMMITTEE MEETING- PAYMENT FOR TRAVEL TIME FOR MEETING ATTENDANCE (ITEM 1077)

14.5.1 To be eligible for payment under this item, a VMO must be attending a meeting in

accordance with Item 1076.

14.5.2 The meeting venue must be more than more than 25 kilometres (by road) from the health facility to which the VMO is appointed, and involve more than 25 kilometres travel each way for the VMO attending the meeting.

14.5.3 The rate would be paid to the nearest 15 minutes, based on reasonable travel time between the venue and the health facility to which the VMO is appointed, or the VMO's return destination, whichever is the lesser.

14.5.4 The travel time rate applicable will be the same as the hourly rate as applies in Item 1076.

14.5.5 VMOs are entirely responsible for their own travel costs apart from the Transport Allowance for vehicle use as detailed in Clause 14.4.

14.5.6 This item may be subject to review between the parties should evidence of excess use of this item become apparent.

15. AMBULANCE CALL OUT

15.1 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.

16. INTRAVENOUS INFUSIONS (ITEMS 1072 and 1074)

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

16.2 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.

16.3 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.

16.4 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.

16.5 Injection/infusion of a radio opaque medium (Item 2837) is chargeable e.g. 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.

16.6 Item 1072 is for the maintenance of an intravenous infusion. This includes all decision-making about the type of fluid and rate of flow, and there must be a reasonable indication, based on clinical need, for the infusion. A claim should be paid whether the cannula was inserted by the VMO or by nursing staff. A change of cannula does not provide a reason for an additional claim of item 1072. The item is not for the insertion of the cannula, or for the setting up of the line (from the intravenous fluid bag to the cannula) for the infusion.

Examples:

- A patient with dehydration from gastroenteritis or a bowel obstruction has a reasonable indication for an intravenous infusion and item 1072 is payable, whether the cannula was inserted by the VMO or nursing staff.
- A patient with chest pain has 2 cannulas inserted by the VMO. Item 1072 is not payable because the cannulas are for the administration of drugs, not an intravenous infusion.

16.7 The insertion of an intravenous cannula and the management of any associated fluids is regarded as part of an anaesthetic procedure and no separate payment for an item 1072 should be made, unless there is a reasonable indication, based on clinical need, for an infusion beyond the anaesthetic.

Examples:

- A patient having a bowel resection, and remaining nil by mouth after surgery, will require an intravenous infusion and an item 1072 is payable.
- A patient having a Caesarean section is cannulated for the anaesthetic, not because of an ongoing need for an intravenous infusion and an item 1072 is not payable.

16.8 Under normal circumstances, a claim for item 1072 would occur only once during any hospital stay. Exceptions may occur if there is justification for the insertion of 2 cannulas, with both being used for infusions, or where the clinical circumstances of the patient justify the re-establishment of an infusion. In these circumstances, there should be clear documentation in the medical record.

Payment is subject to there being an appropriate record of service/s. In most cases, the intravenous fluid order chart will be sufficient evidence. Additional information will however be required in certain circumstances.

Examples:

- The recommencement of an intravenous infusion;
- The need for a second (simultaneous) intravenous infusion; or
- The appropriateness of an intravenous infusion coupled with an anaesthetic.

The additional information should be recorded in the medical record.

17. NURSING HOME TYPE and LONG STAY PATIENTS (ITEMS 1002, 32 and 34)

17.1 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.

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

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

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

17.5 ‘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 18.3.2 about inappropriate visits and charges).

17.6 In facilities that have Commonwealth-funded aged care beds, nursing home-type patients, Medicare should be directly billed. If the patient requires hospital admission (including in the same facility) the RDA Package may be billed.

18. INPATIENTS

18.1 IN-PATIENT VISITS

18.1.1 A patient is not to be admitted under a VMO without the VMO's prior knowledge and consent.

18.1.2 There must be a distinction made between 'ward round' consultations and 'In-patient Special Visits' i.e. –non-ward round/follow-up' consultations.

18.2 WARD-ROUNDS

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

18.3 SPECIAL VISITS

18.3.1 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.

18.3.2 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 their case/s to their 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.

19. X-RAY CONSULTATION

19.1 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.

20. AFTERCARE

20.1 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.

20.2 Aftercare is deemed to include all normal post – operative treatment rendered by the VMOs and need not necessarily be limited to treatment given by the surgeon or to treatment given by any one VMO.

20.3 Where aftercare 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 aftercare) is to be paid to the surgeon VMO with no fees being paid to the aftercare VMO for routine aftercare. Other fees may apply e.g. assistance fees. The sharing of the aftercare is a private arrangement between the surgeon and the attending VMO who undertakes the aftercare. A suggested split is 75%/25% respectively but it is emphasised that this is a private arrangement. The hospital is not to pay the aftercare VMO any fee for routine aftercare.

20.4 For the purposes of aftercare, a confinement is to be considered a procedure, with these rules therefore applying.

20.5 Where aftercare 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 aftercare VMO is paid normal consultation fees for attendances.

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

21. OPERATIONS

21.1 ASSISTANCE AT OPERATIONS (ITEMS 2951 and 2953)

21.1.1 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 the fee in the current Schedule

21.1.2 For an operation (or combination of operations) for which the Surgeon's fee does not exceed the fee in the current schedule, the fee specified in item 2951 is payable.

21.1.3 Where the fee for the operation (or combination of operations) exceeds the dollar 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.

21.1.4 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.

21.1.5 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.

21.1.6 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.

21.2 MULTIPLE OPERATION RULE

21.2.1 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.

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

21.2.3 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.

21.2.4 The multiple item rule only applies to procedures performed by the same surgeon. Where a different surgeon, even if they were initially the anaesthetist or the assistant, performs a procedure, the full fee from the Rural Doctors' Settlement Package Hospitals Indexation of Fees applies to that particular procedure.

21.2.5 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.

22. SUTURING OF LACERATIONS (ITEMS 3050, 3063, 3082 and 3098)

The addition of a descriptor for suturing of deep wounds for payments of items 3050, 3063, 3082 and 3098 will clarify interpretation of these items. For these items to apply, the descriptor ‘a deep

layer of sutures' commonly would be inserted.

23. ECG TRACING AND REPORT (ITEMS 1908 and 1909)

23.1 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.

23.2 The VMO will assist the public hospital(s) to which they are appointed in establishing consistent quality assurance procedures for the data acquisition.

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

23.4 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 deficiency 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.

23.5 A maximum of four 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.

23.6 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).

23.7 As a general rule Item 1908 would apply where the complete procedure was provided by the one VMO. 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, the VMO must have direct involvement in at least part of the service.

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

23.8.1 '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

23.8.2 Personally analysed the data and written the report.

23.9 Item 1909 applies where the tracing and report are provided by different VMOs. 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' i.e. Item 909 from the 1987 MBS.

23.10 Item 1909. All ECGs not covered in Item 1908.

24. ACCOUNTS

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

24.2 The Hospital is entitled to be given details of:

24.2.1 The date of the Service;

24.2.2 The time of the VMO's visit to the Hospital, except in the case of a Ward round when this should be particularly noted as WR or similar;

24.2.3 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;

24.2.4 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;

24.2.5 The fee claimed;

24.2.6 Where an anaesthetic fee is claimed, sufficient detail to identify the procedure/s performed e.g. the Item number or description;

24.2.7 Where Assistance at an operation is claimed, sufficient detail to identify the Surgeon e.g. their initials;

24.2.8 Where the claimant is a non-GP Specialist, practising in their Speciality, treating a referred patient, sufficient detail to identify the referring Doctor must be shown. In a small town, with few VMOs, their initials should suffice.

24.3 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.

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

24.5 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.

24.6 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 e.g. a dubious Worker's Compensation claim, an account may not be able to be rendered until months/years later. These however remain payable.

24.7 Hospitals should itemise where any adjustment has been made to a VMO’s fee statement, in addition to showing the total payment.

24.8 DISCOUNTING OF DELAYED CLAIMS

24.8.1 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.

24.9 PENALTY FOR LATE PAYMENT

24.9.1 Should the Local Health District fail to make payment to the RDSP VMO after 90 days of receiving an account for payment, interest shall accrue on the outstanding account from the date of the receipt of the account at the Supreme Court interest rate applicable at the time. This interest payment would not necessarily apply where the dispute procedure has been invoked.

25. MANDATORY TRAINING (ITEM 1079)

25.1 Public Health Organisations should provide the opportunity for VMOs to complete mandatory training during paid time. Where online mandatory training cannot be completed during paid time, and following discussion with the PHO, the VMO may claim the actual time spent undertaking the training modules subject to that time not exceeding HETI estimated duration. This fee is only payable if there is no opportunity for the VMO to undertake mandatory training during paid time. Supporting documentation to evidence completion of the training is required when making this claim.

25.2 The fee for mandatory training will be as per Item 1079 and paid to the nearest 15 minutes.

APPENDIX 1

Rural Doctors Settlement Package (RDSP) Hospital List

BALLINA – removed from list 2014

BALRANALD

BARHAM

BARRABA

BATEMANS BAY

BATLOW

BEGA – new hospital built named South East Regional Hospital – removed from list 2016

BELLINGEN-BELLINGER RIVER

BERRIGAN WAR MEMORIAL

BINGARA

BLAYNEY

BOGGABRI

BOMBALA

BONALBO

BOOROWA

BOURKE

BOWRAL

BRAIDWOOD

BREWARRINA

BUNDARRA

BYRON-BRUNSWICK

CANOWINDRA SOLDIERS

CARCOAR

CASINO

CESSNOCK

COBAR

COLLARENEBRI

CONDOBOLIN

COOLAH

COOMA

COONABARABRAN

COONAMBLE
COOTAMUNDRA
COROWA
COWRA
CROOKWELL
CUDAL
CULCAIRN
DELEGATE
DENILIQUIN
DENMAN
DORRIGO
DUNEDOO WAR MEMORIAL
DUNGOG
EMMAVILLE-VEGETABLE CREEK
EUGOWRA MEMORIAL
FINLEY
FORBES
GILGANDRA
GLEN INNES
GLOUCESTER SOLDIERS MEMORIAL
GOODOOGA
GOULBURN-ST JOHN OF GOD
GRENFELL
GULGONG
GUNDAGAI
GUNNEDAH
GUYRA WAR MEMORIAL
HARDEN-MURRUMBURRAH
HAY
HENTY
HILLSTON
HOLBROOK
INVERELL
JERILDERIE
JUNEE

KIAMA – aged care facility only – removed from list
KURRI KURRI
KYOGLE-MEMORIAL
LAKE CARGELLIGO
LEETON
LITHGOW
LOCKHART
MACKSVILLE
MACLEAN
MANILLA
MERRIWA
MILTON-ULLADULLA
MOLONG
MOREE PLAINS
MORUYA
MUDGEE
MULLUMBIMBY-BRUNSWICK – hospital closed
MURRURUNDI-WILSON MEMORIAL
MUSWELLBROOK
NARRABRI
NARRANDERA
NARROMINE
NOWRA-SHOALHAVEN – removed from list
NYNGAN
OBERON
PAMBULA
PARKES
PEAK HILL
PORTLAND
QUANDIALLA – hospital closed
QUIRINDI
RYLSTONE
SCONE-SCOTT MEMORIAL
SINGLETON
TEMORA

TENTERFIELD-PRINCE ALBERT MEMORIAL
TINGHA
TOCUMWAL
TOTTENHAM
TRANGIE
TRUNDLE
TULLAMORE
TUMBARUMBA
TUMUT
UNGARIE – hospital closed
URANA- MCCAUGHEY
URBENVILLE
WALCHA
WALGETT
WARIALDA
WARREN
WAUCHOPE
WEE WAA
WELLINGTON
WENTWORTH
WERRIS CREEK
WEST WYALONG
YASS
YEOVAL CO-OP
YOUNG
YOUNG-MERCY CARE