



THE FEES AND CHARGES MANUAL

SEPTEMBER 2009

CONTENTS

PATIENT ACCOUNT CLASSIFICATION 3

NON-CHARGEABLE PATIENTS 5

CHARGEABLE PATIENTS 6

WAIVING OF CHARGES/ WRITE-OFFS 6

TABLES OF CHARGES / FEES 7

 TABLE 1 NON-ADMITTED

 TABLE 2 ADMITTED PATIENTS

 TABLE 3 REHABILITATION

 TABLE 4 ORTHOTIC SERVICES

 TABLE 5 ORAL HEALTH SERVICE

 TABLE 6 MEDICAL EVACUATION

 TABLE 7 RENAL DIALYSIS

 TABLE 8 MEDICAL REPORTS, COPIES OF MEDICAL RECORDS AND
 COPIES OF XRAYs RENAL DIALYSIS

SUBJECT 1 PATIENT ACCOUNT CLASSIFICATION

I. DEFINITION

The source of entitlement and / or payment for treatment and / or care a person receives whilst a patient of a Department of Health and Families hospital.

II. CLASSIFICATIONS

1. Public patient
2. Private patient
3. Medicare ineligible patient
4. Compensable patient:
 - motor vehicle accident interstate third party insurance
 - workers compensation
 - public liability insurance/ common law recoveries
 - Motor Accidents Compensation Scheme
5. Primary care referred patient

1. PUBLIC PATIENT (Medicare Eligible Person)

A Medicare eligible person who chooses to be a **public** patient will not be charged for hospital accommodation, medical, dental, allied health, diagnostic services and prostheses from doctors nominated by NT public hospitals, as well as meals and other health services while in hospital.

Medicare covers people residing in Australia who are Australian citizens, New Zealand citizens or holders of permanent visas.

Some visitors and temporary residents, from countries with which Australia has made reciprocal health care agreements, are eligible for Medicare with some restrictions as outlined in the *Reciprocal Health Care Agreement*.

Reciprocal Health Care Agreement

Ten countries have reciprocal health care agreements with Australia. These countries are Belgium, Great Britain, Finland, Ireland, Italy, Malta, the Netherlands, New Zealand, Norway and Sweden. Visitors (but not visitors studying in Australia) from these countries are eligible for Medicare assistance for immediately necessary medical treatment (but not for pre-arranged treatment). Under the agreements, hospital treatment is provided only if the patient elects to be a **public** patient. The terms of the various agreements differ. The major differences are that the agreements with Ireland and New Zealand cover only hospital treatment and pharmaceutical benefits, and the agreements with Italy and Malta cover only the first six months from the date of arrival in Australia.

2. PRIVATE PATIENT

Medicare Eligible

People who are eligible for Medicare who choose to be **private** patients in public hospitals are charged fees by doctors, and are charged by the hospital for hospital care. This includes hospital accommodation, all medical services including diagnostic services (eg pathology tests and Xrays) performed and/or ordered by the doctor of choice or by other doctors to whom they have been referred, and dental services and prostheses. Charges may also apply for services provided by allied health professionals eg. Physiotherapists.

If the patient holds private insurance, this will usually cover all or nearly all of the charges by a public hospital. Medicare pays benefits subsidising part of the cost of doctors' fees, and private insurance pays an additional amount towards doctors' fees.

Medicare Ineligible

People who are not entitled to Medicare who choose to be **private** patients in public hospitals are charged fees by doctors and are charged by the hospital for hospital care. They are responsible for payment of all fees during the period of hospitalisation at the current \$AUD rate per day.

3. MEDICARE INELIGIBLE PATIENT

A person who is not eligible under Medicare is classed as an **ineligible** patient and is responsible for all charged fees raised by the doctor and/or the hospital.

4. COMPENSABLE PATIENT

A **compensable** patient is or may be legally entitled to the payment of, or has been paid compensation or damages in respect to the injury, illness or disease for which he/she receives treatment and care.

Types of compensation include claims under, or for, workers' compensation, motor vehicle accident interstate third party insurance, common law damages and the *NT Motor Accident Compensation Act*.

A compensable patient is not entitled to Medicare benefits. All charges must be paid for from the compensation.

A compensable patient may choose to be a public compensable patient or a private compensable patient. If the claim for compensation fails, a private compensable patient will be responsible for all fees as a private patient. In the case of a public compensable patient no fees will apply.

NB: DHF hospitals should not raise any charges for treatment of a person entitled to benefits under the *Motor Accidents (Compensation) Act NT* administered by Territory Insurance Office (TIO). This is met under the Agreement between DHF and TIO.

5. PRIMARY CARE REFERRED PATIENT

A primary care referred patient is a Medicare eligible person who is referred to a specialist medical practitioner by name from a General Practitioner or District Medical Officer following provision of a primary care level service in the community for a non-admitted consultation or a procedure, including radiology and pathology services.

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

III. USE GUIDELINES

- Record this information on CareSys when the patient presents for treatment to hospital or as soon as possible after the event.
- A patient whose compensable status is not confirmed on the day the patient is treated may be confirmed at a later date. Any change in status should be retrospectively applied to a patient's non-admitted care. If a compensation claim is denied, the account class for the non-admitted treatment and or care should be cancelled, and the patient recorded as public patient.
- An ineligible person is responsible for charges raised by the doctor and or the hospital.
- Primary care referred patients will be Medicare bulk-billed with no patient contribution through the private trust fund.
- Refer to the DHF Accounting and Property manual Section 21, Accounts Receivable for detailed information about raising invoices, adjustments and credit policy.

SUBJECT 2 NON – CHARGABLE PATIENT

Will not be charged for accommodation, diagnostic, medical, nursing or other services:

- a. By the hospital.
- b. By the hospital to which transferred for further care as an admitted patient; it is expected that if one recognised hospital does not have the facilities necessary for the care and treatment of a patient, the patient should be referred (and if necessary transferred) to another recognised hospital, which has the necessary facilities.
- c. By the hospital to which the patient was referred for a diagnostic or clinical procedure without being admitted as an admitted patient, including the referral of a specimen for pathological examination without the patient having to visit that hospital.

Will be formally admitted at each hospital where admitted patient care is provided to him/her and will sign a separate form of election at each hospital.

Will have post-discharge care carried out in an outpatient clinic.

SUBJECT 3 CHARGABLE PATIENT

Patients who elect in writing to nominate a doctor who will be responsible for their care and treatment will be charged by the hospital a standard daily bed fee. They will also be charged by attending medical officers for services rendered. After 35 days they may be reclassified as 'Nursing Home Type' patients.

SUBJECT 4 WAIVING OF CHARGES/ WRITE - OFFS

Ineligible persons who do not have the financial capacity to pay and who are hospitalised for communicable disease can have the charges waived.

Charges will be raised for the admitted person. As soon as it is established that the person does not have the financial capacity to pay, a briefing showing the amounts owing, and the reason why the charges should be waived shall be submitted to the Executive Director Acute Care, Department of Health and Families (DHF).

In particular cases, where payment of the patient contribution would involve personal financial hardship, or where it is not in the public interest, the Executive Director Acute Care, DHF may remit (waiver) or postpone all or part of the charge under the *Medical Services Act* up to \$1500 (refer *Medical Services Act* Section 15 (2)). Examples include:

- Financially disadvantaged pensioners;
- Patients without any independent source of income, such as children of pensioners.

The Minister for Health also has the power to remit or postpone charges payable to or an expense made under the *Medical Services Act* (refer Section 15 (1) *Medical Services Act*)

Where a waiver occurs, the debt is extinguished and cannot be recovered at any stage in the future.

Debts may also be written off. For Write-Offs, refer to the Section 21.11 of the Accounting and Property Manual - DEBTS – WRITE-OFF, T/D Accounting Series A2-7 and A6-3, and the Delegations Manual regarding the amounts and the Delegation to write-off. Debts written off under the *Financial Management Act 1995* are recoverable at a later stage should the financial circumstances of the patient change.

SUBJECT 5 TABLES OF FEES/ CHARGES**❖ TABLE 1 NON-ADMITTED PATIENTS****INELIGIBLE/ COMPENSABLE**

EMERGENCY DEPARTMENT	Fee
Initial Service	\$281
Review and Dressing Service	\$129
High Cost Diagnostics (CMBS > \$100)	120% of MBS
MRI, CT and Nuclear Medicine	120% of MBS

- Fee inclusive of general diagnostics.
- Commonwealth Medical Benefits Schedule (CMBS).

OUTPATIENT DEPARTMENT	Fee
Hospital Medical Practitioner	\$188
Allied Health Professional	\$62
Nursing Services	\$62
Allied Health and/ or Clinical Nurse	\$96
Diagnostics Services	120% of MBS

PRIMARY CARE REFERRED

- Specialist consultation billed through PPTF at 85% of CMBS.
- Diagnostic Services billed at 85% CMBS.

PRIVATE/AUSTRALIAN DEFENCE FORCE

- Specialist consultations billed through PPTF at a fee level determined by Specialist.
- Radiology Services provided on NT hospital facilities to be billed at 100% of CMBS.
- Fees for diagnostic services undertaken on private facilities will be determined by the Service Provider.

1. **TABLE 2 ADMITTED PATIENTS**

PRIVATE INPATIENT/AUSTRALIAN DEFENCE FORCE

SAME DAY BED FEE	Fee
Same Day Band 1	\$213 per day
Same Day Band 2	\$243 per day
Same Day Band 3	\$282 per day
Same Day Band 4	\$294 per day
Overnight	\$294 per day

- Specialist consultations billed through PPTF at a fee level determined by Specialist.
- Diagnostic Services to be billed at 100% of Commonwealth Medical Benefits Schedule (CMBS).

INELIGIBLE/ COMPENSABLE ADMITTED PATIENTS (EXCLUDING MACA)

FULL BED DAY COST	Fee
ICU, SCN & CCU (RDH / ASH)	\$2,004 per day
HDU (RDH & ASH)	\$1,189 per day
ACUTE CARE (RDH / ASH) (Overnight)	\$1,168 per day
ACUTE CARE (RDH / ASH) (Same Day)	\$772 per day
ACUTE CARE (KH / TCH/ GDH) (Overnight)	\$911 per day
ACUTE CARE (KH / TCH/ GDH) (Same Day)	\$602 per day
HITH (RDH / ASH)	\$349 per day
High Cost Diagnostics (MBS > \$100)	120% of MBS
MRI, CT and Unclear Medicine	120% of MBS

- Full bed day cost inclusive of general diagnostics.
- Specialist consultations billed through PPTF at a fee level determined by Specialist.

Nursing Home Type Patient (NHTP)	Fee
Public Patient	\$45.50 per day
Private (in Public Hospital)	\$113.22 per day

- Fees and charges for NHTP are made up as follows:
 - * 87.5% of the combined Standard Pension and Rent Assistance

INTERSTATE ADMITTED PATIENT

- Cross – Border National Charges.

TIO (MACA) ADMITTED PATIENT

- Payable by TIO annually.

❖ **TABLE 3 REHABILITATION**

NON ADMITTED INELIGIBLE AND COMPENSABLE PATIENTS	Fee
Aboriginal Health Worker	\$126 per service
OCCUPATIONAL THERAPY	\$108 per hour
SPEECH PATHOLOGY	\$171 per hour
SOCIAL WORK	\$143 per hour
PHYSIOTHERAPY	\$81 per hour
CLASSES (including hydrotherapy)	\$37 per service
CONSULTATION FEE Clinical assessment / review by Rehabilitation Specialist	120% of MBS
CASE MANAGEMENT Co-ordination of the care required by individual patient	\$126 per hour
CHECKLISTS Program of service – list provided for Insurance Companies etc	\$35 per list

❖ **TABLE 4 ORTHOTIC SERVICES**

INELIGIBLE PATIENTS Admitted / Non-admitted Patients	Chargeable
COMPENSABLE PATIENTS (WITH THE EXCEPTION OF MACA) Admitted / Non-admitted Patients	Chargeable
PRIVATE INPATIENTS Admitted / Non-admitted Patients	Chargeable
DEPARTMENT OF VETERAN AFFAIRS <ul style="list-style-type: none"> • Admitted (when not required for discharge) • Non-admitted Patients 	Chargeable

PUBLIC PATEENTS	
<ul style="list-style-type: none"> • Admitted • Non-admitted Patients (if not eligible for Pensioner Concession Cards, PCC, HCC or HBC.) 	<p>No charge</p> <p>Chargeable</p>
ORTHOTIC FEE SCHEDULE	See Attachment A
PROSTHETIC FEE SCHEDULE	See Attachment B

❖ **TABLE 5 ORAL HEALTH SERVICES**

ADA * ITEM No.	DESCRIPTION OF SERVICES	FEE
DIAGNOSTIC SERVICES		
11	Initial oral examination (where radiographs are not used)	\$41
12	Periodic oral examination (where radiographs are not used)	\$35
13	Emergency oral examination	\$35
14	Consultation for each 15 minutes	\$51
18	Written Report for each 15 minutes	\$51
21	Complete intraoral series of radiographs (10 films or more, inch bitewings)	\$166
22	Intraoral periapical or bitewing radiograph, single view	\$24
23	2 periapical or bitewing radiographs	\$48
24	Each additional single periapical or bitewing radiograph up to 7, additional to item 023	\$12
25	Intraoral radiograph, occlusal, maxillary or mandibular, single film	\$40
31	Extraoral Radiograph, maxillary or mandibular, single film	\$48
37	OPG	\$96
71	Study (diagnostic) casts two models	\$65
PREVENTATIVE SERVICES		
111	Removal of plaque	\$51
112	Removal of supragingival calculus and plaque	\$51
114	Removal of supra and subgingival calculus and plaque - first visit per 15 minutes	\$51
115	Removal of supra and subgingival calculus and plaque - subsequent visit	\$51

	per 15 minutes	
121	Topical application of fluoride, one treatment	\$70
141	Oral hygiene instruction where appropriate time is allocated	\$51
151	Provision of mouthguard requiring construction of a model	\$120
161	Fissure sealing- per tooth	\$28
165	Application of desensitising agent - per visit	\$29
PERIODONTICS		
213	Treatment of acute periodontal infection	\$51
222	Root planing and sub-gingival curettage per segment of eight teeth or less, per 15 minutes	\$63
225	Non-surgical periodontal treatment where not otherwise specified - per visit	\$63
231	Gingivectomy, per segment of eight teeth or less, per 15 minutes	\$63
ORAL SURGERY		
311	Simple removal of permanent tooth (with local anaesthesia and including post-operative care)	\$75
313	Removal of deciduous tooth or parts	\$51
316	Simple removal of each additional tooth at the same appointment as, and as a complementary procedure, to Item 311 or 313	\$36
321	Surgical removal of erupted tooth (including local anaesthesia and routine post-operative care) for each 15 minutes	\$63
	NOT TO EXCEED	\$253
322	Surgical removal of unerupted or partly erupted tooth not requiring removal of bone or tooth division (including local anaesthesia and routine post - for each 15 minutes	\$63
	NOT TO EXCEED	\$253
323	Surgical removal of unerupted or partly erupted tooth requiring removal of bone or tooth division (including local anaesthesia and routine post-. for each 15 minutes	\$63
	NOT TO EXCEED	\$253
324	Surgical removal of unerupted or partly erupted tooth requiring both removal of bone and tooth division, or of unerupted tooth completely covered by bone (including local anaesthesia and routine post - for each 15 minutes	\$63
	NOT TO EXCEED	\$253
325	Surgical removal of tooth fragment, involving soft tissue (including local anaesthesia and routine post-operative care) for each 15 minutes	\$63
	NOT TO EXCEED	\$253

326	Surgical removal of tooth fragment, involving bone (including local anaesthesia and post-operative care. for each 15 minutes	\$63
	NOT TO EXCEED	\$253
329	Non-routine post-operative treatment - per visit	\$46
392	Incision and drainage of abscess or cyst	\$63
ENDODONTICS		
411	Direct Pulp capping	\$20
412	Pulpotomy - deciduous tooth	\$53
415	Complete chemo-mechanical preparation of root canal - one canal	\$120
416	Complete chemo-mechanical preparation of root canal - each additional canal	\$70
417	Root obturation - one canal	\$120
418	Root obturation - each additional canal	\$70
419	Extirpation of pulp or debridement of root canal(s) - emergency	\$70
431	Periapical curettage with no other treatment. For each 15 minutes	\$63
	NOT TO EXCEED	\$253
432	Apicectomy, per root, including periapical curettage, for each 15 minutes	\$63
	NOT TO EXCEED	\$253
434	Retrograde amalgam, one root including apicectomy and periapical curettage for each 15 minutes	\$63
	NOT TO EXCEED	\$253
436	Sealing of perforation	\$63
	NOT TO EXCEED	\$316
441	Bleaching, one tooth - non-vital (complete course of treatment)	\$102
443	Bleaching, one tooth - vital (complete course of treatment)	\$70
RESTORATIVE SERVICES		
Amalgam filling		
511	1 surface	\$63
512	2 surfaces	\$76
513	3 or more surfaces	\$72
Glass Ionomer Cement -		
521	1 surface	\$59
522	2 surfaces	\$66
523	3 surfaces	\$74

Composite resin restoration - posterior		
531	1 surface	\$72
532	2 surfaces	\$90
533	3 surfaces	\$110
Composite resin restoration - anterior		
537	1 surface	\$72
538	2 surfaces	\$90
539	3 surfaces	\$124
CROWN AND BRIDGE (add on lab or gold costs)		
Crowns		
613	Porcelain jacket crown	\$708
615	Porcelain fused to gold jacket	\$708
618	Cast gold crown	\$660
622	Porcelain bonded to non-precious metal crown	\$708
625	Cast core for crown including post	\$139
Bridgework		
642	Bridge pontic - per pontic	\$660
643	Bridge pontic - porcelain or porcelain fused to gold - per pontic	\$708
647	Bridge pontic, enamel bonded with cast metal sub-structure and porcelain pontic - per pontic ("Maryland")	\$708
648	Bridge pontic, enamel bonded with cast metal sub-structure and resin pontic - per pontic ("Maryland")	\$708
651	Re-cementing crown or veneer	\$63
652	Re-cementing bridge. For each 15 minutes	\$63
659	Repair or replacement of broken facing of crown or bridge. For each 15 minutes	\$63
PROSTHETIC SERVICES - Lab fees additional		
New dentures and denture components		
711	Complete maxillary denture	\$683
712	Complete mandibular denture	\$683
716	Metal palate or plate additional 711, 712, 719	\$173
719	Complete maxillary and mandibular denture	\$1214
721	Partial maxillary denture - acrylic base	\$330
722	Partial mandibular denture - acrylic base	\$330

727	Partial maxillary denture, cast alloy framework	\$380
728	Partial mandibular denture, cast alloy framework	\$380
733	Each additional tooth	\$25
736	Immed. tooth replacement, per tooth, additional to 711, 712, 719, 721, 727	\$20
737	Resilient lining in addition to new denture (in addition to 711, 712, 719, 721, 727)	\$199
Denture Maintenance		
741	Adjustment of complete denture (not associated with new denture)	\$51
742	Adjustment of partial denture (not associated with new denture)	\$51
743	Relining - complete denture - processed	\$278
744	Relining - partial denture - processed	\$196
749	Resilient lining (not associated with new denture)	\$349
Denture Repairs		
761	Re-attach undamaged clasp on denture	\$66
762	Replacing lost or broken clasp on denture	\$119
763	Repairing broken base of a complete denture	\$107
764	Repairing broken base of a partial denture	\$116
765	Replacing tooth on complete denture	\$107
766	Replacing tooth on partial denture	\$90
767	Tooth replacement in addition to other repairs	\$53
768	Adding tooth to partial denture to replace lost tooth (involving clasp, abutment tooth)	\$117
769	Repair to metal casting	\$83
771	Tissue conditioning preparatory to impressions (maxillary or mandibular)	\$53
776	Impressions where required for denture repair	\$32
ORTHODONTIC SERVICES (not to exceed)		\$3352
ADJUNCTIVE GENERAL SERVICES		
911	Palliative emergency treatment	\$51
912	Sedative dressing for emergency	\$51
924	Drug prescription	\$10
943	Sedation - inhalation (N2O)	\$76
949	Loading for removal under general anaesthesia (including routine postoperative care) in addition to 311 and 316	\$76
986	Post-operative care where not otherwise included	\$51

FEES FOR SERVICES NOT SPECIFICALLY IDENTIFIED		
To be charged at:		
1	\$51 per 15 minutes for routine non-specialised and operative procedures	\$51
2	\$63 per 15 minutes for specialised procedures e.g., surgery, C and B etc)	\$63

✚ The complete description of ADA Item Numbers is available in The Australian Schedule of Dental Services and Glossary. ADA Inc.

❖ **TABLE 6 MEDICAL EVACUATION**

INELIGIBLE /COMPENSABLE PATYIENTS	Fee
Medical Evacuation (Doctor & Nurse)	\$10.96 per nm
Medical Evacuation (Nurse)	\$10.37 per nm
Repatriation and Follow up Visits	\$6.40 per nm
Repatriation and Follow up Visits (Nurse)	\$10.23 per nm

* nm = Nautical Mile

- The rate above shall be used in all cases when calculating the total amount of costs to be recovered for a medical evacuation of an ineligible/ compensable patient.
- The costs of repatriating a patient to their home base and any subsequent return visits to hospital for follow up care and return shall be recovered by regions:
 - If DHF provides the transport; or
 - Pays the fare if commercial transport is used.

NB. If DHF aero-medical services are used to repatriate a compensable/ ineligible patient the charge shall be the basic aircraft cost of \$6.40 or \$10.23 per nautical mile.

If other commercial transport is used to repatriate a compensable/ ineligible patient, and DHF pays for the transport, the charge will be the cost of the air and / or bus fare, whichever is appropriate.

❖ **TABLE 7 RENAL DIALYSIS**

The Reciprocal Health Care Agreement (RHCA) between Australia and Sweden, Finland, Italy, Malta and the Republic of Ireland excludes renal dialysis services.

However, the RHCS has an informal arrangement where renal dialysis services for visitors from the United Kingdom. New Zealand and the Netherlands can be accessed free of charge.

The following charges apply for overseas visitors requiring renal dialysis services.

Overseas Visitor	Fee
Renal Dialysis Services	\$ 633 per service

❖ **TABLE 8 FEES FOR MEDICAL REPORTS, COPIES OF MEDICAL RECORDS AND COPIES OF XRAYs**

PROCEDURES

1. Introduction

These Procedures set out the circumstances in which charges should or should not be raised in relation to the provision of medical information to patients and third parties. The fees, as set out in the attached Schedule of Fees, apply to medical information contained in Northern Territory public hospitals.

In setting the fees for supplying access to medical information, the procedures take account of the person making the request and the purpose for the request.

Generally there is no fee or only a nominal fee where the request is made:

- Personally by the patient to whom the information relates; (**‘the patient’** includes the patient’s nominated next of kin, where that person has been authorised in writing by the patient to access the patient’s medical information, or the patient’s legal guardian, but is confined to a person acting to a private or personal, rather than professional capacity.)
- By health professionals in connection with providing continuing care to the patient; and
- By a government organisation in relation to the carrying out of its statutory, regulatory or investigative functions. Examples of requests from government organisations falling within this category include a request from a professional registration board for a medical report or a copy of medical records relevant to the investigation of a complaint, or a request from Family and Children’s Services in connection with an investigation of suspected child abuse.

Where requests are made by another third party, not included within the above categories, the fees for the supply of medical information are based on full-cost recovery. This category refers requests from a person or an organisation such as a solicitor, insurer or employer where the request is for purposes not to do with the patient’s continued treatment or future management, but for legal or employment-related purposes. The only exception where fees do not apply is where the request is from Territory Insurance Office (TIO) and relates to a Department of Health and Families (DHF) employee’s worker’s compensation claim.

Applicants should be asked to put all requests in writing and to provide as much information as possible.

Where a request is received from a third party, written evidence of consent by the patient must be provided before access to the patient’s medical information is given. The form

‘Authority to Supply Medical Information’ – HR 98 should be used, where practicable. Alternatively, a letter using similar wording to that contained in the form and signed by the patient is sufficient evidence of consent.

The procedures for safeguarding the privacy of Medical Records are set out in the Department’s Information Privacy – Code of Conduct (October 1997). As a matter of policy, the DHF recognises the right of a patient to know what information is held about him or her, to access this information and to seek correction of inaccurate information, subject to the provisions in the Code of Conduct. (NB: On commencement of the *Information Act 2002*, patients will have a legal right to access and seek correction of information subject to the exemptions provided in the *Act*.)

2. Procedures relating to requests for information by an insurer or a solicitor in relation to insurance claims for work-related or motor vehicle accident injuries.

Fees for a Medical Report requested by an insurer or solicitor are inclusive of the fee to search for the medical record. Where a request is for a photocopy of information in a medical record, fees include a Search Fee plus charges for photocopying. Where a single request is made for a Medical Report and photocopy of information in a medical record, there is no additional charge for the Search Fee.

The DHF may supply a Medical Report if provided with a declaration signed by the claimant on the insurer’s claim form in respect of Compulsory Third Party insurance or Workers Compensation Insurance. The insurer or solicitor should clearly set out the nature of the claim.

The ‘declaration’ is evidence of the claimant’s consent to the release of information to the insurer or solicitor acting for the insurer. The claimant’s consent should be readily ascertainable from the wording of the declaration. A photocopy of the signed declaration is acceptable regardless of the period that may have elapsed since its signature, providing there is evidence, such as a statement by the insurer, that the claim is ongoing and the information sought relates to the claim. In this regard, any Medical Report provided should only contain information relevant to the claim.

Where photocopies of Medical Records are requested by the insurer or solicitor in addition to a Medical Report, the insurer or solicitor must provide further written consent from the patient stating that the patient:

- Agrees to allow the insurer or solicitor to have a photocopy of all or part of the Medical Record; and
- Is aware that the photocopy may include confidential medical information, which is not relevant to the claim.

In the absence of written consent hospitals should not provide information to insurers or solicitors.

3. Goods and Services Tax (GST)

Where the request for medical information relates to a GST-free hospital treatment and is provided to the patient, all applicable fees will be GST free, irrespective of when it is provided.

However, if this request for medical information relates to a GST-free hospital treatment and is provided to third part (eg. An insurance company or a solicitor) the fees relating to the production/supply of the medical information will be subject to GST.

4. Circumstances under which charges should be raised.

- 4.1 When Medical Reports or copies of Medical Records are requested by solicitors, insurers and other third parties, for legal or employment purposes. NB: This excludes requests from TIO in relation to claims by the DHF staff-member's workers compensation assessment in relation to a claim. (See Charge No A, B and E as applicable);
- 4.2 When searching for the Medical Record, irrespective of whether the Medical Record is found. If however, the Client Master Index (CMI) shows that the patient was treated in that health service but the Medical Record cannot be found because it has been destroyed, misplaced or lost, the fees should be refunded in full. (See Charge No C);
- 4.3 When copies of a patient's Medical Record is requested by the patient. (See Charge No D);
- 4.4 When copies of radiographic films are requested by and provided directly to the patient. (See Charge No F);
- 4.5 When copies of radiographic films are requested by an insurer, solicitor or other third party, subject to written consent being given by the patient. (See Charge No G);
- 4.6 When interstate health authorities or other employers request information in respect to the eligibility of candidates for appointment. (See applicable Charge. Eg. Charge A)
- 4.7 When Medical Reports or copies of Medical Records are requested by solicitors acting on behalf of a victim of Crimes Assistance. (See applicable Charge. Eg. Charge A or B).
- 4.8 When medical photographs or images to CD are requested by and provided directly to the patient. (See applicable Charge H, I or J).

5. Circumstances under which a charge should not be raised

- 5.1 When Medical Reports are requested by TIO for inclusion in a DHF staff-member's workers compensation assessment in relation to a claim;
- 5.2 When the patient requests a copy of the discharge summary and this is provided directly to the patient;
- 5.3 When requests are made for copies of a patient's discharge summary, operation findings and other relevant letters between health professionals, by a health professional concerned only with the patient's continued treatment or care, eg the patient's General Practitioner;
- 5.4 When supervising solicitors, acting for patients or other parties in court proceedings, representatives of insurers or other third parties, during the inspection of Medical Records;
- 5.5 When requests are made by a body responsible for regulating the activities of health professionals, eg a professional registration board investigating the conduct of a professional or a Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing;

- 5.6 When Family and Community Services (FACS) or the Police request records required in the conduct of investigating claims into suspected maltreatment of children;
- 5.7 When requests are made by Community Corrections for reports in relation to matters to do with sentencing, parole and supervision of court orders;
- 5.8 When completing Medical Certificates and Centrelink forms at the time of consultation;
- 5.9 When the patient requests information on own date/time of birth; and
- 5.10 When a single request from a third party is made for a Medical Report and photocopied information from a medical record, no Search Fee is applied, as it is included in the Medical Report Charge.

FEE SCHEDULE

See Attachment C.