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SPECIAL SUPPLEMENT

Workers Compensation (Public Hospital Rates) Order 2006

under the

Workers Compensation Act 1987

I, JON BLACKWELL, Chief Executive Officer of the WorkCover Authority of New South Wales, pursuant to section 62 (1) of the *Workers Compensation Act 1987*, and with the concurrence of the Minister for Health under section 62(8), make the following Order.

Dated this 26th day of September 2006

JON BLACKWELL
Chief Executive Officer
WorkCover Authority

1. Name of Order

This Order is the *Workers Compensation (Public Hospital Rates) Order 2006*.

2. Commencement

This Order commences on the date of its publication in the Gazette.

3. Application of Order

(1) This Order applies to the hospital treatment of a worker at a public hospital, being treatment of a type referred to in clauses 5 to 9 and provided on or after the date of commencement of this Order, whether the treatment relates to an injury that is received before, on or after that date.

(2) Any previous Order of WorkCover in force under section 62 of the Act continues to apply except to the extent that it is inconsistent with this Order.

(3) Any order of the Director-General of the Department of Health made pursuant to clause 18 of the *Workers Compensation (General) Regulation 1995* has effect as if it were an order relating to the classification of hospitals made for the purposes of clause 5 of this Order, subject to any amendment of it made by any subsequent order of the Director-General of the Department of Health.

(4) Any order of the Director-General of the Department of Health relating to the classification of hospitals made for the purposes of clause 5 of this Order or any previous Order under section 62 of the Act has effect, subject to any amendment of it made by any subsequent order of the Director-General of the Department of Health.

(5) Any order relating to the classification of hospitals made for the purposes of clause 5 of this Order may provide that a hospital is not a public hospital of a particular type in respect of treatment provided to a specified class of patient.

4. Definitions

(1) In this Order:

classification refers to a classification of hospital, category of patient or otherwise (or any combination of them), appearing in Column 1 of the Tables to clauses 5 to 8 of this Order.

the Act means the *Workers Compensation Act 1987*.

WorkCover means the WorkCover Authority of New South Wales.

(2) A reference to treatment or services in this Order is (consistent with the definition of "hospital treatment" in section 59 of the Act) a reference to treatment or services provided at a public hospital or at any rehabilitation centre conducted by such a hospital.

5. Fees for hospital patient services generally

(1) The amount for which an employer is liable under the Act for hospital treatment of a worker, being treatment provided to a worker within a classification specified in Column 1 of the Table to this clause is:
(a) in the case of inpatient services, for each day (or part of a day) that the worker is a patient of the hospital, or
(b) in the case of outpatient services, for each occasion of service,
the corresponding amount specified in Column 2 of that Table.

(2) This clause does not apply to hospital treatment of a type referred to in clauses 6 to 8 of this Order.

(3) In this clause and the Table to this clause:

critical care, in relation to a patient, has the same meaning as it has in the "NSW Department of Health – DOHRS" issued by the Department of Health in June 2000 or in any subsequent revision of that document issued by that Department.

metropolitan (non-referral) hospital means a public hospital classified as a metropolitan (non-referral) hospital in an order published in the Gazette by the Director-General of the Department of Health.

metropolitan (referral) hospital means a public hospital classified as a metropolitan (referral) hospital in an order published in the Gazette by the Director-General of the Department of Health.

non-metropolitan hospital means a public hospital classified as a non-metropolitan hospital in an order published in the Gazette by the Director-General of the Department of Health.

other public hospital means a public hospital other than a metropolitan (non-referral) hospital, a metropolitan (referral) hospital, a non-metropolitan hospital or a psychiatric hospital.

outpatient means a patient who does not undergo a formal admission process.

psychiatric hospital means a public hospital classified as a psychiatric hospital in an order published in the Gazette by the Director-General of the Department of Health.

public hospital means a public hospital within the meaning of section 59 of the Act.

Table Fees for hospital patient services generally

Column 1 Hospital classification	Column 2 Amount ($)
(1) Metropolitan (referral) hospital:	
(a) Critical care	2070 per day
(b) Other	835 per day
(c) Outpatient occasion of service (excluding physiotherapy)	95
(2) Metropolitan (non-referral) hospital:	
(a) Critical care	1,205 per day
(b) Other	625 per day
(c) Outpatient occasion of service (excluding physiotherapy)	75
(3) Non-metropolitan hospital:	
(a) Critical care	955 per day
(b) Other	580 per day
(c) Outpatient occasion of service (excluding physiotherapy)	60
(4) Psychiatric hospital:	
(a) Inpatient	350 per day
(b) Outpatient occasion of service (excluding physiotherapy)	60
(5) Other public hospital:	
(a) Inpatient	195 per day
(b) Outpatient occasion of service (excluding physiotherapy)	60

6. Fees for brain injury rehabilitation services

(1) The amount for which an employer is liable under the Act for hospital treatment of a worker, being brain injury rehabilitation services within a classification specified in Column 1 of the Table to this clause, is the corresponding amount specified in Column 2 of that Table.

(2) This clause does not apply to hospital treatment of a type referred to in clause 5, 7 or 8 of this Order.

(3) In this clause and the Table to this clause:

Category A patient means a patient being assessed for or receiving active rehabilitation.

Category B patient means a patient receiving personal and nursing support who is resident in a brain injury program unit.

Category X patient means a patient needing an extremely high level of support.

metropolitan (non-referral) hospital means a public hospital classified as a metropolitan (non-referral) hospital in an order published in the Gazette by the Director-General of the Department of Health.

outpatient means a patient who does not undergo a formal admission process.

Table Fees for brain injury rehabilitation services

Column 1 Item/Hospital classification	Column 2 Amount ($)
(1) Admitted patient services:	
(a) Category A patient	875 per day
(b) Category B patient	560 per day
(c) Category X patient	1,245 per day
(2) Metropolitan (non-referral) hospital:	
(a) Category A patient	625 per day
(b) Category B patient	310 per day
(3) Non-admitted patient services	60 per half hour
(4) Outpatient medical clinic appointments	
(a) Medical consultation – initial assessment	205
(b) Medical consultation – follow-up assessment	105
(5) Group activities	
(a) directly supervised by qualified allied health clinician	40 per half hour
(b) not directly supervised by qualified allied health clinician	25 per half hour

7. Fees for spinal injury rehabilitation services

(1) The amount for which an employer is liable under the Act for hospital treatment of a worker, being spinal injury rehabilitation services within a classification specified in Column 1 of the Table to this clause, is the corresponding amount specified in Column 2 of that Table.

(2) This clause does not apply to hospital treatment of a type referred to in clauses 5, 6 or 8 of this Order.

Table Fees for spinal injury rehabilitation services

[Note: Fees for spinal injury rehabilitation services set out in the Table below are now payable at the *Metropolitan Non-Referral – Other* rate.]

Column 1 Item/Hospital classification	Column 2 Amount ($)
(1) Admitted patients (Northern Area Health Service, Royal Rehabilitation Centre of Sydney)	625 per day
(2) Outpatient services	
(a) Conference	75 per half hour per therapist
(b) Therapy	75 per half hour per therapist

8. Fee amount payable for physiotherapy outpatient services

(1) The amount for which an employer is liable under the Act for hospital treatment of a worker, being physiotherapy services provided to the worker as an outpatient and within a classification specified in Column 1 of the Table to this clause is the corresponding amount specified in Column 2 of that Table.

(2) This clause does not apply to hospital treatment of a type referred to in clauses 5, 6 or 7 of this Order.

(3) The *Workers Compensation (Physiotherapy Fees) Order 2006* contains requirements relating to physiotherapy management plans where more than eight occasions of service are required.

(4) In this clause and the Table to this clause:

complex treatment means treatment related to complex pathology and clinical presentation including, but not limited to, extensive burns, complicated hand injuries involving multiple joints and tissues and some complex neurological conditions.

group/class service means a common service delivered by a physiotherapist to more than one person at the same time. Examples are aquatic physiotherapy classes and exercise groups.

initial consultation and treatment means the first session provided by the physiotherapist in respect of an injury, and may include:

- history taking;
- physical assessment;
- diagnostic formulation;
- goal setting and planning treatment;
- treatment/service;
- clinical recording; and
- communication with referrer.

standard consultation and treatment means treatment sessions provided subsequently to the initial session, and may include:

- re-assessment;
- treatment/service; and
- clinical recording.

two distinct areas means two areas affected by entirely separate compensable injuries or conditions, which are assessed and treated separately. Where areas are distinct, treatment provided for one condition does not affect the symptoms of the other condition. Areas are not distinct where a condition causes referred symptoms to another area.

Table Physiotherapy outpatient services

Column 1 Item/type of service		Column 2 Amount ($)
(1)	Initial consultation and treatment	65
(2)	Standard consultation and treatment	55
(3)	Initial consultation and treatment of two distinct areas	98
(4)	Standard consultation and treatment of two distinct areas	83
(5)	Complex treatment	110
(6)	Group/class service	39 per participant
(7)	Other aspects of treatment not covered by items (1) to (6), for instance case conferencing and employer consultations	130 per hour

9. Charges for health records and medical reports

(1) In relation to Categories A, B and C below the amount for which an employer is liable under the Act for charges for health records and medical reports within a Description specified in a Table to this clause is the corresponding amount specified in either Column A or Column B of that Table.

(2) In relation to Categories A, B and C below the rates shown in Column A represent the GST-free amount while rates shown in Column B are GST-inclusive. Subclause 9(5) provides the basis for determining whether the charge is GST-free or GST-inclusive (ie, a taxable supply).

(3) In relation to Category D below the amount for which an employer is liable under the Act for charges for health records and medical reports within a Description specified in Column 1 of the Table to Category D, is the corresponding amount specified in Column 2 of that Table.

(4) The following are charges for health records and medical reports and are to apply except where rates are otherwise provided under specific legislation.

(5) Goods and Services Tax (GST) in relation to Categories A, B & C (below)

In relation to Categories A, B & C below the fees/charges set that are taxable supplies or that Health Services are to consider for GST implications are as follows:

- Where revenue derived from the preparation of Medical Reports is in the context of the Medical Officers Rights of Private Practice the service is to be regarded as a taxable supply.

- Where the income derived is treated as public hospital revenue, consideration is to be given as to whether it satisfies GST-free status under section 38-250 of the ‘A New Tax System (Goods and Services Tax) Act 1999’ (GST Act).

  ie. Supplies are GST-free if:

  – the charge is less than 50% of the GST inclusive market value of the supply; or
  – the charge is less than 75% of the cost to the supplier of providing the supply.

- NB. Further details are contained in section 3.3 (pages 22 to 24) of the “NSW Health – Finance and Commercial Services – Tax Reform – GST Manual” which is available on the NSW Health Intranet.

- All health services need to ensure that documentation/systems exist to compare the costs (including overheads) of providing health records and medical reports, and being able to assess the GST status as detailed above.

- Where the Service is determined as being **GST-free** the rates at **Column A** (below) apply.

or

- Where the GST free test is not satisfied the service is therefore a taxable supply and the **GST inclusive** rates at **Column B** (below) apply.

Category A – Charges for medical reports

Table Charges for medical reports

Description		**Column A**	**Column B**
(1)	Preparation of a medical report by a medical practitioner appointed to or employed by the health institution/hospital **requiring no further examination of the patient.** This applies to the treating medical practitioner or a medical practitioner who has not previously treated the patient.	$220	$241
(2)	A report made by a **treating** medical practitioner appointed to or employed by the health institution/hospital **where a re-examination of the patient is required.** The fee includes the cost of examination.	$314	$345
(3)	A report made by a medical practitioner appointed to or employed by the health institution/hospital **who has not previously treated the patient where an examination is required.** The fee includes the cost of examination.	$566	$622

Category B - Other charges

1 Preparation of a report by a treating health professional, other than a medical practitioner, appointed to or employed by the health institution/hospital requiring no further examination of, or history from the patient

Table Charges for report by treating health professional

Description	Column A	Column B
Preparation of a report by a **treating health professional, other than a medical practitioner,** appointed to or employed by the health institution/hospital requiring no further examination of, or history from the patient.	$220	$241

2(a) Charges for clinical notes requested by an individual; and charges for clinical notes requested by a patient's solicitor, or properly authorised representative, subject to written consent being given by the patient

Copies of clinical notes supplied in response to a request may typically include, as a minimum: patient registration/front sheet, consent to treatment, discharge summary, referral/transfer letters, ambulance report, continuation notes, operation reports (including anaesthetists and nursing reports), radiology and pathology reports, and nursing care plan. Where additional information is held by a hospital but not routinely released, the person making the request should be made aware that such additional information exists but has not been supplied. A further request for such additional information should be considered as forming part of the original request and no additional charge (other than photocopying, where appropriate) should be raised. The onus is upon the person requesting the information to identify the information they seek.

2(b) Charges for information requested by an insurer

Health facilities should not provide clinical notes or photocopies of notes to the insurer, but may supply a "Medical Report" or "Summary of Injuries" (Category A or C) if provided with a Statutory Declaration signed by the claimant on the insurer's claim form in respect of Compulsory Third Party (CTP) insurance or a declaration signed by the claimant on the insurer's claim form in respect of Workers Compensation Insurance. Such reports should only provide information **relevant to the claim.** This will necessitate the insurer detailing the nature of the claim. Health facilities will be required to exercise their judgement in determining what is relevant information. A photocopy of the CTP Statutory Declaration is acceptable irrespective of the date of signing.

If clinical notes, or part of the clinical notes, are requested by an insurer, the insurer should be requested to provide written consent from the patient stating that the patient:

- agrees to allow the insurer to have a copy of all or part of the clinical notes and

- the patient is aware that clinical notes, or part of the clinical notes, will inevitably include confidential medical information which is irrelevant to the claim.

In the absence of clearly documented written consent, as detailed above, hospitals are not required to provide clinical notes to insurers.

2(c) Client/patient access

As a matter of policy, individuals are guaranteed a right of access to information about their health by public health organisations. They also have a right to access their records under the Freedom of Information Act, as well as under the Privacy and Personal Information Protection Act.

Where a patient wishes to access her/his records under the Freedom of information Act, the requirements of that Act (including charges) apply.

Table Charges in respect of paragraphs 2(a), 2(b) and 2(c) above

The charge applicable in respect of paragraphs 2(a), 2(b) and 2(c) (except requests under FOI), which includes search fee, photocopying charges, labour costs, administrative charges and postage, is as follows:

Description	Column A	Column B
Provision of a copy of the medical record, or part thereof, eg continuation notes, pathology reports, charts. **Maximum eighty pages**	$30	$32
Pages in excess of eighty (per page)	$0.25	$0.27

3 Search fees

Table Charges for search fees

Description	Column A	Column B
Search fees - other than requests made by a party concerned with a patient's continued treatment or future management.	$30	$32

The search fee should be charged:

- for searching for the medical record, irrespective of whether the medical record is found. If however, the Patient Master Index (PMI) or other indexes showed that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the fees should be refunded in full;

- where the applicant subsequently advises that a report/record is no longer required, or

- where a thorough search has ascertained that the patient has never attended that health institution for that particular episode of illness;

- for information on date or time of birth;

- for Motor Accident and WorkCover medical certificates completed at other than time of consultation;

- **NOTE** - The search fee is a component of the fees charged for the preparation of reports, summaries or the production of health records required by subpoena, ie additional fees should **not** be charged on top of those for the preparation of reports, summaries and the production of health records required by subpoena.

The fee covers processing time which includes time for locating the information, decision-making and consultation where necessary.

Category C – Summary of injuries

Table Charges for preparation of "Summary of injuries"

Description	Column A	Column B
Preparation and/or provision of "Summary of injuries"	$30	$32

A "Summary of Injuries" is generally requested by Compulsory Third Party Insurers for patients whose fees are covered by the Bulk Billing Agreement.

The "Summary of Injuries" should include:

- Identifying information (name, date of birth, medical record number)
- Date of first attendance,
- Whether patient was admitted. If so, specify dates,
- Positive findings on examination,

- Level of consciousness, if documented,
- Diagnosis, if known.

A standard form letter may be appropriate.

If a discharge summary, or appropriate correspondence that provides this minimum information, is available at the time of the request, a copy of this may be sufficient. Should further information be required, the appropriate report charge as specified in Sections A or B should be raised. There is no requirement to provide the full clinical notes to third party insurers.

The purpose of the "Summary of Injuries" in relation to the bulk-billing agreement is to establish that the admission occurred as a result of a motor vehicle accident. If the information contained in the "Summary of Injuries" is insufficient or unavailable and a medical practitioner (or other treating health professional, where appropriate) is required to prepare a report, charges for a medical report (or report by a treating health professional) should be raised.

Health Information Managers should consult with the requesting solicitor/insurer/ other party to determine which is required before a fee is raised or report is prepared.

Category D - Health records required to be produced by subpoena

This Table refers to the retrieval of all the information required by the schedule noted on the subpoena and forwarding it to Court.

Table Charges for health records required to be produced by subpoena

Column 1 Description		Column 2
(1)	Where at least 5 working days notice is given for the production of the record to Court * plus a photocopying charge of $0.25 per page	$50*
(2)	Where less than 5 working days notice is given * plus a photocopying charge of $0.25 per page	$75*

Multiple requests on a subpoena should be charged on a fee-per-patient basis.

- In a situation where no record is found, it is appropriate to raise a Search Fee for each record, particularly in situations where incorrect details are given or "blanket" subpoenas are issued and considerable time is spent in locating the

record. However, if the PMI or other indexes shows that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the search fee should not be charged.

- Charges under this category are not subject to GST as they are **'out of scope'** under a Division 81 Determination.

Category E - Administrative procedures

1. Policies and procedures regarding access to health records and disclosure of personal information should be made in accordance with the NSW Health Privacy Management Plan and the Information Privacy Code of Practice.

2. Applicants should be asked to put all requests in writing and to provide as much information as possible. A patient's solicitor should include consent by the patient for access to personal records as detailed in the Information Privacy Code of Practice.

3. Where the original of a health institution's health record leaves the institution (eg health records being tendered to a Court under subpoena), a copy of those records should generally be made beforehand and kept in the institution.

   Charges for photocopying should be charged at 25 cents per page (27 cents per page – GST inclusive). This charge does not apply to Coroner's or Complaints Unit cases.

4. Charges should be collected in advance, where appropriate. For government departments, reimbursement may be sought subsequently from the relevant department or authority. Even where health records are required to be produced by subpoena, payment should still be sought in advance. It is emphasised that a hospital or organisation is expected to comply in due time with the requirements of a subpoena. Non-compliance may result in contempt of Court, which is punishable by fine or in certain cases imprisonment.

5. It may be decided that an examination of the patient (by either the treating medical practitioner or a medical practitioner who has not previously treated the patient) is required.

6. Under such circumstances, the applicant should be asked to pay the balance of the money for the higher fee before proceeding with the request.

7. Fees collected are to be recorded as revenue in the General Fund.

8. Where there are disputes regarding fees or the amount of information, attempts should be made to resolve the matter between the parties involved. This would normally involve the Chief Health Information Manager and/or the General/Medical administration of the health facility.

Category F - Circumstances under which a charge should not be raised

1. When the request has been made by a party concerned only with the patient's continued treatment and/or future management, no charge should be raised (eg where a medical practitioner requests information from a health institution to assist him/her with that patient's treatment);

2. The Government Insurance Office (GIO) as Fund Manager, or solicitors acting for the GIO in such matters, in respect of claims for workers compensation for employees of 2nd, 3rd, 4th and 5th Schedule hospitals, the NSW Ambulance Service and the NSW Department of Health. Health facilities should ensure that solicitors acting for the GIO specify in writing that this is the case;

3. Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing;

4. The Department of Community Services or the Police in respect of children suspected of being abused, or of a parent of a child so suspected;

5. The completion of medical **certificates** at the time of consultation - no charge should be made as the forms for motor accident and WorkCover **certificates** are in the nature of a certificate and not a report. If not completed at the time of consultation, a search fee may be raised.

Category G - Circumstances under which charges should be raised

All cases where the conditions in Category F have not been met including:

1. When medical reports/records are requested by individuals, solicitors, insurance companies, and government departments (with the exception of those indicated in Category F) for purposes other than the patient's continued treatment or future management.

2. The Department of Veterans' Affairs and the Department of Social Security for the purpose of pension/benefits assessment;

3. Interstate Health Authorities in respect of the eligibility of candidates for appointment to the relevant Public Service.

4. NSW Compulsory Third Party Insurers, in respect of a "Summary of Injuries". (Refer to Category C).

5. Discharge summaries requested by health professionals not involved in the care or management of the patient (past, present or future). This includes health professionals employed by insurers.

6. Release of information under the NSW Adoption Information Act, 1990. Charges should be raised in accordance with Circular 91/120 or any circular subsequently amending its provisions.

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