

South Australian Rural Medical Fee
Agreement (SARMFA)

DRAFT

Dated: July 2009

This document is to be read in conjunction with the "South Australian Rural Medical Engagement Responsibilities" and the "CHSA General Practitioner Fee for Service Agreement"

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Rural medical practitioners are engaged as independent contractors to provide patient services for CHSA and its health services. The following payments are made under this agreement.

1. Schedule of Fees

The Schedule of fees payable to eligible medical practitioners is known as South Australian Medical Schedule of Fees (SAMSOF) and forms Schedule X to this document.

Fees payable shall be updated on the 1st November as per CMBS updates and 1st July of each year to reflect movement in the CMBS.

New item numbers may be required for any new services introduced in the CMBS.

Schedule 1 is also available from the Country Health SA (CHSA) website at <http://www.countryhealthsa.sa.gov.au/Default.aspx?tabid=34>

Comment [SLR1]: CHSA's capacity to review and implement changes from this date is not attainable, hence the proposal to implement as from 1st January each year.

2. Eligibility

To be eligible for these payments the GP/GP Proceduralist must:
(i) be credentialed and have current scope of practice at a CHSA health unit, and

(ii) provide the majority of their clinical practice (ie 80% or more) in the geographical boundary of CHSA region at either a CHSA Health Unit or their private practice.

Determination of eligibility in exceptional circumstances will be referred to the Chief Medical Advisor, CHSA, for consideration.

3. Payments

3.1 Fee For Service and Billing

3.1.1 The hospital shall remunerate the medical practitioner in accordance with the terms of SAMSOF and the Rural Health Enhancement Package (RHEP) where applicable

3.1.2 The payment of invoices shall be made via Electronic Funds Transfer (EFT) in most instances, and within 1 month of receiving the appropriate documentation

- 3.1.3 The medical provisioner shall submit all Fee for Service (FFS) claims on a monthly basis but certainly within six months of the date of service provision
- 3.1.4 The medical practitioner shall advise the health unit of the medical practitioner's Australian Business Number (ABN) and quote the ABN on all claims for payment
- 3.1.5 Where the medical practitioner provides medical services as an individual, the medical practitioner's individual ABN must be quoted. Alternatively if the medical services are provided by a partnership, trust or company the ABN of the partnership, trust or company must be quoted
- 3.1.6 The medical practitioner shall immediately advise the health unit of any changes to the ABN details
- 3.1.7 Based on current advice from the Australian Taxation Office, the supply of medical services, in accordance with this agreement, by the medical practitioner to the health unit is a taxable supply. If the medical practitioner is registered for the Goods and Services Tax (GST), and
- if the health unit calculates the amount payable for services rendered by the medical practitioner, the medical practitioner shall enter into a Recipient Created Tax Invoice (RCTI) Agreement with the health unit on an annual basis, or
 - if the medical practitioner calculates the amount payable by the health unit, the medical practitioner shall provide the health unit with a valid tax invoice requesting payment. Should the medical practitioner cease to be registered for GST purposes, or become aware of any reason why the GST registration may be cancelled, the medical practitioner shall advise the health unit.
- 3.1.8 If the contract of a medical practitioner is terminated, the health unit shall thereupon pay all fees to which the medical practitioner is then entitled to within one calendar month of
- receipt of a valid tax invoice detailing the medical services rendered, where the medical practitioner calculates the amount payable; or
 - the health unit generating a Recipient Created Tax Invoice (RCTI) where the health unit calculates the amount payable
- 3.1.9 If the Australian Taxation Office changes its advice on the tax treatment of medical services provided under these arrangements, this document will be amended accordingly.

3.1.10 Where the paying entity is required by virtue of the Superannuation Guarantee Administration Act (SGAA) to provide a minimum level of superannuation support on behalf of the medical practitioner into a complying superannuation fund, then the Fee for Service amounts due under this agreement are deemed to be inclusive of the minimum superannuation support calculated in accordance with Australian Taxation Office advice. The Fee for Service payment paid to the medical practitioner is to be net of the minimum superannuation support. The minimum superannuation support will be paid into the medical practitioner's nominated complying Superannuation Fund in accordance of the requirements of the SGAA.

Superannuation contributions made under an effective salary sacrifice agreement, as defined in the Australian Taxation Office ruling SGD2006/2, are not assessable income to the deemed employee. Thus doctors will not be subject to income tax on their sacrificed payments. Information regarding salary sacrifice agreements is available from the health unit.

3.1.11 FFS accounts should contain the following information to enable health service staff to accurately check against the patient/client medical record.

3.1.12 Accounts can only be paid if the relevant documentation exists in the patient/client medical record.

Accounts should be itemised per patient and contain:

- the patient/client name (not their nickname or abbreviated version)
- patient/client status (i.e. Public, Veteran)
- their Medicare or DVA number
- service item number (from Schedule 1)
- date of service
- time the service started (all consults) and finished (for consult levels C and D in accordance with CMBS requirements)
- the medical practitioner's name and provider number
- the relevant cost for the service and
- the GST amount clearly identified

For 'on-call' charges the amount can be charged as a lump sum or daily but must be accompanied by a breakdown of the charges including a roster showing the date of attendance, the number of days at each charge and if one day is shared by two or more medical practitioners the percentage of payment for each medical practitioner.

Because of the inpatient/outpatient interface and the normal/after hours interface the duration of a service is important as the medical practitioner may be entitled to after-hours fees in instances where they are claiming only normal hours.

Comment [SLR2]: The intent of this statement being that it is important that times be provided where there is a potential impact on FFS payments to inpatient and or after hours status. I believe this statement was contained in the former SARMES document.

Deleted: Not sure what this is getting at??

It is preferable for RHEP and DVA acquittal reporting purposes that one account for a complete month is submitted within 14 days of the end of that month to be fully remitted in that month.

3.2 **Hospital Patients**

With respect to any patient who elects to be a public inpatient, the medical practitioner shall not raise an account with the patient.

3.3 **Private Patients**

With respect to any patient who elects to be a private inpatient, the medical practitioner shall charge at the rate judged by the practitioner to be appropriate to the service, subject to informing the patient of the intended fee.

There is a standard Patient Election form. The Patient Election form allows the patient to be treated as a private or public patient.

The Health Unit will provide a list daily of patients and their status (ie private, DVA, public) relevant to the medical practitioner to the practice accounting personnel.

3.4 **Outpatient/Inpatient Interface**

In South Australian country hospitals, (with the exception of Mount Gambier, and, "After-Hours" at Port Augusta, Port Pirie, and Whyalla health units) outpatient and emergency services are provided under the Medicare system (ie the patient is charged by the medical practitioner and seeks reimbursement from Medicare).

When a patient is seen in the health unit emergency area and then admitted for treatment as a public inpatient the hospital will be billed for the full attendance and services.

Medical practitioners should also be advised, when requested, they have an obligation to attend the hospital/health service for serious emergency presentations.

This obligation also exists whether or not the presentation is in their area of expertise. This would include attendance at triage 1, 2, and many triage 3 patients who present to the hospital/health service, and include patients who present with surgical, medical, obstetric, and mental health concerns.

3.4.1 **Emergency Responder Network**

An Emergency Responder Network has been established across CHSA to provide appropriate cover to medical practitioners who are

prepared to attend out of hospital emergencies close to their geographic base.

Membership of the Network is voluntary for medical practitioners and requires that once registered for the Network they make themselves available to attend emergency situations when called by the South Australian Ambulance Service.

Subject to the Medical Practitioner admitting any patients seen to the local health service, the Network offers a clearly defined structure which ensures appropriate remuneration and professional support in these out of hospital situations. The Medical Practitioner can invoice the local health service for such attendances from the period of time from when they were called until the time when they return to the local health unit using SAMSOF item numbers 160-164.

3.4.2 Multi-Purpose Services

Across CHSA there are a number of smaller Health Units that have become or will become a Multi-Purpose Services (MPS). The impact of this change for Medical Practitioners is that newly admitted Aged Care residents after a certain date, which varies between MPS's, to a commonwealth funded MPS bed will in effect be private patients in terms of payment for medical services. Therefore payment through ~~Fee for Service~~ will not be available for the routine medical care of these individual's as is the case in other commonwealth residential aged care facilities.

Existing 'Nursing Home residents' as at the time of conversion of the Health Service to MPS status, and where on-going medical care was previously provided through Fee for Service payments, will continue to receive access to Fee for Service payments for medical care following the change of status of the health service to an MPS.

It is essential that Medical Practitioners clarify the applicable situation for individual patients at the time of change of status of the local health service to an MPS. Each MPS will maintain a list of grandfathered patients present at the time of the MPS becoming operational.

Comment [SLR3]: Have removed the suggested insertion of Hospital prior to the Fee for Service due to the fact that this document, except for a few allowances, only uses FFS as the basis of payment.

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3.5 Health Unit to Health Unit Transfer

All acute patients requiring observation and/or stabilisation to be transferred from one health unit to another by ambulance should be admitted to their health unit of presentation. An inpatient fee for service billing applies on this occasion. Medical Practitioners accompanying patients on inter-hospital transfers are to be remunerated on a time based system as well as for the journey back.

Comment [SLR4]: I have assumed that discussion as to rate applicable will take into account the timing of when the service is provided.

Deleted: And any time in after hours time be acknowledged in payment of appropriate loading

3.6 Intravenous and Intraosseous Therapy

Intravenous or intraosseous therapy (other than that associated with an anaesthetic, chemotherapy or other services that require an intravenous insertion) shall have an item number (*SAMSOF IVT*) and will attract a payment. This item only applies where the IV insertion is performed by the medical practitioner and noted as such in the medical records. Payment for IV insertion done prior to admission can be claimed. This payment does not attract benefits under the RHEP

3.6.1 Chemotherapy

Inpatient public chemotherapy should be charged in accordance with the following formula:

Initial Treatment:

Level B Consult + Chemotherapy Fee (eg Items 13915 or 13918)

Subsequent Treatments:

Chemotherapy Fee only (eg item number 13915 or 13918 unless formal consultation or change of management instigated).

For the purpose of payment for outpatient public chemotherapy, when approved by the health service for public funding, the GP will be able to access Item No's 13915 or 13918 when the service is provided as an outpatient service.

Payment of a SAMSOFIVT fee will not apply.

3.7 Emergency Care

3.7.1 Where a medical practitioner is required to return to a hospital in a situation where the patient is in imminent danger of death, requiring the medical practitioners' undivided attention for continuous life-saving emergency treatment, the following criteria and fee structure has been determined:

- Emergency item numbers 160-164 (Prolonged Professional Attendance) may only apply to a service on a patient in Triage Category 1 and 2, where required for more than one hour.
- A patient requiring treatment for whom the emergency number being paid would need to have a triage score of 1 or 2 as well as meeting the requirement of the constant presence of a medical practitioner to be maintained.
- Less than one hours attendance where a doctor is required to attend urgently for specific patient care indicative of Category 1 and Category 2 less than one hour SAMSOF 50 would apply.
- Payment for continued assessment over one hour is billed in 15 minute segments (1/4 of amount of item 160)

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- Where two or more doctors are required to attend urgently to treat a patient in an emergency situation both eligible to claim. Both doctors must document their role in management and times present

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 1	Immediate simultaneous assessment and treatment	Immediately Life-Threatening Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention.	Cardiac arrest Respiratory arrest Immediate risk to airway - impending arrest Respiratory rate <10/min Extreme respiratory distress BP< 80 (adult) or severely shocked child/infant Unresponsive or responds to pain only (GCS < 9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation Severe behavioural disorder with immediate threat of dangerous violence
Category 2	Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)	Imminently life-threatening The patient's condition is serious enough or deteriorating so rapidly that there is the potential of threat to life, or organ system failure, if not treated within ten minutes of arrival Or Important time-critical treatment The potential for time-critical treatment (e.g. thrombolysis, antidote) to make a significant effect on clinical outcome depends on treatment commencing within a few minutes of the patient's arrival in the ED Or Very severe pain Humane practice mandates the relief of very severe pain or distress within 10 minutes	Airway risk - severe stridor or drooling with distress Severe respiratory distress Circulatory compromise <ul style="list-style-type: none"> • Clammy or mottled skin, poor perfusion • HR<50 or >150 (adult) • Hypotension with haemodynamic effects • Severe blood loss Chest pain of likely cardiac nature Very severe pain - any cause BSL < 2 mmol/l Drowsy, decreased responsiveness any cause (GCS< 13) Acute hemiparesis/dysphasia Fever with signs of lethargy (any age) Acid or alkali splash to eye - requiring irrigation Major multi trauma (requiring rapid organised team response) Severe localised trauma - major fracture, amputation High-risk history: <ul style="list-style-type: none"> • Significant sedative or other toxic ingestion • Significant/dangerous envenomation • Severe pain suggesting PE, AAA or ectopic pregnancy Behavioural/Psychiatric: <ul style="list-style-type: none"> • violent or aggressive • immediate threat to self or others • requires or has required restraint • severe agitation or aggression

3.7.2 Obstetric Emergency Antenatal Consultation

3.7.2.1 Important time-critical treatment

Assessment and treatment of a woman in threatened premature labour requiring immediate care, which may require consultation with a tertiary neonatal and maternity hospital. Treatment may involve tocolysis and transfer to tertiary centre. Where the time in attendance is less than one hour, then SAMSOF 50 applies

3.7.2.2 Imminently life-threatening

Assessment of a pregnant woman with significant signs of pre-eclampsia requiring urgent assessment and investigation of hypertension and treatment with hypotensive medication and consultation with tertiary centre regarding further management, transfer, retrieval, and where there is no local specialist support.

Where a consultant or local specialist can manage the case locally but the same clinical situation applies ie the time attending is less than one hour, then SAMSOF 50 applies.

3.7.2.3 Antenatal woman presenting for management of moderate or more blood loss in pregnancy requiring urgent CTG assessment, intravenous resuscitation, and in consultation with tertiary neonatal centre, transfer, retrieval etc:

- less than one hour – item SAMSOF 50;
- greater than one hour – refer to description in CMBS (Nov 2008), Section A.12 for item numbers 160-164 inclusive. The payment rates will be items 160-164 (which equates to CMBS items 160-164 plus a 50% loading);
- if the emergency care is initiated after hours - the 'After Hour Payment Rules' will apply (see clause 1.10);
- any other relevant procedural fees (inclusive of RHEP) - are payable until the emergency care ceases and/or the patient is transferred to another centre.
- where a definitive procedures occur – (eg in Theatre) this would be considered to be the end of the resuscitation phase and the commencement of the definitive procedure phase which would be covered by the relative procedural payment.

The following table represents the structure for payments:

(Items 160-164 represents the CMBS payments which includes a 50% loading)

	Mon – Fri 0800 – 1800 Sat 0800 – 1200	Mon – Fri 1800 to 2300 Sat 1200 to 2300 Sun & PH 0800 to 2300	Mon – Fri 2300 to 0800 Sat 2300 to 0800 Sun & PH 2300 to 0800
Less than 1 hr	Item SAMSOF 50	Item SAMSOF 50 + Item 1	Item SAMSOF 50 + (Item 1 x 1.5)
Less than 2 hrs	Item SAMSOF 160	Item SAMSOF 160 + Item 1	Item SAMSOF 160 + (Item 1 x 1.5)
Less than	Item SAMSOF 161	Item SAMSOF 161 +	Item SAMSOF 161 +

3 hrs		Item 1	(Item 1 x 1.5)
Less than 4 hrs	Item SAMSOF 162	Item SAMSOF 162 + Item 1	Item SAMSOF 162 + (Item 1 x 1.5)
Less than 5 hrs	Item SAMSOF 163	Item SAMSOF 163 + Item 1	Item SAMSOF 163 + (Item 1 x 1.5)
5 or more hrs	Item SAMSOF 164	Item SAMSOF 164 + Item 1	Item SAMSOF 164 + (Item 1 x 1.5)

3.7.3 Where a medical practitioner is required to attend a hospital to provide emergency care to more than one patient, and they require continual monitoring and treatment prior to transfer, or specialist intervention, and the treatment prevents the medical practitioner from leaving the hospital, the following payments will apply for each patient:

- the payment shall be item SAMSOF 50 for the initial one hour, and then each subsequent one hour segment, or part thereof need ¼ hrly sums payable here also
- if the emergency care is initiated after hours, the 'After Hour Payment Rules' will apply (see clause 1.10)
- any other relevant procedural fees (inclusive of RHEP where applicable) are payable until the emergency care ceases and/or the patient is transferred to another centre
- A medical practitioner may be able to deliver care to another patient whilst awaiting retrieval assistance to another patient

3.8 Other Medical Practitioners

"Other Medical Practitioners" (as defined in the CMBS) shall be paid at the Vocational Registered rate for public inpatient care.

3.9 Surgical Procedural Rates

Surgical procedural rates that have differential payments for specialist and non specialist medical practitioner shall all be paid at the specialist rate (the fees shown in SAMSOF reflect this point).

3.10 Scope Procedural Rates

For the purposes of payments for colonoscopy, endoscopy and oesophagoscopy services approved by the hospital/health service for public funding, the scope Proceduralist and Anaesthetist will be able to access the current 'inpatient' MBS item numbers whether the procedure is performed as a public inpatient or outpatient.

3.11 After Hours Attendances and Payments

3.11.1 Definitions

After hours shall be defined as being:

- 3.11.1.1 Monday – Friday from 18:00 hrs and before 0800 hrs Saturdays, Sundays and Public Holidays – all day/night until 0800 hours the following day.
- 3.11.1.2 Eligibility for claiming after hour payments (item 1) – refer to CMBS (Nov 2009), Section A.10.1 item 601 is not relevant for the purpose of SAMSOF 2010.
- 3.11.1.3 Descriptions of Level A, B, C, D – refer to CMBS (Nov 2009), Section A.5.
- 3.11.1.4 Where Christmas Day or New Years Day falls on a weekend, both the public holiday and the Monday that the public holiday is observed are deemed as Public Holidays for the purposes of After Hours.

3.11.2 **General Practice Payments**

Payment for all after hours inpatient consultations (inclusive of obstetric patients unrelated to confinement and postnatal care) that is not considered part of 'normal after care' will be either:

3.11.2.1 **Level A and B:**

18:00 hrs to 23:00 hrs as per item 1 fee;

23:00 hrs to 08:00 hrs as per item 1 fee + 50%.

3.11.2.2 **Level C and D:**

18:00 hrs to 23:00 hrs as per item 1 fee + the fee for Level C or D (whichever is applicable);

23:00 hrs to 08:00 hrs as per (item 1 fee + 50%) + the fee for Level C or D (whichever is applicable)

Where an urgent consultation is requested which is not considered part of 'normal after care', the medical practitioner can claim a 'not normal after care' item on the proviso that there is appropriate documentation within the medical records which supports the claim. Routine ward rounds performed after hours (i.e. not at the specific request of the hospital or nursing staff) on any day are considered part of normal after care and do not attract the after hours item. If during or subsequent to the occasion of an item 1 service, further services are provided to that patient or further patients, during an unbroken period of attendance at the hospital, the item 1 fee is not chargeable. Remuneration for these services will be provided according to the SAMSOF Schedule.

3.11.2.3 **Case conferences**

Item numbers are to be used for medical practitioners attending Case Conferences for patient management.

3.11.2.4 **Video and telephone conferences**

Items numbers are to be used for medical practitioners attending video or telephone conference for patient management.

3.11.3 **Procedural (inclusive of Surgery and Anaesthesia) Payments**

Payment for after hours procedural items (excluding Obstetric items 16515–16636) shall be:

3.11.3.1 **Anaesthesia:**

18:00 hrs to 23:00 hrs as per item 25025 fee + the SAMSOF fee for the procedural item;

23:00 hrs to 08:00 hrs as per (item 25025 + 50%) fee + the SAMSOF fee for the procedural item.

Additional cases added prior to an elective list prior to 0800 do not qualify for after hours payment

For the purposes of payments for item 25025, the definition of after hours shall be in line with clause 1.10

3.11.3.2 **Surgical:**

18:00 hrs to 23:00 hrs as per item 1 fee + the SAMSOF fee for the procedural item;

23:00 hrs to 08:00 hrs as per (item 1 + 50%) fee + the SAMSOF fee for the procedural item.

For the purposes of payments for item 1, the definition of after hours shall be in line with clause 1.10

3.11.3.3 **Epidural:**

For the purposes of payments for Epidural items 18226 and 18227, the definition of after hours shall be in line with clause 1.10.

3.12 **Obstetric/Neonatal Care**

Where a medical practitioner is called to attend a baby of a public inpatient mother, and the baby requires resuscitation and/or other significant unusual medical care outside that customarily provided (refer to CMBS (Nov 2008), Section T4.4.7) there can be a separate

charge raised. This charge shall apply to the mother as the neonate is not normally a separately admitted person during the period following birth. The medical practitioner called to resuscitate the neonate at delivery will be paid from the requested arrival time to await delivery until the neonate passes back into normal care unless there are other paid activities that they can undertake during this waiting time.

3.13 **Caesarean Sections**

The payment of non-referred Caesarean sections shall be paid as per item 16520.

3.14 **Electrocardiography (ECG)**

Under the CMBS there are three item numbers that relate to Electrocardiography (ECG). Item 11700 (Twelve-lead Electrocardiography, tracing and report) should only be used if a full 12-lead ECG is performed.

This item should only be paid if the medical practitioner places all 12 leads. Examinations involving less than twelve leads are regarded as part of the accompanying consultation (refer to CMBS (Nov 2007), Section D1.18.1).

Item 11701 (Twelve-lead Electrocardiography, report only), should be used where the ECG tracings are referred to a practitioner for a report without an attendance on the patient by that practitioner. In cases where the leads are placed by a nurse and the results are interpreted by a medical practitioner then this item should be used.

Item 11702 (Twelve-lead Electrocardiography, tracing only), should be used where the ECG tracings are performed by a medical practitioner.

3.15 **Rural Health Enhancement Package (RHEP)**

3.15.1 **Eligibility requirements**

To be eligible for RHEP payments the GP/GP Proceduralist must:

(i) be credentialed and have current scope of practice at a CHSA health unit,

(ii) provide the majority of their clinical practice (ie 80% or more) in the CHSA region at either a CHSA Health Unit or their private practice, and **if you specify 80 % disadvantage some locums**

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(iii) participate in a health service A&E on-call roster on a monthly basis **locums may miss out if only visit infrequently eg interstate, some metro locums**

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Determination of eligibility in exceptional circumstances will be referred to the Chief Medical Advisor, CHSA, for consideration.

3.15.2 Availability/On-call Allowance

'On-call' is defined as being a service which has been determined to be essential by the Region/hospital (as ratified by Country Health SA) to meet the public need at a public health unit 24 hours a day, 7 days a week.

3.15.2.1 An On-call Allowance per 24 hour period for provision of after hours services at a public health unit;

- An on-call period commencing on Monday to Thursday inclusive is paid at **\$tbd** per 24 hour period.
- An on-call period commencing on Friday is paid at **\$tbd** per 24 hour period.
- An on-call period commencing on Saturday or Sunday is paid at **\$tbd** per 24 hour period.
- An on-call period commencing on the day that a public holiday is celebrated is paid at **\$tbd** per 24 period in lieu of the above rates.
- The maximum number of public holidays payable in any one year is 11.

The On-call Allowance will be indexed on 1 July each year by the Adelaide CPI for the year **concluding at the March quarter prior to this date.**

3.15.2.2 The maximum On-call Allowance payable to the health service per service roster per annum is **\$tbd**. A service roster for each location is attached in **Appendix 1**.

3.15.2.3 There will be one payment only per provider in recognition of their availability. The exception to this ruling is where a practitioner is required to cover two locations during any one 24 hour period. The location should be within approximately 30 minutes travel by road. Practitioners who are providing on-call to two locations will attend each location as clinically necessary in that period and will be paid an additional 50% of the applicable on-call payment.

Example 'A'

A practitioner who is providing on-call to two locations for general medicine and will attend each location as clinically necessary in that period will be paid as follows;

- An on-call period commencing on Monday to Thursday inclusive is paid at \$tbd per 24 hour period
- An on-call period commencing on Friday is paid at \$tbd per 24 hour period
- An on-call period commencing on Saturday or Sunday is paid \$tbd per 24 hour period
- On-call period commencing on the day that a public holiday is celebrated is paid at \$tbd per 24 period in lieu of the above rates

Example 'B'

A practitioner who is providing on-call to two locations, one for general medicine and one for a speciality (e.g. Anaesthetics), and will attend each location as clinically necessary in that period will be paid as follows;

- An on-call period commencing on Monday to Thursday inclusive is paid at \$tbd per 24 hour period
- An on-call period commencing on Friday is paid at \$tbd per 24 hour period
- An on-call period commencing Saturday or Sunday is paid at \$tbd per 24 hour period
- On-call period commencing on the day that a public holiday is celebrated is paid at \$tbd per 24 period in lieu of the above rates

The cost of this on-call arrangement will be shared equally by the affected health units. Multiple on-call payments at one site:

- where there is approval from CHSA for a range of services to be available 24 hours a day, 7 days a week there will be on-call availability payable to each resident practitioner who is on the roster for an identified 24 hour period
- if the practitioner has the recognised privileges to justify a dual role (e.g. GP Medicine and Obstetrics) they will be paid one on-call payment only
- Schedule X identifies all on-call services per location and those services approved for RHEP payment
- any additional services must be supported by the region and ratified by the CHSA within the agreed service delineation framework for each region

3.15.2.4 The On-call Allowance is to be paid according to the following criteria:

- all medical practitioners required by the hospital to be on-call and specified in Schedule 2 of the Contract, unless special local arrangements are made;
- who are eligible for RHEP;
- who participate in on-call rosters; and

- who do not have any existing contractual arrangements outside of SAMSOF

3.15.3 **Special Fee For Service Payments**

- 3.15.3.1 Anaesthetic and Surgical Procedural item numbers shall have a loading of 20%. The full RHEP fee is shown in SAMSOF under the RHEP column.
- 3.15.3.2 Obstetric item numbers (16500–16636) shall have a loading of 50%. The full RHEP fee is shown in SAMSOF under the RHEP column.
- 3.15.3.4 Obstetric item numbers (16500–16636) are not subject to after hours loadings (refer to clause 1.10).

4. **Other Allowances and Payments**

4.1 **Managerial Allowance**

Medical practitioners appointed to the role of Principal Medical Officer will remain as contractors in this capacity and will be remunerated by way of a small or large unit management allowance that is applicable to consultants employed under the Department of Health Salaried Medical Officers Enterprise Agreement 2008.

4.2 **Clinical Audits**

Medical practitioners will be remunerated at \$tbd per hour when participating directly in Clinical Audits and other professional activities on behalf of CHSA. This should not be confused with remuneration or reimbursement for the undertaking of professional development activities of a personal nature (Clause 5.4).

4.3 **Locums**

GPs are entitled to receive subsidised locum support funding/allowances in accordance with guidelines of the Rural Doctors Workforce Agency (RDWA). Medical practitioners should contact the RDWA or visit www.ruraldoc.com.au/Locums/ for further details regarding support arrangements and eligibility criteria.

4.4 **Travel Allowances**

- 4.4.1 In circumstances where a general medical practitioner has to travel a direct route distance to a recognised hospital of more than 20km from the place of his or her nearest established practice (which must be outside of the Adelaide Statistical Division) to provide medical services for which a Fee for Service is payable by the health unit, a travel allowance shall be payable. The allowance shall be applicable for round trips in excess of 40 kilometres. **For non routine visits all**

travel over 5kms will be reimbursed at the above rate plus time at the agreed RDASA hourly rate.

4.4.2 The allowance shall be based on the per kilometre rate prescribed in the 'SA Health (SAHC Act and IMVS Act) Human Resources Manual' (Part 8 – Travelling and Expenses Reimbursement), applicable to a vehicle with an engine of more than four cylinders.

4.4.3 This allowance is to be paid once per visit, not per patient, regardless of the number of patients seen.

4.5 **Attendance of Medical Practitioners at Meetings**

Where the hospital requires attendance of a medical practitioner at a pre-arranged meeting regarding accreditation of a health service or as a member of a formal committee (e.g. Central Clinical Privileges Advisory Committee), the medical practitioner shall be paid an allowance calculated at an hourly rate of \$tbd (after 18.00 hours on weekdays, and after midday on Saturdays).

Where meetings are scheduled during normal practice hours remuneration shall be paid at the hourly rate of \$tbd (between the hours of 08:00 and 18:00 hours).

Reading time applies for up to two hours at half the agreed hourly meeting rate.

This fee does not apply in the following situations:

- medical practitioners appointed to a Health Advisory Council (HAC)
- a medical practitioner, who being a member of Health Advisory Council, is then nominated by the Health Advisory Council to be a member of a sub committee of the Health Advisory Council or as a Health Advisory Council representative on another Health Service or (SA Health) committee
- medical practitioners on Advisory Committees (unless formal approval has been obtained from SA Health) or Ministerial Advisory Committees of SA Health and
- this section does not apply for the provision of payment to a Principal Medical Officer for other than health units with formal approval from the Executive Director, Finance and Infrastructure, Country Health SA, to create such a position

4.6 **Telephone**

4.6.1 **Emergency**

Where a health unit remote from the medical practitioner's usual base seeks advice from the medical practitioner by telephone, in an emergency situation, where the local medical practitioner or his/her

locum/cover cannot be contacted after hours (as defined in clause 1.10) a Level A consult shall apply for each telephone call if the medical practitioner is not required to see the patient.

4.6.2 **Overnight phone advice**

Where a health unit seeks advice from the medical practitioner by telephone, between the hours of 2300 to 0800, and the medical practitioner is not required to physically attend, a payment of item number 3 will be paid subject to the following:

- this only applies to medical practitioners eligible for RHEP and who on-call for that night
- this will exclude all medical practitioners whose existing contractual arrangement are outside of the current SAMSOF agreement

5. **Grants and Incentives**

5.1 **Medical Indemnity Support Grant**

The Rural Health Enhancement Package (RHEP) 'Medical Indemnity Support Grant' Option 1 is available to medical practitioners, clinics or partnerships that satisfy the eligibility criteria for the RHEP. See clause 3.15.1 of this Schedule for more detailed information regarding eligibility. To access a copy of the RHEP Grant application form, visit the Country Health SA website at [http://www.countryhealthsa.sa.gov.au/Portals/0/Medical%20Indemnity%20grant%20app%20form%202008-09%20\(2\).pdf](http://www.countryhealthsa.sa.gov.au/Portals/0/Medical%20Indemnity%20grant%20app%20form%202008-09%20(2).pdf)

Payments of Medical Indemnity Grants will promptly be made to Medical Practitioners from the date of receipt of all the required information by the health service.

5.1.1 **Where the selected Medical Indemnity Insurance Providers is other than The Medical insurance Group (MIGA)**

Responsibility of the Medical Practitioner:

Medical Practitioners need to provide all to the following to the Health Unit to process the grant application:

1. the Insurance Tax Invoice which lists the Base Premium, the Premium Support Scheme amount (PSS) and the amount of cover taken (e.g. \$150,000 - <\$200,000)
2. an Official receipt – to show the invoice has been paid by the doctor, and
3. a completed Medical Indemnity RHEP Grant Application form

Responsibility of Country Health SA and the Health Unit:

The Health Unit will send the information provided by the Medical Practitioner to the CHSA Parent Business Centre for approval, calculation of payment due and forwarding to Shared Services SA for prompt payment.

Health Unit Staff must break the payment down to clearly identify what the Medical Practitioner is being paid for. For example the remittance advice must show

1. What payment is for (eg GP Medicine and or Anaesthetist)
2. GST component
3. Any additional Premium Support Scheme (PSF) payment

Whilst every Delays will occur when the wrong or incomplete information is provided and in these situations a 30 day timeframe can only begin once CHSA receives all the required information for processing.

5.1.2 **Where the selected Medical Indemnity Insurance Provider is The Medical insurance Group (MIGA)**

Medical Practitioners who are eligible for the RHEP and who elect to purchase appropriate Medical Indemnity cover through MIGA will only be invoiced by MIGA for the net of their Grant entitlement and MIGA will obtain reimbursement of the Grant entitlement direct from CHSA. This arrangement will minimise administration for eligible Medical Practitioners associated with claiming the Grant and will mean there is no out of pocket period waiting for reimbursement.

Responsibility of the Medical Practitioner:

The Medical Practitioners need to ensure that MIGA are advised that are eligible for RHEP when purchasing Medical Indemnity cover.

Responsibility of CHSA:

CHSA will validate Medical Practitioner directly with MIGA.

5.2 **Rural Female GP Pre-School Childcare Grant**

The Rural Female GP Pre-school Childcare Grant will provide female general practitioners and registrars currently practising in rural and remote South Australia a financial incentive to remain in general practice during their children's pre-school years. This grant supports the broad retention strategies of the Rural Doctors Workforce Agency (RDWA) and acknowledges the increasing contribution of female medical practitioners to the rural and remote medical workforce in South Australia.

5.3 **Rural Doctors Workforce Agency (RDWA) – Initiatives/Grants**

The RDWA also offers a number of other initiatives/grants for rural medical practitioners.

For more information visit the Rural Doctors Workforce Agency website at www.ruraldoc.com.au or telephone (08) 8357 7444.

5.4 Professional Development Grant

There will be an annual grant (indexed annually) available for medical practitioners as outlined on the RDWA website www.ruraldoc.com.au . Medical practitioners can also claim on CPD events where Commonwealth subsidies may apply.

6. Disputes over payment of fees

From time to time there will be uncertainties or disputes as to what the appropriate fee should be for a particular service. On most occasions this is as a result of technical interpretation of the agreement that should be able to be resolved between the medical practitioner and the health service.

When a payment has been rejected by a health service or CHSA and the medical practitioner believes the decision to be incorrect, a meeting between the medical practitioner and the PMO or Director of Medical Services of the health service must occur within 10 working days of the medical practitioner being informed of the rejection of a payment. If the dispute cannot be resolved in this manner, the following process is to be applied.

The process will involve the registering with CHSA, by the Rural Doctors Association of South Australia, Australian Medical Association (South Australia) and Country Health SA, a list of medical practitioners that the three agencies collectively agree are experts in the interpretation of the fee schedule as at the introduction of this agreement.

Within 5 working days of the breakdown in the discussions identified above, the medical practitioner concerned and CHSA must each select a person from the list of registered experts identified as a result of this agreement. The two selected medical practitioners (the Panel) must then meet with the medical practitioner and the person responsible for the rejection of the payment within 5 working days of the people being identified. Where ever possible the people selected should have special expertise in the area of conflict.

The process to be applied is for the panel to hear each person individually and then discuss the matter with them jointly to ensure that each has had a chance to hear the others point of view. Following the hearing of this information the panel must provide a decision within 2 working days. If the panel is unable to reach a decision acceptable to both of them, the matter can be referred to an extended panel of 4 medical practitioners selected from the

registered group of experts and chaired by an independent person agreed to by both parties. If the parties are unable to agree on the independent chair, then a person recommended to the Parties by the President of the Law Society of South Australia, will have this responsibility. This group must meet without unreasonable delay.

Each Party will bear its own costs in respect of the dispute resolution process and where the Parties jointly incur costs, those costs will be borne by both Parties equally unless determined by the extended panel that the dispute was unreasonable and costs should be borne by one party only.

It should be noted that no payments other than the disputed amount can be withheld while a matter is being resolved.

7. International Medical Graduates

The application of all terms and conditions described within this document apply equally to local and International Medical Graduates, subject to all essential criteria, where applicable, having been met.

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Appendix 1 – On-call – Quantum and Mix of Services

The following describes the services that are agreed as being potentially eligible for on-call payments, on the basis that they provide services on a 24/7 roster, listed by health service location.

Note: There are some rosters which may include providers who, when on-call, may not be entitled to the On-call Allowance for that day, depending upon their agreement (e.g. separate contracts, sessional payments, salaried medical officers and pre-existing agreements). Where there is an on-call roster for emergency it would be expected the doctor is part of the roster unless arrangements with the local medical doctors allow for cover.

Health Service	Anaesthetics	Emergency	General Surgery	General Medicine	Obstetrics	Orthopaedics	Paediatrics	Surgery
Angaston/ Tanunda	X	X			X at Tanunda only			
Balaklava		X						
Barker		X						
Berri	X	X	X		X Gynaecolog y			
Boomeroo		X			X			
Bordertown		X						
Burra		X						
Ceduna	X	X			X			
Clare/ Snowtown	X at Clare only	X			X at Clare only			
Cleve		X			X			
Cooper Pedy		X						
Cowell		X						
Crystal Brook		X			X			
Cummins		X			X			
Elliston		X						
Eudunda/ Kapunda		X			X at Kapunda only			
Gawler	X	X			X		X	
Gladstone		X						
Gumeracha		X						
Hawker		X						
Jamestown		X			X			
Kangaroo Island	X	X			X			
Karoonda		X						
Kimba		X						
Kingston		X						
Lameroo		X						
Laura		X						
Leigh Creek		X						
Loxton		X			X			
Maitland		X						
Mannum		X						
Meningie		X						

Health Service	Anaesthetics	Emergency	General Surgery	General Medicine	Obstetrics	Orthopaedics	Paediatrics	Surgery
Millicent		X			X			
Minlaton		X						
Mount Barker	X	X			X			
Mount Gambier	X				X	X	X	X
Mount Pleasant		X						
Murray Bridge	X	X			X			X
Naracoorte	X	X			X			
Orroroo		X						
Penola		X						
Peterborough		X			X			
Pinnaroo		X						
Port Augusta	X	X			X		X	X
Port Broughton		X						
Port Lincoln	X	X		X Physician	X			X
Port Pirie	X	X	X		X			
Quorn		X						
Renmark		X			X			
Riverton		X						
Roxby Downs		X						
South Coast	X	X			X			
Strathalbyn		X						
Streaky Bay		X			X			
Tailem Bend		X						
Tumby Bay		X						
Waikerie		X			X			
Walleroo	X	X			X			
Whyalla	X	X		X Physician	X			X
Woomera		X						
Wudinna		X						
Yorketown		X						

Appendix 2 – On-call Grant

There are a range of locations across country South Australia where there are resident GP services, without the presence of a local public hospital, and they routinely receive after hours emergency cases that are transported to them by the South Australian Ambulance Service (ie they are recognised by this Emergency Services as providing a 24/7 Accident and Emergency Service).

1. In recognition of the work provided in these clearly defined situations, CHSA will pay a grant per registered provider and an annual allocation of \$3,000 for practices to supplement the cost to support emergency services (eg defibrillator). This grant is capped at \$65,000 per location per year inclusive.
2. GPs providing this service will need to maintain Scope of Clinical Practice in both GP Medicine and Emergency Medicine
3. This service will require the provider to physically attend on an after hours basis at their practice or the private hospital they service.
4. A recommended minimum core set of medical equipment will need to be maintained on site.
5. These payments are made in addition to the Commonwealth funded Practice Incentive Payments which also recognise after hours effort by accredited general practitioners
6. The general practitioner/practice must maintain a record of accident and emergency calls and consultations made between 18:00 hours and 08:00 hours on weekdays and weekends, and supply this information to CHSA on a monthly basis.
7. The general practitioners who are in towns where there is an on-call roster for the provision of Accident and Emergency services to a public health unit would not be eligible to this arrangement.

Deleted: . ?? has this ever been paid

Comment [SLR5]: A process will need to be agreed upon.

Deleted: What is mechanism for this ? I understand this has not occurred in past

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Number of general practitioners in a Practice	Annual on-call payment for each general practitioners providing service	Annual equipment payment per practice
1	\$td	\$td
2	\$td	\$td
3	\$td	\$td
4 or more	\$td	\$td

8. This grant is potentially applicable to the following locations subject to the above criteria being met:

- Ardrossan?

- Normanville/Yankalilla
- Hamley Bridge?
- Robe
- Keith
- Goolwa
- Moonta?

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Appendix 3 – Summary of rates not included in SAMSOF

Comment [SLR6]: All dollar sums will be reflective of any new rates agreed as part of the negotiation process.

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ITEM	Description	Basis of calculation	Rate
SAMSOF Transfer	Time medical practitioner spends accompanying patients between health units (Clause 3.5)	Actual time spent in transit.	\$0.00 per hour
On-call Monday to Thursday	RHEP On-Call (Item 3.15.2.1)	24 hour period	\$0.00 per day
On-call Friday	RHEP On-Call (Item 3.15.2.1)	24 hour period	\$0.00 per day
On-call Saturday or Sunday	RHEP On-Call (Clause 3.15.2.1)	24 hour period	\$0.00 per day
On-call Public Holiday	RHEP On-Call (Clause 3.15.2.1)	24 hour period	\$0.00 per day
Maximum On-call per service roster	RHEP On-Call (Clause 3.15.2.2)	Per annum	\$0.00 per annum
Management Allowance	Role of Principal Medical Officer (Clause 4.1)	As per <u>the large or small unit management allowance outlined in the Department of Health Salaried Medical Officers Enterprise Agreement 2008.</u> <u>Payment is to be invoiced and paid on a quarterly basis.</u>	\$0.00 per annum
Clinical Audits	Conduct of Clinical audits and other professional activities on behalf of CHSA (Clause 4.2)	Actual time taken paid at an hourly rate.	\$0.00 per hour
Meetings – business hours	Attendance at Meetings (Clause 4.5)	Actual time taken paid at an hourly rate.	\$0.00 per hour
Meetings – after hours	Attendance at Meetings (Clause 4.5)	Actual time taken paid at an hourly rate.	\$0.00 per hour
Reading time	Preparation time paid at the same rate irrespective of the scheduled meeting time (Clause 4.5)	Paid at 50% of the actual time spent at the meeting.	\$0.00 per hour
On-call grant +1	On-call grant approved location – 1 medical practitioner	Annual payment per practitioner	\$0.00 per annum
On-call grant +2	On-call grant approved location – 2 medical practitioners	Annual payment per practitioner	\$0.00 per annum
On-call grant	On-call grant approved location – 3	Annual payment	\$0.00 per annum

+3	medical practitioners	per practitioner	
On-call grant +4 or more	On-call grant approved location – 4 or more medical practitioners	Annual payment per practitioner	\$0.00 per annum
On-call grant – equipment allowance	On-call grant - annual equipment allowance per practice	Annual sum per practice setting	\$0.00 per annum

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