Guidelines for the provision of treatment of Medicare ineligible patients in Western Australian public hospitals
Contents

1. Introduction 2
2. Purpose of the Guidelines 2
3. Scope 2
4. Background 2
5. Medicare Eligibility 3
6. Provision of Care
   6.1 Emergency Treatment 3
   6.2 Urgent treatment 4
   6.3 Special category treatment 4
      6.3.1 RHCA eligibility for public health care 4
      • Child birth 4
      • Dialysis services 4
   6.3.2 Treatment of patients with communicable diseases. 4
7. Provision of non-urgent or extended treatment 5
   7.1 Process for accepting patients not eligible for Medicare: 5
   7.2 Clinician’s responsibilities: 5
   7.3 Hospital responsibilities 5
   7.4 Role of delegated officers 6
8. Treatment costs 6
9. Billing and debt recovery 7
10. Appeal process 7
11. Accountability and record keeping 7
12. Document Review 7
13. Appendix 7
   Appendix 1: Assessment pathway for Medicare ineligible patients 9
   Appendix 2: Concept of Informed Financial Consent 10
   Appendix 3: Submission Template to Health Service Chief Executive and Director General11
1. **Introduction**

At a given point of time, there are approximately one million overseas visitors in Australia (excluding New Zealand citizens). Some will require medical attention at a public hospital. Not all are eligible for Medicare coverage. The Hospitals and Health Services Act 1927 (WA), Hospitals (Service Charges) Regulations 1984 and the National Healthcare Agreement obliges ineligible patients to pay for their care.

Emergency and urgent treatment is to be provided to all patients regardless of Medicare eligibility as a duty of care. In addition, as it may not always be reasonable for long term visitors/temporary residents to travel to their home country for treatments, some Medicare ineligible patients may seek elective or non-urgent treatment. This operational guideline acknowledges the health service’s duty of care and seeks to ensure that where care is provided, measures are taken to enable later efforts of cost recovery. Having proper processes to determine eligibility enables cost recovery and reduces the risk of unpaid debt.

2. **Purpose of the Guidelines**

The purpose of this operational guideline is to ensure Health Services identify non-Medicare (ineligible) patients at the point of admission and assess the ability of non-Medicare patients to pay for the full costs of care.

3. **Scope**

This operational guidance applies to all medical staff working within WA Health and the Area Health Services.

4. **Background**

Western Australian public hospitals are frequently requested to provide medical care for Medicare ineligible patients including:

- Overseas travellers
- International students
- Non-permanent residents of Australia including holders of business, retirement and family visas and
- Medical tourists who deliberately enter Australia to access treatment.

The insurance coverage and eligibility for “free” treatments for each of the above groups varies and many patients do not have any form of health cover.

WA Health has identified several issues which hamper later efforts at cost recovery. These issues include:

- failure of Health Services to identify Medicare status of patients on presentation or admission
- failure of Health Services to assess the ability of a Medicare ineligible patient to pay (in full or part) for treatment.

As a consequence, Health Corporate Network (HCN) or WACHS Finance are unable to commence debt recovery procedures for treatment costs when an
ineligible patient does not pay for treatment. In other instances, Health Services have been obliged to consider waiving costs part-way through treatment to permit continuing care. Both issues frequently result in WA Health off-setting the cost of treatment provided to non-Medicare patients.

5. Medicare Eligibility

Medicare Eligibility must be determined at the time of admission. Medicare entitlement is not automatic and a person needs to apply for enrolment. A Medicare number may be issued on the day of application. Patients who are eligible for Medicare but have not yet applied for a Medicare number, should be encouraged to apply as soon as possible.

Generally, Medicare eligibility is restricted to people living permanently in Australia who are:

- Australian citizens (who are resident in Australia)
- Permanent Australian residents (who have permanent visas)
- New Zealand citizens
- persons with applications for permanent visas under consideration (excluding applicants for aged parent visas -subclass 804), who also have either,
  - authority from Department of Immigration and Border Protection (DIBP) to work, or
  - an Australian citizen or permanent resident spouse, parent or child.

While overseas visitors and temporary residents generally do not have access to Medicare, there are exceptions. The Health Services Patient Fees and Charges Manual (Appendix F and G) and the related Operational Directive (OD) 0536, Reciprocal Health Care Agreement (RHCA), describe these exceptions and provided guidance on how to determine Medicare eligibility. At the time of writing, these exceptions include:

- visitors from countries with which Australia has a RHCA. These visitors have restricted access to Medicare.
- A person or classes of person declared by the Commonwealth Minister of Health to be Medicare eligible
- some asylum seekers.

6. Provision of Care

Emergency care and urgent treatment should be provided, irrespective of Medicare eligibility as a duty of care.

6.1 Emergency Treatment

Patients requiring emergency or urgent treatments will be treated in a comparable manner as Medicare eligible WA patients. This applies regardless of their Medicare eligibility, other health or travel insurance coverage or whether the patient (or proxy) agrees to pay treatment costs.

HCN or WACHS Finance will attempt to recover the cost of providing emergency or urgent treatments to non-eligible Medicare patients retrospectively. Appropriate processes should be in place to receive payment or obtain approval for payment from the travel insurer, for the

---

1 Australian citizens based overseas retain their access to Medicare for any return visits to Australia for up to five years from when they were last resident in Australia.
urgent treatment provided to the patient prior to discharge from the health care facility. To facilitate this, such patients should be clearly identified. If a patient continues to require further treatment after emergency care has been provided, the process in Section 7 regarding provision of non-urgent care should be followed.

Please also refer to flowchart in Appendix1.

6.2 Urgent treatment

Where treatment, although not medically necessary, cannot be deferred until the patient returns home or where there is a risk that a pre-existing or new medical condition may deteriorate into a life-threatening condition without timely treatment, patients should receive medically necessary care.

The hospital should ascertain the patient’s compensable status. If the patient is Medicare ineligible, insurance coverage should be determined. Where required, an up-front payment or the provision of credit card or approval from the travel insurer or other personal payment details must be taken to cover the estimated treatment cost. The appropriate process in Section 7 and Appendix 1 should be followed.

6.3 Special category treatment

6.3.1 RHCA eligibility for public health care

- Child birth
  Some RHCA agreements include medical coverage for the birth of a child. Medicare eligibility for the birth of a child depends on the hospital’s assessment of the purpose of their visit to Australia, length of stay and duration of their visa. Further information regarding eligibility is available in OD 0536.
  There would be no criteria applied in the case of a medical emergency.

- Dialysis services
  Some RHCA include dialysis services. Please refer to OD 0536 for additional information.

6.3.2 Treatment of patients with communicable diseases.

The Health Act 1911 provides for the treatment of patients with venereal disease. Additionally, OD 229 provides for free treatment to care to overseas patients admitted to public hospitals with tuberculosis or leprosy. Similarly, hospitals should provide free assessment, pathology services and treatment for all notifiable sexually transmitted infections including syphilis, gonorrhoea, chlamydia HIV and hepatitis B. This includes assessment and pathology tests.

A proportion of these patients will be long-term residents in WA and must hold current private health insurance as a condition of visa approval. Hospitals must ensure that such patients are aware of both the need for compliance with prescribed therapies and their ineligibility for continuing subsidised treatments and therapies if uninsured. Hospitals must have systems in place to recoup treatment costs for privately insured patients.

Where it is anticipated that in excess of two months treatment will be required, hospitals must have in place, processes for the prospective approval of such costs. If the anticipated cost of treatment exceeds $10,000 per annum, once agreement has been obtained from relevant
clinical departments and approval granted by the hospital Executive Director and Area Health Service Chief Executive, final authorisation must be sought from the Director General.

In the event that subsidised HIV or hepatitis B treatment is refused by a Health Service, the Health Service must provide an appeal process that recognizes compassionate or public health considerations.

7. Provision of non-urgent or extended treatment

In the case of non-urgent or extended treatment, health services should adopt processes akin to that of private facilities in ensuring costs of treatment are met.

Where patients are Medicare ineligible or do not have private health or travel insurance coverage, up-front payment of anticipated treatment costs should be obtained.

7.1 Process for accepting patients not eligible for Medicare:

Please refer to Flowchart in Appendix 1.

7.2 Clinician’s responsibilities:

- The admitting medical practitioner determines the urgency and necessity for treatment.

- To enable efficient and timely decision making, it is important that the medical practitioner work with the hospital executive team and provide information on the nature of treatments required, duration and cost estimates. This should include information on the nature of pre-intervention assessment, the follow-up required and the estimated total cost of treatment including pre-intervention and follow-up phases.

- It is the medical practitioner’s responsibility to ensure that approval for treatment is obtained from their Head of Department, hospital Executive Director and Area Health Service Chief Executive (or other respective process in WACHS e.g. Operations Manager, Regional Director, Area Health Service Chief Executive).

- If the anticipated cost of treatment exceeds $10,000, once agreement has been obtained from relevant clinical departments and approval granted by the hospital Executive Director and Area Health Service Chief Executive, final authorisation must be sought from the Director-General.

- Once an ineligible patient is admitted, information must be submitted to the responsible department in the hospital.

7.3 Hospital responsibilities

- It is recommended that health services establish treatment cost thresholds to support clinicians in their decision making for admission.

- Hospitals need to ensure that the provision of treatment would not disadvantage Australian residents.

- Upon admission (and/or leading to acceptance for care), the hospital should confirm a patient’s identity and eligibility status.

- Hospitals need to ensure that the estimated costs are correct and that the patient has provided informed financial consent (see Appendix 2).

Superseded by: OD: 0663/16
• Hospitals need to ensure that either the payment is made in advance or patient is adequately covered by a private health insurance or sufficient identification information has been gathered to enable billing and debt recovery or pre-approval from the travel insurer has been sought.

• Hospitals should apply normal debt recovery and/or assurance of payment policies to facilitate the full payment of hospital fees. This may require one of the following methods:
  o taking credit card details and verification of available limits sufficient to cover estimated medical costs,
  o cash deposit or bank cheque to that amount, or
  o guarantee from a patient’s health insurance fund or referring agency.

• All hospitals, health services and clinical departments need to ensure adequate systems are in place with staff appropriately trained to:
  o ensure ineligible patients are identified
  o ensure patients are informed of their liability for the costs of treatment. This may require written information and staff with the knowledge and skills to convey such information and obtain informed financial consent
  o interview patients to establish whether they are exempt from charges or liable for charges
  o issue invoices and/or initiate debt recovery procedures.

7.4 Role of delegated officers
Hospitals are expected to identify specific staff to familiarise themselves with the contents of this document. The delegated officer would:

• counsel a patient about their entitlements and estimated costs of their treatment
• ensure that patient and clinician are aware of the patient’s Medicare eligibility
• advise the patient about the option of receiving treatment in a private facility
• complete necessary forms for record keeping, information and audit purposes
• collect specific identification information from admitted patients according to circumstances, i.e. temporary Medicare number, passport and visa, sponsor details, address in Australia and overseas, travel insurance details
• liaise with external agencies like the Department of Immigration and Border Protection and the Health Insurance Commission to determine eligibility and travel insurance agency to obtain pre-approval for treatment costs.

The overseas patient unit at HCN or WACHS Finance would process all such accounts. They may also be contacted for specific advice.

8. Treatment costs
Patients need to be informed of the cost and eligibility of medical treatment.

It is the responsibility of the medical practitioner accepting a patient, to ensure that the patient or referrer is informed of all anticipated costs.
Clinicians and clinical departments need to refer to the current Health Services Patient Fees and Charges Manual for detailed information on accommodation and associated medical services costs for prospective medical treatment.

Note: the Fees Manual only details hospital fees. It excludes clinicians’ fees, which overseas visitors will be liable and cannot be charged against the MBS. If the service is provided by a salaried doctor, it is recommended that the AMA List of Medical Services and Fees be used as a basis for charging for medical treatment by medical practitioners.

Additionally, patients need to be advised of other associated costs: pathology and imaging, surgically implanted prostheses, orthoses, transport and medical escorts. Where pre-operative assessment and follow-up are required, these should be considered in the cost of medical care.

The published Diagnosis Related Groups codes may assist in estimating the cost of a procedure.

9. Billing and debt recovery

Invoices should be issued to all patients not eligible for Medicare or where Medicare eligibility cannot be determined. HCN or WACHS Finance will process all such accounts. HCN may also be able to issue a tentative invoice at the time of discharge of the patient or an estimate during admission to enable prepayment.

Defaulters will be recorded and debt recovery measures may be undertaken as appropriate.

10. Appeal process

Section 33 (6) of Hospital and Health Service Act 1927 enables the State Minister for Health, notwithstanding any other provision of the Act, where the Minister thinks it reasonable to do so, having regard to the means of the person indebted and the circumstances of the case, may reduce or waive payment of any fees for hospital service that would otherwise be payable.

Doctors can choose to waive their private billings but the hospital costs can only be waived by Minister for Health.

11. Accountability and record keeping

Area health services should make normal provisions for keeping updated records of treatment of ineligible patients. This information would be reported to the Director General annually. Special forms may need to be designed to collect data from ineligible patients.

12. Document Review

This document would be reviewed every three years.

13. Appendix
Appendix 1: Assessment pathway for Medicare ineligible patients

Patient presents to emergency department

Emergency treatment required

- Emergency treatment given
  - Yes
    - Admitting Clinician review to assess urgency of treatment and length of stay
  - No
    - Data Collection and eligibility

D/c after collecting patient details

Recommended for admission

- Yes
  - Admitting Clinician review to assess urgency of treatment and length of stay
  - Patient Counselling about costs expected entitlements and options
  - Ineligible Patient form filled and sent
  - Informed financial consent obtained
  - Identification data collected

Recommends for admission

- Agreed for private Hospital admission
  - Decision taken to admit and provide
    - Patient Counselling about costs expected entitlements and options
    - Ineligible Patient form filled and sent
    - Informed financial consent obtained
    - Identification data collected

- No
  - Prolonged or non-urgent treatment required
    - Yes
      - Seek Prospective approval of Hospital Executive or Director General
      - Appeal Process
      - Inform HCN overseas patient unit
    - No
      - Patient willing and able to pay private
        - Yes
          - Payment received
            - Yes
              - Patient or insurance billed, encouraged paying in advance
              - Prolonged or non-urgent treatment required
            - No
              - Debt collection process initiated by HCN
        - No
          - Patient or insurance billed, encouraged paying in advance
          - Prolonged or non-urgent treatment required

Roles

- HCN
- Clinician
- Patient
- Hospital

Superseded by:
OD: 0663/16
Appendix 2:
Concept of Informed Financial Consent

Informed financial consent (IFC) occurs when patients undergoing treatment as a private patient receive relevant cost information about their treatment prior to the treatment taking place. IFC is important as it allows patients to make informed decisions. The AMA and Productivity Commission encourage IFS in all cases of private admission as even patients who are privately insured may have significant “out-of-pocket” expenses. Ideally IFS should be obtained in writing but it is not always practicable to do so especially in case of an emergency. The Private Health Insurance Ombudsman notes that virtually all complaints to his office about health fund benefits for hospital treatment concern unexpected gaps in the coverage of benefits and, as a result, unexpected bills for health fund members. These complaints include the situation where IFC has not been provided to members by doctors, and the member has an unanticipated out-of-pocket payment. Overseas visitors are expected to bear most of the cost of treatment provided therefore IFS becomes much more important for this group of patients.

When more than one provider is involved it might be difficult to get exact estimates of the cost e.g. when pathology and radiology service are involved. Hospitals may already have procedures and forms in place to obtain informed financial consent. Alternately, the AMA provides forms that can be used to obtain informed financial consent.
Appendix 3:
Submission Template to Health Service Chief Executive and Director General
# Treatment of Medicare ineligible patients

**Place UMRN sticker here**

## Treatment available in Patient's home country

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Passport number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address in home country</td>
<td>Address in Australia (if available)</td>
</tr>
</tbody>
</table>

## If Patient is a minor

<table>
<thead>
<tr>
<th>Name of Parent/Guardian</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationality</td>
<td>Passport Number</td>
</tr>
<tr>
<td>Address in home country</td>
<td>Address in Australia (if available)</td>
</tr>
</tbody>
</table>

## Diagnosis:

- Relevant medical history

## Insurance Agency

| Name of Agency | Authorised person |

## Address and contact details

| Patient reference number |

## Proposed Procedure

<table>
<thead>
<tr>
<th>Name of procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of treatment</td>
</tr>
<tr>
<td>Details of medication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected length of stay in hospital</th>
<th>Expected length of stay in Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected dates of treatment</td>
<td>Expected location / hospital</td>
</tr>
</tbody>
</table>

## Details of other support available

- Intervention is an established and recommended treatment supported by strong evidence base.

## Clinical support/follow up and Medications available in home country

- Treatment is not at the expense of Australian residents

## Cost

<table>
<thead>
<tr>
<th>Estimated cost of procedure</th>
<th>Total cost of treatment medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated cost of follow up in Australia</td>
<td>Amount covered by patient's own finances</td>
</tr>
</tbody>
</table>
Estimated of Pre-procedure assessment

Amount covered by private health insurance

Further comments to support the application

Name and designation of specialist making the application

Signature

Approved

Department Head

Name

Designation

I Certify the information provided as correct and support the application

Comments

Signature

Date

Hospital or Area Health Service Executive

Name

Designation

I certify the information provided as correct and support the application

Recommendation to Director General

Signature

Date

Further Information Required

Referred to following for comments

Application reviewed and: Approval granted O Approval Not Granted O

Sign off:

HOSPITAL CHIEF EXECUTIVE

Date

AREA HEALTH SERVICE EXECUTIVE

Date

If the anticipated cost of treatment exceeds $10,000 per annum and approval is granted by the above personnel, final authorization must be sought from the Director General.

DIRECTOR GENERAL

Date

Ref No.