The Country Health SA Local Health Network

and

Rural Doctors Association of South Australia

South Australian

Rural Medical Fee Agreement (SARMFA)

For Contracted GP Related Services in

Small Rural Hospitals

Version 4

Effective 1 December 2017
IMPORTANT INFORMATION

This document is to be read in conjunction with:

o the “Country Health SA Local Health Network 2017 Rural General Practitioner Fee for Service Agreement”
o the “South Australian Rural Medical Engagement Responsibilities” (SARMER) Version 3, and
o “The Policy for Credentialing and Defining the Scope of Clinical Practice for Medical and Dental Practitioners” March 2015 SA Health
Endorsement of Agreement

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Endorsement of Agreement

The Agreement applies only to services provided within the 45 smaller, grant funded hospitals (as defined at 1 December 2017).

The Agreement operates for three (3) years and comes into effect 1 December 2017.

The Agreement, where relevant, forms a part of the Country Health SA Rural General Practitioner Fee For Service Agreement, as consistent with government policy, along with the South Australian Rural Medical Engagement Responsibilities (SARMER). For explanatory purposes, these three, together, form the general practitioner / Country Health SA service contract when voluntarily signed at local level.

CHSALHN Actions During the Life of the Agreement

Country Health SA will continue to work with rural GPs to provide additional support with the South Australian Virtual Emergency Service (SAVES) and encourage its use over the term of the agreement. A continuation of the Emergency on call roster payment and fee for service payments remain available to GPs who make themselves available for triage Category 1 and 2 emergencies.

Country Health SA will seek continuous improvement and review the success of non-monetary clauses during the life of the Agreement in the areas of:

- quality improvement,
- clinical engagement
- work force sustainability

Country Health SA agrees to consultation with the RDASA prior to any substantial changes related to models of care, administrative practices and equipment or IT purchases.

Not later than 1 February 2020, Country Health SA will, in writing, invite RDASA to discuss opportunity for a replacement agreement.
Executed by the Parties as “The Agreement”:

Country Health SA

EXECUTED by COUNTRY HEALTH SA LOCAL HEALTH NETWORK INC
by Maree Geraghty, Chief Executive Officer who is duly authorised in that regard in the presence of:

............................................................
Signature

............................................................
Signature of Witness

............................................................
Print Name

............................................................
Date

Rural Doctors Association of South Australia

EXECUTED by RURAL DOCTORS ASSOCIATION OF SOUTH AUSTRALIA
by Dr Peter Rischbieth, President who is duly authorised in that regard in the presence of:

............................................................
Signature

............................................................
Signature of Witness

............................................................
Print Name

............................................................
Date
1. **Schedule of Fees**

The Schedule of Fees payable to eligible medical practitioners is known as ‘SAMSOF for SARMFA’ (South Australian Medical Schedule of Fees for medical practitioners covered by the South Australian Rural Medical Fee Agreement) and forms Schedule 1 to this document.

‘SAMSOF for SARMFA’ shall be updated on the 1st of December and the 1st of July of each year to reflect movement in the most current Medicare Benefits Scheme (“MBS”).

Fees and their interpretation are generally based on those defined in the MBS except where different items or interpretations are detailed within SARMFA.

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

Schedule 1 is also available on the SA Health website ([www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au))


2. **Eligibility**

It is a requirement that a GP or GP registrar be signed up to the Country Health SA Local Health Network Rural General Practitioner Fee-for-Service Agreement in order to provide public inpatient medical services in a CHSALHN hospital.

Under a signed standard GP Agreement it is a requirement that the GP be part of a complete on-call emergency roster arrangement for the primary location where public medical services are to be provided, except in those locations where there is a general requirement for two or less GPs with current scope of clinical practice and responsibility for the provision of the Emergency on-call roster.

Under the standard GP Agreement a fee-for-service loading for inpatient services will be paid as follows:

- 10.1% of the Medicare Benefits Scheme rate for consults A, B, C, D (refer 3.11.1.3)
- 10.1% of the Medicare Benefits Scheme rate for item 597 (refer 3.11.1.2 and 3.11.2)
- 7.1% for of the Medicare Benefits Scheme rate, as previously paid under the Rural Health Enhancement Program.

Under the standard GP agreement a $220 (Level E) payment for extended consultations of 90 minutes or more will be paid. (Refer clause 3.11.1.4 and 3.11.2.3.)

On-call payments will apply based at the applicable rate.

Under certain circumstances eligibility to be under a standard GP Agreement but not be part of 365 day on-call emergency roster is possible and the 7.1% loading will still apply for public inpatient services. The exceptions include:
• a GP through senior years either withdraws or provides a reduced participation in the on-call roster, which is in turn compensated for and agreed by the remaining GPs who form the local emergency roster

• a GP who though personal illness or family illness either withdraws or provides a reduced participation in the on-call roster, which is in turn compensated for and agreed by the remaining GPs who form the local emergency roster

• a GP due to pregnancy or child rearing commitments either withdraws or reduces their participation in the on-call roster, which is in turn compensated for and agreed by the remaining GPs who form the local emergency roster

• a GP proceduralist who is one of a small number locally that participate in a complete 365 day procedural roster, provides at least a 25% full time equivalent participation in the complete emergency roster, which is in turn compensated for and agreed by the remaining GPs who form the local emergency roster

• a CHSALHN endorsed on-call arrangement where a limited number of hours on-call availability is provided locally (eg before a designated time in the evening) and support at other times is provided through an on-call emergency services roster at a nearby larger hospital. Payment for on-call availability will be paid in accordance with SARMFA (Version 4) clauses 3.17, 3.18 and 3.19.

Where a GP registrar is a party to a standard GP Agreement but does not support local GPs in the provision of inpatient after hours emergency services, irrespective of location, they will not be eligible for the additional 7.1% loading to the MBS fee-for-service rate.

GP proceduralists will be eligible for an additional fee-for-service loading for the provision of anaesthetic and surgical items (20.0% each) and obstetrics (50.0%) for public inpatients services. In designated locations where an applicable procedural on-call roster is funded by CHSALHN, it is a requirement for the proceduralist to participate in a complete 365 day roster.

In exceptional circumstances, a medical practitioner may apply to the Executive Director Medical Services for consideration of eligibility for the inpatient consultation loading and for sign up to the standard GP Agreement.

(1) In situations where there is a general requirement for two or less GPs with responsibility for the supply of the Emergency on call roster, special consideration will be given where the local medical workforce cannot sustain a 365 day commitment to the roster but is willing to enter into a workable local solution that may involve occasional remote on call cover after hours.

3. Payments

3.1 Fee For Service (FFS) and Billing

3.1.1 CHSALHN shall remunerate the medical practitioner in accordance with the terms of ‘SAMSOF for SARMFA’.

3.1.2 The payment of invoices for services shall be made via Electronic Funds Transfer (EFT) within 20 business days of receiving a compliant claim (refer 3.1.11).
3.1.3 The medical practitioner 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 contracting medical practitioner (refer definition Country Health SA Rural General Practitioner Fee For Service Agreement) shall advise CHSALHN of its Australian Business Number (ABN) and quote the ABN on all claims for payment. The contracting medical practitioner is defined in Country Health SA Rural General Practitioner Fee For Service Agreement clause 1.1.9 and Schedule 1 item 1.

3.1.5 Where the contracting medical practitioner is an individual, that persons 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 contracting medical practitioner shall immediately advise CHSALHN 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 contracting medical practitioner to CHSALHN is a taxable supply. If the contracting medical practitioner is registered for the Goods and Services Tax (GST), and

- if CHSALHN calculates the amount payable for services rendered by the contracting medical practitioner, the medical practitioner shall submit claims on a CHSALHN standard worksheet and shall enter into a Recipient Created Tax Invoice (RCTI) Agreement with CHSALHN for the term of their contract for services,

or

- if the contracting medical practitioner calculates the amount payable by CHSALHN, the medical practitioner shall provide CHSALHN with a valid tax invoice requesting payment. Should the contracting medical practitioner cease to be registered for GST purposes, or become aware of any reason why the GST registration may be cancelled, the contracting medical practitioner shall advise CHSALHN.

3.1.8 If the medical practitioner is terminated, CHSALHN shall thereupon pay all fees to which the medical practitioner is then entitled to within 20 business days of

- receipt of a valid tax invoice detailing the medical services rendered, where the medical practitioner calculates the amount payable; or

- CHSALHN generating a Recipient Created Tax Invoice where CHSALHN 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 CHSALHN.

3.1.11 Minimum payment requirements

FFS claims (worksheet or Tax Invoice) should be itemised per patient and must contain the minimum following information:

- the patient/clients full legal name (hospital patient sticker preferred on worksheet)
- patient/client status (i.e. Public, Veteran)
- patient’s Date of Birth or Medical Record number
- service item number (from Schedule 1)
- date of service
- time the service was initiated
- either the duration of the service, or the time the service finished, for all time related items, except Consultation Levels A and B
- the medical practitioner’s name and provider number

If submitting Tax Invoices, the following information is also required.
- the relevant cost for the service
- the GST amount clearly identified

Claim Payments
Claims will be paid within 20 business days (refer clause 3.1.2) subject to the above minimum information and signed declaration (worksheet only) or a Tax Invoice being submitted. Claims may be audited in accordance with clause 3.1.12 which may result in the recovery of payments made to Medical Practitioners.

Episode of Care payment
The Episode of Care claim duration (time claimed from service initiation to service finish when completed cumulatively or consecutively) includes the clinical and associated administrative work, such as the completion of the required patient discharge summary or patient transfer documentation.
On-call
For 'on-call' charges the amount can be charged as a lump sum or daily rate but must
be accompanied by a breakdown of the daily rate, a roster showing the date of
attendance and the number of days at the applicable rate. Where on-call for a 24 hour
period is shared by two or more medical practitioners, a pro-rated payment is applicable
in accordance with clause 3.19 for each medical practitioner.

After-hours fees
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.

Claiming on-call allowances and DVA patients
It is preferable for on-call allowances and Department of Veterans’ Affairs (DVA)
acquittal reporting purposes that one account for a complete month is submitted within
10 business days of the end of that month to be fully remitted in that month.

Benefits of RCTI Agreement & worksheet claims
Country Health SA encourages Medical Practitioners to sign RCTI agreements which
enables prompt payment to be prepared based on the information from the worksheet
(Daily In-patient Fee For Service Record). If a Tax Invoice is submitted for multiple
patient claims and there are errors with the items and claim amounts the invoice will be
returned for amendment and resubmission which may delay payment.

3.1.12 Audits
Consistent with best practice standards, CHSALHN conducts audits from time to time.
Audits are only conducted on a random basis or where CHSALHN can reasonably
suspect that a practitioner’s claims are outside a range comparable to their peers.

The audit process involves the use of staff with a clinical background and focuses on
documented evidence to support the claim submitted by the medical practitioner. Prior
to Country Health SA raising a concern about a medical practitioners claim with the
practitioner, the claim will first be reviewed by a medical practitioner with relevant
experience.

Where supporting clinical evidence is not found the medical practitioner will be notified
and invited to supply the required information, or if the incorrect item has been claimed
the medical practitioner will be invited to submit a revised request for payment.

Declaration Required
A declaration is included on the worksheet:

- I hereby claim payment of the medical services specified above, provided in
  respect of the hospital patients.
- This claim is consistent with clinical notes I documented in each patients’
  medical record.
- I understand my claim may be audited and the payment may be recovered if the
  minimum standards required for payment are not met.
Disputes about claims or payments
If the medical practitioner disagrees with the outcome from this process, clause 6, ‘Disputes about claims or payments’ is available for actioning by the medical practitioner.

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.

CHSALHN will provide a daily list of patients and their status (ie private, DVA, public) relevant to the medical practitioner.

3.4 After hours GP services, emergency services and outpatient/inpatient services interface

3.4.1 After Hours GP services

In the majority of South Australian country hospitals, GP after hours services are available at the hospital normally in the emergency service area. Under the National Health Reform Agreement (2011) this is provided under Clause G21.

It states “In those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own GP, either as part of continuing care or by prior arrangement with the doctor.”

Most medical practices in the region of CHSALHN use the infrastructure and nursing support of CHSALHN health emergency service areas for provision of after hours services to their patients. Thus patients attending the hospital for these services may be charged Medicare Benefits Schedule items and gap payments where appropriate.

Those hospitals that have onsite GP after hours services are listed on the CHSALHN website: http://www.sahealth.sa.gov.au/

3.4.2 Emergency services

When a patient is seen in the CHSALHN hospital emergency area and then decision is made to admit as a public inpatient the hospital will be billed for the full attendance and services. For those services billed to CHSALHN a charge may not occur to the patient or to Medicare for the same service.

3.4.3 Outpatient

Private outpatient services are also provided in hospitals as per the National Health Reform Agreement 2011 under clause G21.
3.4.4 Inpatient

An inpatient (including same day admitted patients) is a patient who is receiving care that involves a prolonged procedure or a post-procedural recovery period; whereas the non-admitted patient is receiving simpler and less prolonged treatment. Patients having chemotherapy and scopes are treated as outpatients in all cases unless otherwise approved.

3.4.5 Outpatient/Inpatient Interface

In South Australian country hospitals, (with the exception of Mount Gambier, South Coast and, “after hours” Upper Spencer Gulf Agreement parties (Port Augusta, Port Pirie, and Whyalla) outpatient and GP after hours 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 for emergencies that present to the hospital/health service and include patients who present with surgical, medical, obstetric and mental health concerns.

3.4.6 Rural Emergency Responder Network

A Rural Emergency Responder Network (RERN) has been established across CHSALHN to provide appropriate cover to medical practitioners who are prepared to attend out of hospital emergencies close to their geographic base.

Membership of the RERN is voluntary for medical practitioners and requires that once accepted and registered for the RERN they make themselves available to attend emergency situations when called by the South Australian Ambulance Service Emergency Operations Centre (EOC).

The RERN offers a clearly defined structure which ensures appropriate remuneration and professional support for these out of hospital situations. The medical practitioner can invoice CHSALHN as detailed in procedures for members of the RERN. For such attendances, from the period of time from when they were called until the time when they return to the local CHSALHN hospital, payment will be as per clause 3.7 ‘Emergency Care”. Where CHSALHN has remunerated the RERN GP there is to be no charge to the patient but CHSALHN may charge appropriately to external funders such as insurance companies for overseas patients.
Medical practitioners not part of the network will also be paid for the time spent assisting the patient in an out of hospital situation from the time they were called until the time that they return to the local health unit or alternative site at the rate of the rate of $249.20 per hour prorated in 15 minute intervals. Payment will only be made to the practitioner if they are called by the local hospital or ambulance service to attend the emergency.

3.4.7 Multi-Purpose Services

Across CHSALHN there are a number of health services that have become or will become a Multi-Purpose Services (MPS). The impact of this change for medical practitioners is that Aged Care residents newly admitted to a Commonwealth funded MPS bed after a certain date (which varies between MPSs), 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 individuals as is the case in other Commonwealth residential aged care facilities.

Existing ‘Nursing Home residents’ as at the time of conversion of the hospital 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 hospital 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 hospital to an MPS. Each MPS will maintain a list of grandfathered patients present at the time of the MPS becoming operational.

As at September 2011, health service sites situated at the following locations may have grandfathered residents:

- Burra
- Coober Pedy
- Crystal Brook
- Cummins
- Hawker
- Kingston
- Laura
- Meningie
- Penola
- Quorn
- Snowtown
- Tailen Bend
- Tumby Bay
- Waikerie
3.5 Hospital to Hospital Transfer

All acute patients requiring observation and/or stabilisation to be transferred from one hospital to another from within CHSALHN by ambulance should be admitted to their hospital of presentation. An inpatient fee for service billing applies on this occasion.

Where it has been agreed, (based on clinical need as discussed between the local medical practitioner and the on duty medical officer for the South Australian Ambulance Service Emergency Operations Centre), that the local medical practitioner accompany a patient in the ambulance, the medical practitioner is to be remunerated at the rate of $249.20 per hour prorated at 15 min intervals for the trip to the receiving hospital and the return trip in the ambulance.

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 any Special Fee for Service Payments.

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 practitioner's undivided attention for continuous life-saving emergency treatment, the following criteria and fee structure has been determined:

- Emergency item numbers 160-164 +6% (Prolonged Professional Attendance) may only apply to a service on a patient in Triage Category 1 and 2, where the medical practitioner is required for more than one hour.
- A patient requiring treatment for whom the emergency number being paid would need to have a triage Category 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 +6% would apply.
- Attendances of one hour or more (MBS Items 160-164 +6%) are paid on a prorated basis calculated on completed and partial 15 minute intervals.
- Where two or more doctors are required to attend urgently to treat a patient in an emergency situation both are eligible to claim. Both doctors must document their role in management and attendance times.
- GPs will also be paid a rate of $249.20 per hour (prorated at 15 minute intervals) for time spent travelling when called to the hospital during scheduled consulting times for Triage Category 1 and 2 situations.
<table>
<thead>
<tr>
<th>ATS Category</th>
<th>Response</th>
<th>Description of Category</th>
<th>Clinical Descriptors (indicative only)</th>
</tr>
</thead>
</table>
| 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  
- 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)  
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:  
- Significant sedative or other toxic ingestion  
- Significant/dangerous envenomation  
- Severe pain suggesting PE, AAA or ectopic pregnancy  
Behavioural/Psychiatric:  
- violent or aggressive  
- immediate threat to self or others  
- requires or has required restraint  
- severe agitation or aggression |
The following table represents the structure for payments:

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

<table>
<thead>
<tr>
<th></th>
<th>Mon – Fri 0800 – 1800</th>
<th>Mon – Fri 1800 to 2300</th>
<th>Mon – Fri 2300 to 0800</th>
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<td>Sat 0800 – 1200</td>
<td>Sat 1200 to 2300</td>
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<td>Sun &amp; PH 0800 to 2300</td>
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<td>Less than 1 hr</td>
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<td>Item 597 ) +6%</td>
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<td>Less than 2 hrs</td>
<td>Item SAMSOF 160 +6%</td>
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<td>Less than 3 hrs</td>
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<td>Less than 4 hrs</td>
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3.7.2 Where a medical practitioner is required to attend a hospital to provide emergency care to more than one patient, and the patients 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 60 for the initial two hours and then pro-rated on completed and partial 15 minute intervals for every hour thereafter
- if the emergency care is initiated after hours, the ‘After Hour Payment Rules’ will apply (see clause 3.11)
- any other relevant procedural fees 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

3.7.3 Obstetric Emergency Antenatal Consultation

3.7.3.1 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.
3.7.3.2 **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 +6% applies.

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

- less than one hour attendance – item SAMSOF 50 +6%;
- attendance of one hour or more – refer to most recent description in MBS for item numbers 160-164 inclusive. The payment rates will be items 160-164 +6% (which equates to MBS items 160-164 plus a 50% loading) to be paid on a prorated basis calculated on completed and partial 15 minute intervals;
- if the emergency care is initiated after hours - the ‘After Hour Payment Rules’ will apply (see clause 3.11);
- any other relevant procedural fees - are payable until the emergency care ceases and/or the patient is transferred to another centre;
- where a definitive procedure occurs – (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.

3.8 **Other Medical Practitioners**

“Other Medical Practitioners” (as defined in the MBS) 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 for SARMFA’ reflect this point).

3.10 **Scope Procedural Rates**

For the purposes of payments for colonoscopy, endoscopy and oesophagoscopy services as approved by CHSALHN, 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 public outpatient.
3.11 After Hours Attendances and Payments

3.11.1 Definitions

After hours shall be defined as being:

3.11.1.1 Monday to Friday from 1800 to 0800 the following morning;
Saturday from 1200 to 0800 the following morning,
and
Sunday/Public Holidays from 0800 to 0800 the following morning.

3.11.1.2 Eligibility for claiming after hour payments (item 597) – refer to the most recent version of MBS on line having been used for the purpose of updating SAMSOF as at 1\textsuperscript{st} of December and 1\textsuperscript{st} of July as may be applicable.

3.11.1.3 Descriptions of Level A, B, C, and D – refer to the most recent version of MBS on line having been used for the purpose of updating SAMSOF as at 1\textsuperscript{st} of December and 1\textsuperscript{st} of July as may be applicable.

3.11.1.4 Description of Level E is for complex cases requiring an extended consultation which lasts 90 minutes or longer is paid at $220 (for after hours or generally refer clause 2 and 3.11.2.3). Level E is not contained within the current MBS and has been introduced specifically by Country Health SA in recognition that complex cases require an extended consultation.

3.11.1.5 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 After Hours Inpatient Consultations

Payment for all after hours inpatient consultations item 597 (refer clause 2 and 3.11.1.2) paid with a loading of 10.1% of the Medicare Benefits Schedule (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 hours to 23:00 hours as per item 597;
23:00 hours to 08:00 hours as per item (597 fee + 50%).

3.11.2.2 Level C and D:

18:00 hours to 23:00 hours as per item 597 fee + the fee for Level C or D (whichever is applicable);
23:00 hours to 08:00 hours as per (item 597 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 (ie 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 597 service, further services are provided to that patient or further patients, during an unbroken period of attendance at the hospital, the item 597 fee is not chargeable. Remuneration for these services will be provided according to the ‘SAMSOF for SARMFA’ Schedule.

3.11.2.3 **Level E**

18:00 hours to 23:00 hours as per item 597 + $220 Level E fee

23:00 hours to 08:00 hours as per item 597 fee + 50% + $220 Level E fee

Note level E also applies separately for General consultations refer clause 2 and 3.11.1.4

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 hours to 23:00 hours as per item 25025 fee + the ‘SAMSOF for SARMFA’ fee for the procedural item;

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

Additional cases added 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 3.11.1.1 of this document.

3.11.3.2 **Surgical:**

18:00 hours to 23:00 hours as per item 597 +3% fee + the ‘SAMSOF for SARMFA’ fee for the procedural item;

23:00 hours to 08:00 hours as per ((item 597 + 50%) +3%) fee + the ‘SAMSOF for SARMFA’ fee for the procedural item.

For the purposes of payments for item 597, the definition of after hours shall be in line with 3.11.1.1 of this document.
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 3.11.

### 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 most recent version of MBS) there can be a separate charge raised. This charge shall apply to the mother as the baby is not normally a separately admitted person during the period following birth. The medical practitioner called to resuscitate the baby at delivery will be paid from the requested arrival time to await delivery until the baby 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 MBS there are three item numbers that relate to Electrocardiography (ECG).

#### 3.14.1 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 most recent version of the MBS).

#### 3.14.2 Item 11701

(Twelve-lead Electrocardiography, report only), should be used where the ECG tracings are referred to a medical practitioner for a report without an attendance on the patient by that medical 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.

#### 3.14.3 Item 11702

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

### 3.15 Availability/On-call Allowance

#### 3.15.1 ‘On-call’

‘On-call’ is defined as being a service which has been determined to be essential by Country Health SA to meet the public need at a CHSALHN hospital 24 hours a day, 7 days a week. GPs that are rostered on-call to a CHSALHN hospital must be able to reach the hospital within 40 minutes of being contacted.

#### 3.15.2 An On-call Allowance is paid per 24 hour period for provision of after hours services at a CHSALHN hospital:
3.15.3 An on-call period commencing on Monday to Thursday inclusive is paid at $265 per 24 hour period commencing at 08:00 hours for Anaesthetics or Obstetrics and $292 for Emergency.

3.15.4 An on-call period commencing on Friday/Saturday/Sunday or Public Holiday is paid at $662 per 24 hour period commencing at 08:00 hours for Anaesthetics or Obstetrics and $728 for Emergency.

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.

3.16 On-call eligibility

All medical practitioners are required to be on-call as specified in Clause 2 “Eligibility” of this document and as specified in Schedule 3 of the Rural General Practitioner Fee for Service Agreement.

3.17 On-call services provided to a remote site from the base site

3.17.1 There will be one payment only per provider in recognition of their on-call availability. The exception to this ruling is where a practitioner is required to cover two or more hospitals during any one 24 hour period. The locations should ideally be no more than 30 minutes apart if travelling by road. Payment will be calculated as per clauses 3.17.2 to 3.17.6.

3.17.2 If the medical practitioner is providing on-call to two or more locations and routinely attend the remote hospitals to treat all patients after hours, they will be eligible for an additional payment of 50% of the applicable on-call payment for each of the additional locations covered.

3.17.3 If the medical practitioner is providing on-call to two or more locations and elects to routinely provide patient care by video-conference to the remote site, they will be eligible for an additional payment of 50% of the applicable on-call payment irrespective of the number of subsequent sites that after hours on-call is being provided.

3.17.4 For those services provided by videoconference (and thereby covered by the additional payment of 50% of the applicable on-call payment) a charge may not occur to the patient or to Medicare for the same service.

3.17.5 In the event that the Medicare Benefits Schedule is amended to include general practitioner non-admitted patient services by video-conferencing, CHSALHN reserves the right to withdraw entitlements under items 3.17.3 and 3.17.4

3.17.6 If the medical practitioner routinely provides on-call to two or more locations and routinely elects to provide patient care instructions to nursing staff over the telephone, a telephone consult is claimable.

An item ‘TC001’ will be claimable on a per call basis for telephone advice provided between 08:00 and 23:00 hours, and ‘TC002’ will be claimable on a per call basis payable for telephone advice provided between 23:00 and 08:00 hours.
TC001 and TC002 are respectively paid at $23.05 and $30.69 per telephone call and will be indexed on 1 July each year by the Adelaide CPI.

3.17.7 On-call payments of 50% cannot be charged in a given month if the medical practitioner is not routinely providing services by video-conference or is claiming either items ‘TC001’ and ‘TC002’ for the provision of telephone advice. The GP is to determine which method of engagement he or she prefers and this advice is to be clearly provided to staff in advance at the base and remote hospitals being covered.

3.18 Multiple on-call payments at one location

3.18.1 Where there is approval from CHSALHN for a range of services to be available 24 hours a day, 7 days a week, there will be an on-call availability payable to each resident practitioner with appropriate scope of practice who is on the roster for an identified 24 hour period.

3.18.2 If the medical practitioner has the recognised Credentials to justify a dual role (e.g. GP Medicine and GP Obstetrics) they will be paid only one on-call payment for a given 24 hour period.

3.18.3 Appendix 1 identifies all on-call services per location and those services approved. Any changes to Appendix 1 must be supported by CHSALHN within the agreed service delineation framework for each cluster.

3.19 Shared on-call payment within a 24 hour period at one location

Where an on-call roster is shared between multiple practitioners and there is a 24 hour availability provided, a pro-rated hourly rate will be paid to each practitioner based on the applicable daily rate.

In the example where two doctors provide 8 and 16 hours respectively over a 24 hour period, payments would be made at 8/24ths and 16/24ths of the applicable daily rate.

3.20 Special Fee-For-Service Payments

3.20.1 Anaesthetic and Surgical Procedural item numbers shall have a loading of 20% on the MBS fee.

3.20.2 Obstetric item numbers (16500–16636) shall have a loading of 50% on the MBS fee.

3.20.3 Obstetric item numbers (16500–16636) are not subject to after hours loadings (refer to clause 3.11).

3.21 Sessional Payments

Sessional complicated obstetric and anaesthetic payments are an option for medical practitioners at larger selected country sites that are providing obstetric and anaesthetic services of sufficient volume. The sessional payments model is an alternate to the traditional fee-for-service and on-call payments model and if chosen, requires a commitment of all eligible medical practitioners within the respective location.
A combination of sessional and fee-for-service payments within the same clinical domain is not possible; however, different payment models can apply for obstetric and anaesthetic services in the same location where supported locally.

The sessional payment model is not an option at those sites using the salaried model of engagement for obstetric or anaesthetic services.

Receipt of a sessional payment does not preclude the medical practitioner from providing other medical services unrelated to services covered by the sessional payment.

Negotiation and sign up to the Sessional Payment model can occur at any stage and will continue for the remainder of the term of the Agreement.

### 3.21.1 Obstetric Sessional Payments

Sessional payments for complicated obstetric services is an option at sites expected to perform more than 250 public and private births per year, with the total of 250 being attainable through the inclusion of nearby sites where a local commitment is given to a collaborative approach to the provision of obstetric services.

The sessional payment requires the medical practitioner to provide all public inpatient medical obstetric services covered by:

- MBS items 16500 to 16636
- SAMSOF50, SAMSOF60 and MBS items 160-164 when related to an Obstetric Emergency Antenatal consultation as described under clause 3.7.2 within SARMFA
- Planned and unplanned caesarean sections
- On call obstetric services for the 24 hour session
- may include some teaching and supervision responsibilities.

Where only one Obstetric Sessional payment per session applies locally, the medical practitioner providing assistance at a caesarean section will be paid FFS for their assisting role.

Where the GP Obstetrician who is in receipt of the sessional payment for the session requires a second GP Obstetrician to perform the caesarean section, a pre-agreed local protocol will need to be in place whereby CHSALHN is limited to only paying the one sessional payment and FFS for the assisting role.

In those hospital groupings where emergency caesarean sections can safely be provided at more than one site, it is possible to rotate the location for emergency caesarean sections based on a roster that mirrors the on-call availability of medical practitioners.

The sessional payment provides a guaranteed income for medical practitioners engaged through the sessional payment model for the provision of public obstetric services.
A 24 hour sessional payment commences at 08:00 and is paid at $1816 per 24 hour period. The sessional payment rate will be indexed on 1 July each year by the Adelaide CPI for the year concluding at the March quarter prior to this date.

When rostered for a given session, the medical practitioner may work within their practice setting subject to them giving first priority during the session to the delivery of public obstetric services.

In addition to receiving the sessional payment, medical practitioners are able to admit patients and retain all income generated from the provision of private patient services and fee-for-service generated by the provision of non-obstetric public services.

Sites considered potentially suitable for sessional payments for the provision of public obstetric services include:
- Berri
- Mount Barker
- Murray Bridge
- Port Pirie
- Port Augusta
- Port Lincoln

Medical practitioners interested in considering the Obstetric sessional payment for their location should contact their Regional Rural Director.

### 3.21.2 Anaesthetic Sessional Payments

Sessional payments will apply for emergency and elective anaesthetic services, the provision of support in the event of a life-threatening emergency, major trauma or other circumstance as may be clinically appropriate, and some teaching and supervision responsibilities.

In addition to the sessional payment, a theatre list payment may also be applicable where the historic or prospective anaesthetic workload across elective lists (at the location), demonstrate an overall reduction in the total funding that would otherwise be paid under the fee for service model for anaesthetic services.

A sessional payment commences at 08:00 and is paid at $1816 per 24 hour period.

The sessional payment and any theatre list payment (as may be deemed appropriate for the location) will be indexed on 1 July each year by the Adelaide CPI for the year concluding at the March quarter prior to this date.

Sites considered potentially suitable for Anaesthetic sessional payments include:
- Port Lincoln
- Wallaroo
- Murray Bridge
- Mount Barker
- Berri
- South Coast
- Gawler
- Clare
Where due to local demands on theatre access time it is necessary to schedule two elective lists concurrently, the anaesthetic list of lesser value (based on the MBS for listed public cases) is to be provided by the anaesthetist who is not in receipt of a sessional payment on that day. In this situation, Fee for Service will be the means of payment to the anaesthetist who provides public anaesthetic services for those patients on the elective list of lesser value.

When rostered for a given session, the medical practitioner may work within their practice setting subject to them giving first priority during the session to the delivery of anaesthetic services and support in the event of a life threatening emergency, major trauma or circumstance as may be clinically appropriate.

Medical practitioners interested in considering the Anaesthetic sessional payment for their location should contact their Regional Rural Director.

3.22 Hospital Initiated Clinic Call Out within the Medical Practice Business Hours

The Hospital Initiated Clinic Call Out Item ‘HICCO’ can be used in situations where the medical practitioner is called back to their hospital during booked consulting sessions for events not already covered under the SAMSOF for SARMFA emergency item numbers.

An applicable consulting fee and/or procedural item number including ECG, CTG, IVT, baby resuscitation and assistance at non-booked (emergency) LSCS, is payable at 100% of the Medicare Benefits Scheme rate when accompanied by a claim for HICCO for public inpatients.

Routine post-operative management (where included as part of the global fee), deliveries and assessment in labour are not eligible to be accompanied by a claim for HICCO.

Payment is only applicable where the interruption is significant, requires the medical practitioner to be recalled to the hospital from their clinic and be absent for at least 30 minutes during a booked morning or afternoon consulting session, and where patients have to be rescheduled. There is to be clear documentary evidence indicating the arrival and departure time of the medical practitioner, the reason for the call back to the hospital and medical services provided.

Call outs that do not intrude by at least 30 minutes into a booked morning or afternoon session, or occur during a normal lunch break or after completion of an afternoon session for the usual consulting times for the practice, will not be eligible for this payment.

This payment will be a $112.88 for the first half hour and $56.44 for each 15 minutes on a pro-rated basis thereafter.

Eligibility for a travel payment will apply where the return distance between the medical practice and hospital by the nearest route is greater than 40 kilometres.
This item does not apply where a patient presents at the Emergency Department during business hours and is assessed as not requiring urgent medical attention. In this situation, the patient is either referred to the medical practice for treatment by their medical practitioner, or is attended at the hospital at a later time by their medical practitioner.

The applicable rate will be indexed on 1 July each year by the Adelaide CPI for the year concluding at the March quarter prior to this date.

(1) Interpretation of call back can include situations where the medical practitioner, although not yet at the practice to undertake a scheduled consultation session, is required due to an acute clinical episode needs to remain at (or return to) the hospital to provide patient care that could not be rescheduled until later in the day. Such instances do not extend to the inclusion of life threatening emergencies that fall outside of the scope of this item.

### 3.23 Safe working hours payment

The Safe Working Hours payment (SWH001) applies across all sites for medical practitioners when providing overnight cover in the following situations:

- an Anaesthetic or Obstetric roster under the standard FFS arrangement.
- an Emergency roster in a grant funded hospital under the standard FFS arrangement.

The payment recognises circumstances where a medical practitioner may be rostered on-call and experiences limited sleep due to significant interruptions between the hours of midnight and 06:00 hours due to providing public emergency and inpatient care commitments that adversely affect the medical practitioners practice the following day.

The Safe Working Hours payment will apply when any of the following criteria are met, and the medical practitioner after completion of the overnight shift is so affected that they declare themselves unfit to undertake a previously booked full consulting session within their clinic on the day the overnight shift finishes:

- the medical practitioner is required to attend the hospital in person for at least 2 hours consecutive or not during the hours of midnight to 06:00 hours and receive other contact from the hospital in relation to patient care issues
- the medical practitioner has received 4 or more requests to attend the hospital to assess and treat patients during the hours of midnight and 06:00 hours whether in attendance when a second or subsequent request to attend occurs

For the purposes of this item, cancelled clinic consulting sessions are limited to weekdays (Monday to Friday).

All claims for the Safe Work Hours payment are to be submitted on a dedicated Safe Work Hours claim form.

The applicable rate is $792, which is indexed annually on 1 July each year by movement in the Adelaide CPI (All groups) for the year concluding at the immediate prior March quarter.

Payment of SWH001 is limited to one cancelled average three and half hour session on a given business day.
3.24 Determination that life is extinct

The issue of a death certificate is not payable; however, an attendance on an inpatient at which it is determined that life is extinct can be claimed under the appropriate attendance item.

The benefit payable is for the attendance component only and is generally payable as a consult level B.

In the case of a deceased person being brought into the hospital, fee for service cannot be claimed but a claim through Medicare is applicable for the purpose of determining that life is extinct.

Where a person presents in an emergency department and treatment is instigated by the medical practitioner prior to life being extinct, the patient is to be admitted and fee-for-service is claimable for the admitted patients episode of care.

3.25 Payment for Individuals involved in a motor vehicle accident that was initially assessed as being eligible for compensation but is subsequently declined eligibility

Country Health SA would encourage all medical practitioners to utilise the option to submit claims via the bulk claim process – refer 4.6.2

Where claims may have been submitted by the medical practitioner directly to the Motor Vehicle Accident appointed compulsory third party insurer and the episode of care is deemed unclaimable or is rejected by the insurer.

The health service will approve payment of any fee-for-service inpatient claim relating to that episode of care, subject to verification through a copy of the rejection letter from the insurer, or in a single vehicle accident through the notes made at the time by the medical practitioner or the South Australian Ambulance Service. The rates to be paid are as per this agreement.

Payment will not be made for any claims:
- where ‘fault’ cannot be determined (eg a multiple vehicle accident where the matter should be referred to the insurer to determine who was the driver at fault)
- if patient chooses to voluntarily waive their right to compensation
- if a patient fails to submit a claim to an insurer where compensation would be claimable

A claim form needs to be completed and the supporting documentation provided whenever a claim is made.

4. Other Allowances, Payments and Support
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, clause 9, or appropriate clause in any subsequent agreement.

Principal Medical Officers will be appointed at the discretion of the Executive Director Medical Services, Country Health SA Local Health Network.

4.2 Clinical Audits, Clinical Safety and Quality Activities and Service Planning Meetings

Country Health SA (CHSALHN) is committed to the delivery of safe and quality health services across country South Australia.

The provision of safe and quality services is aligned to the Australian Commission on Safety and Quality in Health Care accreditation standards, the Clinical Services Capability Framework, and is embedded within a matrix governance structure.

CHSALHN acknowledges that medical practitioner involvement in the safety and quality governance is essential to ongoing quality improvement at site level, regional level and across the Local Health Network (LHN).

To support CHSALHN in achieving a comprehensive safety and quality framework, medical practitioners will be remunerated at a rate of $226.40/hr with a minimum one (1) hour payment (then prorated at 15 minute intervals) and when participating directly in approved meetings or activities. Each medical practitioner is required to attend a minimum of two (2) meetings per year. This payment will be indexed on 1 July each year by the Adelaide CPI for the year concluding at the March quarter prior to this date.

Compulsory meetings / activities may have a local, regional or LHN wide focus, may be multi-professional, and could include, but not limited to:

- clinical safety and quality improvement activities
- CHSALHN initiated clinical audits; e.g. peri-operative, obstetric
- health service accreditation
- development and implementation of models of care
- health service planning
- health service performance; e.g. potentially preventable admissions, hospital acquired complications, unwarranted clinical variation.

Attendance at designated meetings or activities will, wherever possible, be authorised in advance by the CHSALHN staff member assigned responsibility for the relevant area (“Director Medical Services”) in consultation with the relevant Regional Director. The Director of Medical Services will provide a list of eligible safety and quality activities, and include terms of reference and membership information.

Nominated relevant medical practitioners are expected to fulfil the roles and responsibilities of members as outlined in the terms of reference.
A list of participants will be notified by CHSALHN to finance for authorisation of payment. Unless otherwise approved, meeting payments do not include payment for preparation time.

This payment should not be confused with remuneration or reimbursement for the undertaking of professional development activities of a personal nature (Clause 5.3), the delivery of clinical care (e.g. case conferences or clinical handover) or investigation of performance related issues.

Where the hospital requires attendance of a medical practitioner at a pre-arranged meeting specifically regarding accreditation of a hospital or as a member of a formal committee (e.g. CHSALHN Credentialling and Scope of Clinical Practice Advisory Committee), the medical practitioner shall be paid an allowance calculated at the rate of $226.40/hr with a minimum one (1) hour payment (then prorated at 15 minute intervals), and will be indexed on 1 July each year by the Adelaide CPI for the year concluding at the March quarter prior to this date. Reading time applies for up to two (2) hours at half the agreed hourly meeting rate.

Fees applicable under this item do 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 subcommittee of the Health Advisory Council or as a Health Advisory Council representative on another SA Health committee
- medical practitioners on Advisory Committees (unless formal approval has been obtained from SA Health) or Ministerial Advisory Committees of SA Health

4.3 Enterprise Patient Administration System (EPAS)

SA Health will be implementing an Enterprise Patient Administration System across all of South Australia's public health care facilities to improve clinical work practices. In particular, an EPAS will support the provision of better integrated care by allowing timely multiple electronic access to clinical information across multiple sites.

At the time of preparing this statement, EPAS is undergoing continued development and refinement in selected locations across the health system before being implemented more broadly across all sites. The intent of this ongoing work is to achieve a quality product that is fit for purpose and delivers the required level of integration which allows timely access to clinical information and improved clinical work practices. To this end, CHSALHN is committed.

Following further refinement it will become a requirement for all medical practitioners to become competent in the use of EPAS in a timely manner and to implement it in full once their local hospital goes live with the new product.

In recognition of this change in work practice and the need to become proficient in entering and using the information stored, there will be an initial one off training and set up payment to the medical practitioner, and ongoing support and resources provided to ensure the effective implementation of the new system.
The one off payment will be authorised through the supply of a list by an authorised trainer once the medical practitioner has satisfactorily completed the required training components and commences using EPAS for their patients.

The one off payment will be $1500 per medical practitioner and is not transferable to someone else to undertake the required training on their behalf.

GP Registrars who are in effect only on placement within a rural setting are not eligible for the one off payment but will receive training as required in the use of EPAS

4.4 Locum Arrangements

4.4.1 RDWA Locum Support

GPs may be eligible for locum support through the RDWA GP Locum Program which provides fully funded or substantially subsidised locum placements (depending on the GPs category) in order that resident rural GPs can take planned leave. CHSALHN is a major funder of this program.

Medical practitioners should contact the RDWA for further details regarding registration, support arrangements and eligibility criteria.

4.4.2 Fully funded locum placements

Where a GP is registered for the GP Locum Program and is in receipt of a fully funded locum as part of their annual entitlement, the on-call allowance and fee for service (generated through the provision of public inpatient services) will not be payable by CHSALHN.

Medicare billings that are generated in the medical practice and through the provision of non-admitted after hours services are assigned to the resident GP.

4.4.3 Procedural locum support

Where the usual local availability of GP Proceduralists is such that a minimum commitment of 1 night in 3 is required to maintain a complete 365 day procedural on-call roster, the location will be eligible to receive six (6) weeks procedural locum support in each financial year for the applicable procedural roster. The six (6) weeks procedural locum support will be distributed evenly between the participating GP proceduralists who form the complete local roster.

For those medical practitioners already eligible for support through the RDWA GP Locum Program, they will have the ability to convert their existing entitlement from a non-procedural locum to an appropriately skilled procedural locum.

4.4.4 Determination of eligibility in exceptional circumstances will be referred to the Chief Medical Advisor, CHSALHN, for consideration.
4.5 Travel Allowances

4.5.1 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 CHSALHN, a travel allowance shall be payable. The allowance shall be applicable for the proportion of round trips in excess of 40 kilometres.

4.5.2 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.

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

4.6 Support in collecting fees from designated admitted patient types not covered by Medicare

Items 4.6.1 & 2 are opting in processes initiated at the discretion of the respective treating medical practitioner.

4.6.1 When providing patient care to an overseas admitted patient who is thought not to be covered under Medicare, the medical practitioner can elect to seek payment for medical services provided to the patient by the use of the CHSALHN appointed Collection Agency – AusHealth. The alternate is for the medical practitioner to seek payment direct from the patient or their Travel insurance provider.

The rate to be invoiced is not restricted to the Public Patient rates or MBS rates. Medical Practitioners are able to use AMA recommended rates.

Invoices for submission to AusHealth must be;
- GST Compliant
- Invoice raised in the name of the patient for the services provided
- have Bank Account details for payment to be made into (EFT Payments only)
- Submitted within 7 days of patient being discharged.
- Forwarded to the CHSALHN Fee for Service Officer for the respective hospital site where the services were provided.

Upon receipt of the invoice from the medical practitioner, CHSALHN will forward to AusHealth who will commence the collection process.

Fees will be remitted to the medical Practitioner from Country Health SA upon receipt of payment from Aushealth through SSSA Accounts Payable process minus a 24% Aushealth Service fee.

Medical Practitioners (or their representative) will be required to follow up the progress of the collection direct with AusHealth on 1800 724 457.
Where upon checking by the Collection Agency the status of the patient is such that they are deemed eligible to receive free medical care in Australia (eg under a Reciprocal Healthcare Agreement with Australia for non-existing medical conditions, and certain Visa types etc.), the medical practitioner will be advised and FFS will be payable.

4.6.2 When providing care to an admitted patient involved in a motor vehicle accident covered by the South Australian Third Party arrangement, the medical practitioner has the option of seeking payment for medical services from CHSALHN through the Motor Vehicle Accident Commission appointed insurance provider.

The alternate approach is for the medical practitioner to seek payment from the patient through the Motor Accident Commission appointed insurance provider.

The rate to be invoiced is not restricted to the Public Patient rates or MBS rates. Medical Practitioners are able to use recommended AMA rates.

Invoices are to be provided by the 8th working day of the next month to ensure it is submitted in the current month bulk claim process.

Invoices must be;
- GST Compliant
- Contain date of accident
- State “The services provided are in relation to an injury sustained from a motor vehicle accident.”
- have Bank Account details for payment to be made into (EFT Payments only)

On receipt of the invoice, CHSALHN will submit the invoice as part of the Bulk Claim process for submit.

The medical practitioner is guaranteed payment at 80% for in scope services when electing to seek payment through this process.

Funds received by CHSALHN from the Compulsory Third Party (CTP) Regulator on behalf of the medical practitioner will be processed through the SSSA Accounts Payable process.

The payment will be remitted for collected fees minus a 20% fee remission (which is retained by the Insurer).

4.7 GP Regional Delegates

Six GP Regional Delegates are to be trialled for the life of the Agreement from 1 December 2017

A total of six GP Regional Delegates will be appointed, one for each CHSALHN defined region:
- South East
- Barossa Hills Fleurieu
- Yorke and Northern
- Riverland Mallee Coorong
- Eyre and Far North
- Flinders and Upper North

Each GP Regional Delegate position will be selected annually on a consensus basis by contracted GPs at a regional level through a transparent process overseen by CHSALHN.

In the unlikely event that a consensus cannot be reached at a Regional level, a process overseen by the AMA(SA) will occur in the respective region.

GP Regional Delegates will
- be responsible for ensuring their advice generally reflects the collective opinion of rural GPs in the designated region.
- participate in four (4), two (2) hour meetings per annum (quarterly) with the Executive Director of Medical Services, of which two of the four meetings will also include the regionally responsible Director of Medical Services.
- be remunerated at $226.40 per hour for attendance at meetings that may occur by video conference.

There will be the ability to utilise GP Regional Delegates as a reference point, and for one off advice, if there are region specific medical workforce issues or any significant service model changes being proposed. In the latter case, CHSALHN will request ad hoc / special purpose meetings, which will only occur with the agreement and support of the designated GP Regional Delegate.

Any meetings above the planned four a year will be scheduled with the aim of minimising any impact on the designated GP Regional Delegate private practice arrangements.

Prior to the end of each 12 month term, GP regional and CHSALHN delegates will meet to evaluate the strengths, weaknesses and achievements of the GP Regional Delegate structure. The evaluation agenda will include:
- determining trial success indicators & measures
- opportunities to improve the structure of the GP Regional Delegate role
- what key issues have arisen & their solutions.

4.8 Critical Incident Debriefing

Country Health SA will involve the relevant medical practitioner in the on-site Critical Incident Debriefing counselling for any critical incident in which they were involved in a Country Health SA facility. Critical incident debriefing occurs as a standard process after a traumatic or violent incident.

In any instance where a medical practitioner, together with other SA Health employees, has been exposed to a potentially traumatic incident and the above Critical Incident Debriefing counselling has been offered or provided, the medical practitioner is open to access further Employee Assistance Program (EAP) counselling through an SA Health approved EAP provider. The medical practitioner can access a maximum of four counselling sessions by contacting the EAP provider directly and reference that the request for counselling relates to an SA Health related traumatic event. This is in line with the SA Health Employee Assistance Program Policy Directive. SA Health approved EAP providers directly provide advice on flexible options for accessing counselling services as relevant for country South Australia. Contact details for current SA Health EAP providers are available during Critical Incident Debriefing or from the local hospital.
5. Grants and Incentives

5.1 Medical Indemnity Support Grant

Medical practitioners under the Country Health SA Local Health Network 2017 Rural General Practitioner Fee-for-Service Agreement are eligible to receive the Medical Indemnity Support Grant.

To access a copy of the Medical Indemnity Support Grant application form, visit the SA Health website at http://www.sahealth.sa.gov.au or email HealthGPAgreement@sa.gov.au

Payments of Medical Indemnity Grants will promptly be made to medical practitioners from the date of receipt of all the required information by CHSALHN.

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 CHSALHN 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 medical practitioner, and
3. a completed Medical Indemnity Support Grant Application form

Responsibility of Country Health SA Local Health Network:
CHSALHN will send the information provided by the Medical Practitioner to the GP Agreements team, calculation of payment due and forwarding to Shared Services SA for prompt payment.

CHSALHN 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

Delays may occur when the wrong or incomplete information is provided and in these situations a 20 business day timeframe can only begin once CHSALHN 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 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 CHSALHN. 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 they are eligible for the Medical Indemnity Support Grant when purchasing Medical Indemnity cover.

Responsibility of CHSALHN:
CHSALHN will validate medical practitioner eligibility directly with MIGA.

5.2 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.

5.3 Professional Development Grant

There may 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 Continuing Professional Development events where Commonwealth subsidies may apply.

6. Disputes about claims or payments

To reduce disputes over the payment of fees, medical practitioners are advised that every claim needs to be supported through adequate documentary evidence within each patients’ hospital medical record to support the respective FFS items being claimed.

Claim rejection by CHSALHN
When a claim has been audited (refer clause 3.1.12) and rejected by CHSALHN this assessment will be advised in writing to the medical practitioner.

- At that moment, either party is deemed to be making no admission of liability
- No party may take any further action in relation to the original claim except through the Rural General Practitioner Fee For Service Agreement clause 14 ‘Dispute Resolution process’

Medical Practitioner agrees with claim rejection
If the medical practitioner agrees to CHSALHN assessment:

- Repayment of paid claim within 30 days or by agreed instalment where it is reasonably apparent that there is incapacity to pay.
- resubmission of amended claim if applicable

Medical Practitioner disagrees with claim rejection
DMS Meeting – meeting requested with respective Director Medical Services (or nominee) within business 10 days. If no agreement is reached on the claim assessment, the medical practitioner can request that the dispute is referred in writing to Executive Director Medical Services (EDMS).
Executive Director Medical Services – The EDMS with advice from an experienced medical practitioner selected with a relevant clinical background will consider the claim within 10 business days. A decision will be communicated to the medical practitioner in writing.

If the medical practitioner remains in dispute, the matter may be referred to a panel of three medical practitioners that CHSALHN, the Rural Doctors Association of South Australia, and Australian Medical Association (South Australia) collectively agree are experts in the interpretation of the fee schedule as at the introduction of this agreement. Wherever possible the people selected should have special expertise in the area of conflict.

The Panel will hear both points of view individually and then discuss the matter jointly to ensure that each party has had a chance to hear the other party’s point of view. Following the hearing of this information the panel must provide a unanimous or majority decision in writing within two (2) business days.

The Flowchart (refer Appendix Three) is a part of this Clause 6 Disputes about claims or payments. The Flowchart is the method by which disputes are managed.
SCHEDULE 1

SOUTH AUSTRALIAN MEDICAL SCHEDULE OF FEES RELATING TO THE SOUTH AUSTRALIAN RURAL MEDICAL FEE AGREEMENT
‘SAMSOF for SARMFA’

In accordance with ‘Item 1’, this document is updated on the 1\textsuperscript{st} of December and the 1\textsuperscript{st} of July of each year by CHSALHN to reflect movement in the most current Medicare Benefits Scheme (“MBS”).

A copy of the latest version is available from:

## APPENDIX ONE

### ON-CALL AVAILABILITY

The following describes the on-call services, listed by health service location, that are agreed as being potentially available on a 24/7 basis.

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 a public funded on-call roster for emergency, it would be expected that doctors will be part of the emergency roster unless arrangements with the remaining local doctors allows for them to be covered for this commitment. In respect of this expectation, refer also, clause L of the Agreement and item 8.5 of the Country Health SA Rural General Practitioner Fee For Service Agreement.

<table>
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<tr>
<th>Region</th>
<th>Health Service</th>
<th>Emergency(2)</th>
<th>Anaesthetics</th>
<th>Obstetrics</th>
<th>Surgery</th>
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Note: The table above shows the on-call services provided by public funding. The 'Emergency(2)' column indicates the availability of emergency services, while the other columns show the availability of specific medical services. The 'GP After Hours provided on site' column indicates the number of doctors available outside regular hours.

---

2. This column refers to the availability of emergency services, which may vary depending on the specific roster.
## PUBLIC FUNDED ON-CALL SERVICES

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<th>Region</th>
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(1) Item 3.4.1 relates

(2) GP After Hours and Emergency Services on-call are generally provided by the same individual
Options available when the standard configuration of services as defined within SARMFA require a location specific solution

While the standard (Base) Agreement is considered appropriate for the needs of most locations across country, it is recognised that for some locations there are unique circumstances where the standard Agreement requires special consideration in order to meet local service needs while maintaining a consistent and equitable approach to the remuneration and support of contracted Medical Practitioners. In all cases, a medical practitioner is required to be under a current contract as an employee or service provider in order to deliver public medical services in a CHSALHN health service.

The need for special consideration generally results from restrictions upon the local GP workforce preventing maintenance of inpatient services and the required number of complete on call rosters appropriate to the needs of the health service.

Special consideration may be requested by either the local medical workforce or CHSALHN, with the outcome dependent on the potential to develop a sustainable cost effective workforce solution for the location.

Examples of locally applied considerations include:

- Obstetric services at Berri and Mount Barker operate under the Sessional Payment model
- Emergency services at Whyalla, Port Augusta and Port Pirie operate under a modified Sessional Payment model (Upper Spencer Gulf Agreement) due to a long standing arrangement between the Commonwealth and State.
- Acute inpatient and emergency services are provided by a locum medical workforce at Millicent.
- Emergency services at Gawler, Berri and Mount Barker operate under special funding models
- Anaesthetic services at South Coast and Naracoorte operate under the Sessional Payment model

In future, special considerations of the standard Agreement will require that the local service model:

- provide for an appropriate 365 day, 24 hour service solution for the required location(s)
- have a hospital based public patient service construct,
- give priority to ensuring an emphasis on quality and safety in the provision of clinical services
- plan for flexibility within the medical workforce while being consistent and aiming for sustainability
- support an appropriate skill mix including General Practitioners, Rural Generalists and Specialists with access to professional development/training and clinical support
- be based on collaborative partnerships for maximising impact and outcomes
- embed best practice as the way of doing business
- continue the current Outpatient/Inpatient interface arrangement as described in clause 3.4.5 (in this document), where any alternate provider of services would need to be eligible to invoice through Medicare for non-admitted patient services
- be cost effective and affordable

Key elements appropriate in a move to a location specific public model of service delivery could consist of:
- sessional payments for anaesthetic and/or obstetric services based on volumes and service mix
- a hybrid workforce model involving an appropriate mix of GP, Rural Generalist and Specialist input, with individual practitioners engaged on a contracted or salaried basis.
- the creation of part time salaried training positions for rural GP Registrars to work in larger health services to support the provision of emergency and procedural training.

Larger sites considered eligible for the granting of a site specific public solution include:
- Mount Gambier
- Whyalla
- Gawler
- Berri
- Port Lincoln
- Port Augusta
- Port Pirie
- Murray Bridge
- Mount Barker
- South Coast
- Naracoorte
- Wallaroo
SARMFA Agreement – Fee For Service Claims Dispute Resolution

Dispute about claims or payment

No Admission of liability by either party

Medical Practitioner Disagrees

Medical Practitioner Agrees

No party may take any further action in relation to the original claim except through Agreement Clause 14 “Dispute Resolution”

Repayment of paid claim within 30 days or be agreed instalment where it is reasonably apparent that there is incapacity to pay.

Resubmission of amended claim

Meeting with Director Medical Services for potential resolution

Resolved

Not Resolved

Written referral of dispute to Executive Director Medical Services for decision

Panel of 3 experts agreed CHSLIN / AMA (SA) / RDASA

Panel majority or unanimous decision is final

Dispute is closed

Repayment / Resubmission maybe required by Medical Practitioner dependant upon advice from panel

Claim Processed
CHSA Site:
Medical Officer: 
Service Date: 

* I hereby claim payment of the medical services specified below provided in respect of the hospital patients
* This claim is consistent with clinical notes I documented in each patients’ medical record

I understand my claim may be audited and the payment may be recovered if the minimum standards required for payment are not met

Signature: 
Date: 

FFS Officer: 

Date Processed: 

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Total

DAILY IN-PATIENT FEE FOR SERVICE RECORD

CHSALHN FFS Officer Only

SARMFA GP Agreement - RDASA 2017