Administrator
National Health
Funding Pool

Business rules for determining July to December 2012 hospital services eligible for Commonwealth funding

Volume 1

Proof of concept

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Document Control Sheet

Document Information

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Approval

Title	Administrator of the National Health Funding Pool
Name	Bob Sendt
Signature	
Date	

Title	NHFB Chief Executive Officer
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Date	

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Preface

I am pleased to present the first iteration of the business rules for determining hospital services eligible for activity based funding (ABF) in 2012-13, and wish to thank all jurisdictions for their involvement in their development. These business rules arise from clauses A6 and A7 of the National Health Reform Agreement (the Agreement), and deal with potential "double dipping" between hospital services and MBS and PBS claims.

Matching hospital services data to MBS and PBS data using a common Medicare PIN has never been undertaken before. I acknowledge states' and territories' concerns about both the evidence in relating hospital services to MBS and PBS claims, and the unknown financial impact of this process on them as we transition into the growth years of national health reform. In recognising these concerns, I have decided that this matching process will, as part of the first six monthly reconciliation between estimated and actual hospital service data from July to December 2012, be conducted on a 'proof of concept' basis only. Any hospital services being assessed as ineligible for funding due to matching with MBS or PBS claims, will not be incorporated into any adjustment of LHN ABF funding relativities within each state or territory, or into any adjustment of Commonwealth cross border ABF liabilities across states and territories, for the July to December 2012 reconciliation period.

This 'proof of concept' will be an opportunity for all stakeholders to participate in and become more comfortable with the data matching process. Any revision of the business rules or other changes to the reconciliation process identified from this 'proof of concept' stage will be implemented as part of the annual reconciliation for the full 2012-13 financial year. The business rules will continue to evolve, with stakeholder input, over each six monthly reconciliation period, taking into account learnings from prior reconciliation periods, including process and data improvements.

The fundamental principle in implementing the intent of clause A6 in the Agreement, is that I will only assess a hospital service (or part of that hospital service) as having been funded through an MBS or PBS claim if it can be clearly established that the particular MBS or PBS claim was part of the funding for the hospital service.

The privacy, secrecy and security of all data provided by jurisdictions are of particular importance to me. Systems and processes used for collection, storage and reporting have been designed to ensure security of information. Where data may be considered 'personal information' within the meaning of the *Privacy Act 1988*, its collection and use are in accordance with the Information Privacy Principles in that Act and with the secrecy and patient confidentiality provisions in the *National Health Reform Act 2011* and other statutory protections. I will be working with jurisdictions to ensure that the processes surrounding the collection and use of the required data for this matching process are as rigorous and transparent as possible. I will also work with states and territories and the Commonwealth to develop agreed practices for the provision of information back to jurisdictions and any dissemination of information more broadly.

RJ Sendt
Administrator
National Health Funding Pool

1 Introduction

The business rules for determining hospital services eligible for Commonwealth ABF funding in 2012-13 should be viewed in the context of the reconciliation process overview shown in Appendix C.

For 2012-13, these business rules will be used in the context of the data requested in the Administrator's *Determination 03: Provision of actual 2012-13 hospital services data for reconciliation with estimated data*". For 2013-14 onwards, these business rules will be further refined and documented in the context of the data requested in the Administrator's 2013-14 three year rolling data plan.

The Independent Hospital Pricing Authority (IHPA) determines the hospital services in scope for ABF funding for 2012-13, and states and territories provide data detailing these in scope hospital services for confirmation of eligibility by the Administrator.

1.1 Document purpose

The purpose of this document is to:

- Provide the business rules for confirming the 2012-13 ABF hospital services which are eligible for National Health Reform Commonwealth ABF funding, considering the 'double dipping' provisions in clauses A6 and A7 of the National Health Reform Agreement (the Agreement).

  Only ABF hospitals are eligible for Commonwealth ABF funding (Refer to section 12.6 for a list of ABF hospitals)

  The business rules form the 'intent' for an agile process which will match data on hospital services with data in the Medicare Benefits Schedule (MBS) on Medicare claims and with data in the Pharmaceutical Benefits Scheme (PBS) on prescriptions filled, informed by patterns and limitations observed in the actual data.

  Hospital services which are matched to MBS or PBS and are assessed as ineligible for funding will be reported to states and territories. States and territories will be given a time-limited opportunity to review these and indicate, where appropriate, why these matched services should be funded.
- Provide an opportunity for stakeholders to participate in the confirmation of the business rules.

1.2 Document structure

This document is organised according to the following structure:

- **Matching principles** (section 2) outlines the intent of matching hospital services with MBS, PBS, or any other Commonwealth programs.
- **Data preparation** (sections 3 to 5) details what is needed to prepare the data for matching.
- **Initial matching** (section 6) performs a basic level of matching to set up for an iterative and more detailed matching process. Supporting process diagrams are shown, providing a further level of detail for the matching process overview in Appendix D.

- **Detailed matching** (sections 7 to 10) provides a more detailed level of matching designed to operate through an investigative process, informed by patterns and limitations observed in the actual data. Supporting process diagrams are shown, providing a further level of detail for the matching process overview in Appendix D.
- **Matching scenarios and decision paths** (Appendix A). Illustrates particular situations where a hospital service may match to MBS or PBS, showing the path that each scenario takes through the detailed process flows, in the context of the Appendix D process overview.
- **Reference data requirements** (Appendix B). Requirements for reference data are listed.
- **Reconciliation and matching process overviews** (Appendix C and D). These overviews together provide a context for the matching process diagrams provided in sections 6 to 10.

1.3 Data matching

In accordance with clause A6 of the Agreement, patient identified data on MBS and PBS and other Commonwealth programs will be compared to patient identified data provided by states and territories, based on Medicare PINs (de-identified Medicare numbers). Where there is a match, these services will be reviewed to determine whether they remain eligible for Commonwealth activity based funding.

Clause A7 of the Agreement identifies exceptions to the principle outlined in clause A6.

Any service that has been matched will be reviewed by using relevant elements (for example date of birth and gender) contained within both the patient services data and MBS, PBS and other Commonwealth programs data. Appropriate information about identified matches will then be communicated to states and territories for their review.

Only services that remain eligible following the data matching process will be used to calculate actual National Weighted Activity Units (NWAU) feeding into the reconciliation and adjustment process for National Health Reform Commonwealth activity based funding.

1.4 Privacy considerations

As stated in clauses B87 and B94 of the Agreement:

B87 Privacy of individual healthcare users is paramount and will be protected at all times. The agencies referred to in clause B97 will collect, secure and use information in accordance with relevant legislation and National Privacy Principles, ethical guidelines and practices in order to protect the privacy of individuals. To give effect to this commitment, the Commonwealth will consult with relevant privacy stakeholders on Commonwealth-related data aspects of this Agreement.

B94 Where patient identified data is required, States will provide that data with patients identified by a Medicare Card Number to the Commonwealth Department of Human Services. The Department of Human Services will then de-identify that data and provide it to the relevant national body. Where patient identified data is required it will be subject to existing Commonwealth statutory protections of individuals' privacy.

1.5 Related documents

The business rules in this document should be read in conjunction with the following documents, which collectively detail the Administrator's requirements for the end to end reconciliation process (refer Appendix C for a reconciliation process overview).

- Determination 03: Provision of actual 2012-13 hospital services data for reconciliation with estimated data, and
- 2012-13 Reconciliation Framework.

This document also is also intended to be consistent with the Administrator's rolling Three Year Data Plan covering the period 2013-14 to 2015-16 and the Commonwealth contribution calculation methodology.

2 Principles for matching hospital visits to MBS/PBS

2.1 Principles for all services provided in public hospitals to admitted private patients

All services provided in *public* hospitals to *admitted private* patients are eligible for funding (discounted via the private patient adjustment), and so are excluded from matching to MBS or PBS. This is consistent with exceptions listed in clauses A7b and A7d.

2.2 Principles for all hospital services to public patients

These principles apply to services provided in *public* hospitals to *public* patients, and services provided in a *private* hospital to *public* patients.

Based on a previous analysis of hospital services and MBS and PBS claims, there are expected to be some 'double dipping' matches of MBS imaging and pathology claims to non-admitted hospital services, and fewer matches in other areas involving PBS matches to non-admitted services and MBS or PBS matches to public admitted or emergency department hospital services. The focus in 2012-13 will therefore be on matching non-admitted consultations with MBS imaging and pathology services. The focus of analysis is further limited to medical practitioners not in a GP role by examining MBS providers that have a derived specialty recorded.

The fundamental principle in implementing the intent of clause A6 in the Agreement, is that the Administrator will only assess a hospital service (or part of that hospital service) as having been funded through an MBS or PBS claim if it can be clearly established that the particular MBS or PBS claim was part of the funding for the hospital service.

The general principles are:

- Hospital services that public hospital doctors perform while working on public hospital time which are matched to MBS or PBS claims may not be eligible for funding.
- Any hospital service that has been matched to MBS or PBS claims based on a common Medicare PIN will be confirmed by using relevant data elements (for example date of birth and gender) common to hospital services data and MBS and PBS claims data.
- Generally, for public admitted patients who did not take leave during their hospital stay, if a medical practitioner not in a GP role referred an MBS service or wrote a PBS script within the dates recorded for the hospital stay, then the hospital service should not be eligible for Commonwealth funding in the 2012-13 period.

Ideally, the data should be analysed to understand whether the MBS service or PBS script was related to the condition for which the patient was admitted. However, there are very significant challenges with this, and for the 2012-13 period there is insufficient information to reliably match hospital diagnoses and conditions to relevant MBS conditions or PBS drugs. The Administrator will participate in initiatives to establish agreed rules for identifying MBS services and PBS drugs linked to conditions being treated in hospital services. In advance of these rules, some admitted patient services may remain eligible even where an MBS service or PBS script is related to the admitted service.

2.3 Principles for MBS exemptions under subsection 19(2) of the *Health Insurance Act 1973* (re NHRA clause A7a)

Subsection 19(2) background

Subsection (ss) 19(2) provides:

> *Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:*
>
> *a) the Commonwealth;*
>
> *b) a State;*
>
> *c) a local governing body; or*
>
> *d) an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.*

The purpose of ss19(2) is to prevent 'double dipping', that is, where a single medical service is paid for twice – for example by a state or territory through a medical practitioner's salary or other source, and by the Commonwealth through a Medicare benefit.

However, the Commonwealth has long taken the view that it is possible for salaried medical practitioners employed within state and territory hospitals to exercise rights of private practice whilst working within those hospitals, and to claim fees (medical benefits) in respect of those professional services.

In general, the 'rights of private practice' approach is consistent with ss19(2). Where salaried medical practitioners are rendering professional services on their own account, or under an arrangement or contract between them and the patient, the transaction does not fall within the terms of ss19(2) and accordingly, payment of medical benefits is permitted.

In this context, the purpose of ss19(2) is effectively to ensure a clear demarcation between professional services rendered to public patients which are paid for by states and territories, and professional services rendered to private patients in respect of which Medicare benefits are payable by the Commonwealth. Ss19(2) does not prohibit private practice arrangements between state and territory health authorities and employed medical practitioners, which permit private practice using public hospital facilities.

In seeking to apply ss19(2) more broadly, the issue is whether professional services for which Medicare benefits are claimed are rendered 'under an arrangement with' one or more of the entities listed in ss19(2).

Where, for example, private practice arrangements permit or contemplate the provision of professional services to private patients by salaried practitioners; but do not require or direct those practitioners to provide professional services to private patients, this is likely to be consistent with ss19(2) – i.e. is not likely to constitute an 'arrangement' for the purposes of ss19(2). Where practitioners agree to provide professional services to private patients, as contemplated by their private practice agreements, they will do so under an arrangement between the patient and the medical practitioner. Normally in such cases, there will not be an arrangement between the patient and, for example, a state or territory authority.

Subsection 19(2) principles

Subsection 19(2) exemptions can apply at two levels. Either the establishment (hospital) has a 19(2) exemption, or individual patient services are 19(2) exempt where identified by states and territories.

- An establishment (hospital) may have a 19(2) exemption based on a location under one of the directions noted below. If it does, then all services at that facility are 19(2) exempt, and no matching is required to MBS. However matching is still required with PBS.
- If a service is identified by states and territories at the patient level as related to a 19(2) direction (as allowed for in Submission B data in the Administrator's Determination 03), then no matching is required to MBS. However matching is still required with PBS.

Active subsection 19(2) *Health Insurance Act 1973* directions as of January 2013 are outlined below.

The challenge is to be able to associate locations specified under these *directions* with the establishment (hospital) for each hospital service in order to establish a hospital level 19(2) exemption.

Table 1 – Active subsection 19(2) directions

#	Title	Signed date	End date
1	SA – Parks, Port Adelaide, Women's Health, Second Story Health Services	26 Jun 2009	30 Jun 2013
2	TAS – Clarence, Risdonvale, Flinders Island Health Services	26 Jun 2009	30 Jun 2013
3	QLD – Inala Health General Practice	26 Jun 2009	30 Jun 2013
4	Royal Flying Doctor Service – Rural Women's General Practice Service	1 Mar 2011	30 Jun 2014
5	OATSIH[1] QLD Government	13 Jun 2011	30 Jun 2014
6	OATSIH NT Government	13 Jun 2011	30 Jun 2014
7	Aboriginal Community Controlled Health Services	19 Sep 2011	30 Jun 2014
8	Nurse Practitioner – Aged Care Models of Practice Program	1 Sep 2011	30 Jun 2014
9	Diabetes Care Project	19 Dec 2011	30 Jun 2014
10	COAG Better Access to Primary Care WA	16 Feb 2012	30 Jun 2015
11	COAG Better Access to Primary Care NT	8 Mar 2012	30 Jun 2015
12	COAG Better Access to Primary Care NSW	6 Jun 2012	30 Jun 2015
13	COAG Better Access to Primary Care QLD	16 Jul 2012	30 Jun 2015

[1] Office for Aboriginal and Torres Strait Islander Health

2.4 Principles for Pharmaceutical Reform Agreement exemptions (re NHRA clause A7c)

Pharmaceutical Reform Agreements have been signed between the Commonwealth and all states and territories, other than NSW and ACT. However, within states and territories that have signed, not all hospitals have enrolled as “reform” hospitals. There is a need to record and utilise an attribute indicating Pharmaceutical Reform Agreement participation at hospital level.

Hospitals participating in the pharmaceutical reform agreement have access to the PBS for non-admitted and admitted patients *on discharge*.

2.5 Principles for exemptions under the Highly Specialised Drugs program

HSD program background[2]

Highly Specialised Drugs (HSD) are subsidised through the PBS. These medicines are for the treatment of chronic conditions that, because of their clinical use or other special features, are restricted to supply through public and private hospitals that have appropriate specialist facilities. To prescribe these medicines under the Pharmaceutical Benefits Scheme (PBS), medical practitioners must be affiliated with these specialist public or private hospital units. A medical practitioner or non-specialist hospital medical practitioner, who is not affiliated with the public or private hospital, may only prescribe HSD to provide maintenance therapy under the guidance of the treating specialist affiliated with the public or private hospital.

The HSD program is a joint initiative of the Commonwealth and state and territory governments.

In 2008, the Council of Australian Governments (COAG) agreed to stop funding public patient access to HSD through Special Purpose Payments (SPP) to states and territories, and fund these payments through a new Commonwealth Own Purpose Expenditure (COPE) mechanism.

As part of this change, the Department of Human Services (DHS) started administering the HSD program and PBS trastuzumab early stage (Herceptin®) program with payments being initially made to state and territory health departments through an offline claiming solution.

The legislative basis of this program is an arrangement made under section 100 (s100) of the *National Health Act 1953 (NH Act).*

From 1 July 2010, DHS began providing an electronic paperless online claiming and payment process for all public hospitals supplying HSD. Electronic claiming and payment is via DHS existing Online Claiming for PBS claiming channel.

Public hospitals that want to claim HSD under this initiative will need a section 94 (s94) approval (or section 100 in the case of non-dispensing public hospitals) under the *NH Act* which will allow them to supply PBS medicine.

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[2] Sourced from: http://www.medicareaustralia.gov.au/provider/pbs/highly-specialised-drugs/

Special arrangements are in place under s100 of the *NH Act* to allow HSD to be claimed by non-dispensing public hospitals. Non-dispensing public hospitals will need a s100 approval under the *NH Act* which will allow them to claim HSD.

A non-dispensing public hospital is allowed to use an agent for the supply of HSD provided the non-dispensing public hospital has obtained s100 approval. Non-dispensing public hospitals will be treated as if they were approved under s94, for the purposes of claiming under this program.

HSD are listed under section 100 of the Pharmaceutical Benefits Schedule (PBS) and are listed as Authority required (streamlined authority code) for public hospitals, with the exception of Complex Authority Required (CAR) medicines and trastuzumab which will remain as Authority required. An authority approval is required for HSD increased quantities and HSD increased repeats. The medical practitioner does not need prior approval from DHS when prescribing Authority required (streamlined authority code) HSD for public hospital HSD clinic patients. In order to supply the medicine as a PBS benefit, the public hospital pharmacist should make sure the medical practitioner has included the four digit streamlined authority code on the prescription. Streamlined codes are not for HSD patients in private hospitals and cannot be dispensed in community pharmacies.

To gain access to a government funded medicine under this program, a patient must attend a participating hospital and be a:

- day admitted patient
- non-admitted patient, or
- patient on discharge.

A government subsidy is not available for hospital in-patients. Patients must also be under appropriate specialist medical care, meet the specific medical criteria and be an Australian resident in Australia (or other eligible person).

HSD program principles

All PBS HSD claims should be matched with hospital services as for any other PBS claim, except for hospitals approved to claim HSD drugs, and only under the following circumstances:

- If a hospital service for a day admitted patient, or non-admitted patient is matched to a PBS HSD claim, then that service is *eligible* for funding (subject to assessment of other factors)
- If an admitted hospital service is matched to a PBS HSD claim where the PBS script was written on the day of discharge, then that service is *eligible* for funding (subject to assessment of other factors).

3 Prepare hospital service data for matching

3.1 Prepare patient level service data

For non-admitted aggregate data, establish if any establishments (hospitals) reported in the aggregate data also exist in non-admitted patient level data. If so, then to avoid double counting, consult with the state or territory to resolve and resubmit the data.

For each category of patient level service (admitted, non-admitted and emergency department), the following steps must be carried out:

1. Apply the following criteria to the selection of patient services:
    - All services must have been provided in an ABF hospital.
    - If there are multiple hospital services in the same category (admitted, non-admitted and emergency department) provided on the same day to the same patient, then these services must be excluded from the selection for matching, as they cannot be matched conclusively to an MBS or PBS service.
    - For admitted services, only include in the selection for matching:
        - Services where the "admitted service leave days" is zero (if there are any leave days, this puts an unacceptable element of doubt into any MBS or PBS match).
        - Services which have the IHPA specified funding source for ABF as follows[3]:

Attachment B – Funding source and election status values in-scope for ABF

Funding source[20]	Election status[21]	Public hospitals (Establishment Sector[22] 1)	Private hospitals (Establishment Sector[23] 2)
01 Australian Health Care Agreements	All values	Public	Public
02 Private health insurance	All values	Private	Out of scope
03 Self-funded	All values	Private	Out of scope
04 Worker's compensation	All values	Out of scope	Out of scope
05 Motor vehicle third party personal claim	All values	Out of scope	Out of scope
06 Other compensation	All values	Out of scope	Out of scope
07 Department of Veterans' Affairs	All values	Out of scope	Out of scope
08 Department of Defence	All values	Out of scope	Out of scope
09 Correctional facility	All values	Out of scope	Out of scope
10 Other hospital or public authority (contracted care)	1 Public	Public	Public
	2 Private	Public	Out of scope
	9 Not stated	Public	Out of scope
11 Reciprocal health care agreements (with other countries)	All values	Public	Public
12 Other	All values	Out of scope	Out of scope
13 No charge raised	All values	Out of scope	Out of scope
99 Not stated	All values	Out of scope	Out of scope

[3] From IHPA National Pricing Model Technical Specification 2012-2013

        - Public patient services. This includes services provided in *public* hospitals to *public* patients, and services provided in a *private* hospital to *public* patients. (services provided in *public* hospitals to *admitted private* patients are automatically eligible for funding and so are excluded from this selection for matching to MBS or PBS)
    - For non-admitted services, only include in the selection for matching:
        - services where the tier 2 clinic is 10 or 20 (indicates a consultation)

2. Sort <category> patient services (Table1) by state record identifier and establishment identifier.
3. Sort <category> submission B data received from states and territories via DHS (Table 2) by state record identifier and establishment identifier.
4. Merge Table1 and Table 2 by State record identifier and establishment identifier, into a new table "<category> Service with PIN", identifying in the dataset any Table 2 rows which didn't match to a Table1 row, and listing them in an exception report for follow up with the relevant state or territory.

Note that services provided in public hospitals to admitted private patients are included in these data as they are eligible for funding (at a discounted rate) and do not need to be matched to MBS and PBS claims.

The outcome of this process should be three datasets:

- Admitted service with PIN.
- Non-admitted service with PIN
- Emergency department with PIN

along with up to three exception reports for follow up with the relevant state or territory.

4 Prepare MBS claims data for matching

MBS claims are made for Medicare services subsidised by the Commonwealth government.

For admitted patients, it is important to focus on MBS services provided in hospital (Hospital indicator is 'H'), but if at least one matching MBS service was provided in hospital for a patient, also look at the MBS services provided to the patient out of hospital.

For non-admitted patients, the hospital indicator is not relevant.

Note that the term 'hospital' may mean different things in the MBS or Hospital service context.

A view of MBS data needs to be prepared that includes:

Specific columns from the MBS claims data as identified in the attachment to the Administrator's Determination 03.

Rows from the MBS claims data where ALL of the following statements are true:

- The date of service is greater than or equal to 1 July 2012, and less than or equal to 31 December 2012
- The requesting/referral reason is NOT in the following list:
  P (possible self-determined, Lost or emergency)
  L (lost) *(the reason for this rule is that we don't want to match MBS services from lost referrals. If a referral is lost and has to be replaced, and if the new referral date is on the same date as an outpatient consult, this may cause an incorrect match)*
- The MBS service type is NOT in the following list: (these are duplicate records co-located for ease of analysis – but we don't want these)
  Q (Patient claim by referring provider)
  E (Direct bill by referring provider)
  I (Private health by referring provider)
- The MBS line type is NOT in the following list:
  R (Rejected record)
  X (Substantiation of fee paid)
  W (Pathology coning reject)
  I (Information line for anaesthetics)
  H (Identifies services transferred to history where an overpayment has occurred or line suppressed)
- The MBS service is NOT a reversal of another service (Adjust reason for a reversal will be "ORG") *(check rules set up in EDW for MBS – reversals may already be handled – also check that an original service subsequently found to be fraudulent and reversed is handled correctly – if there is a fraud and the claim is reversed, the original claim shouldn't be present to wrongly cause a match)*
- The MBS service was NOT provided by a GP (refer to reference table of provider numbers). There may be situations where we want to look at MBS services performed by a GP, but for this first reconciliation, we only want to focus on specialist MBS services

- The MBS Category and Group is *present* in the below table of MBS Categories and Groups for MBS services which can be performed by medical practitioners not in a GP role (non-GPs).

> ***Note:*** *Some groups are not in this table because they require a GP visit first to develop a plan e.g. allied health.*

Table 2 – MBS Categories and Groups for services which can be performed by non-GPs

Category	Group	Item	Group name
1	A03	(All)	Attendances – Specialist
1	A04	(All)	Attendances – Consultant Physician
1	A08	(All)	Attendances – Consultant Psychiatrist
1	A11	(All)	Attendances – Urgent Attendance After Hours
1	A12	(All)	Attendances – Consultant Occupational physician
1	A15	820-838, 855-866, 871, 872, 880	GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
1	A21	(All)	Attendances – Medical Practitioner (Emergency Physician)
1	A24	(All)	Pain and Palliative Medicine
1	A26	(All)	Attendances – Neuro-Surgery Attendances
1	A28	(All)	Attendances – Geriatric Medicine – Consultant or Specialist
1	A29	(All)	Attendances – Early Intervention Services for Children with Autism, Pervasive development disorder
2	(All)	(All)	Diagnostic Procedures
3	(All)	(All)	Therapeutic Procedures
4	(All)	(All)	Oral and Maxillofacial Services
5	(All)	(All)	Diagnostic Imaging Services
6	P01	(All)	Pathology Services – Haematology
6	P02	(All)	Pathology Services – Chemical
6	P03	(All)	Pathology Services – Microbiology
6	P04	(All)	Pathology Services – Immunology
6	P05	(All)	Pathology Services – Tissue Pathology
6	P06	(All)	Pathology Services – Cytology
6	P07	(All)	Pathology Services – Genetics
6	P08	(All)	Pathology Services – Infertility And Pregnancy Tests
7	(All)	(All)	Cleft Lip and Cleft Palate Services

5 Prepare PBS claims data for matching

Under the PBS, the Commonwealth government subsidises the cost of medicine for most medical conditions. Most of the listed medicines are dispensed by pharmacists, and used by patients at home.

An extract of PBS claims data needs to be prepared that includes:

Specific columns from the PBS claims data as identified in the attachment to the Administrator's Determination 03.

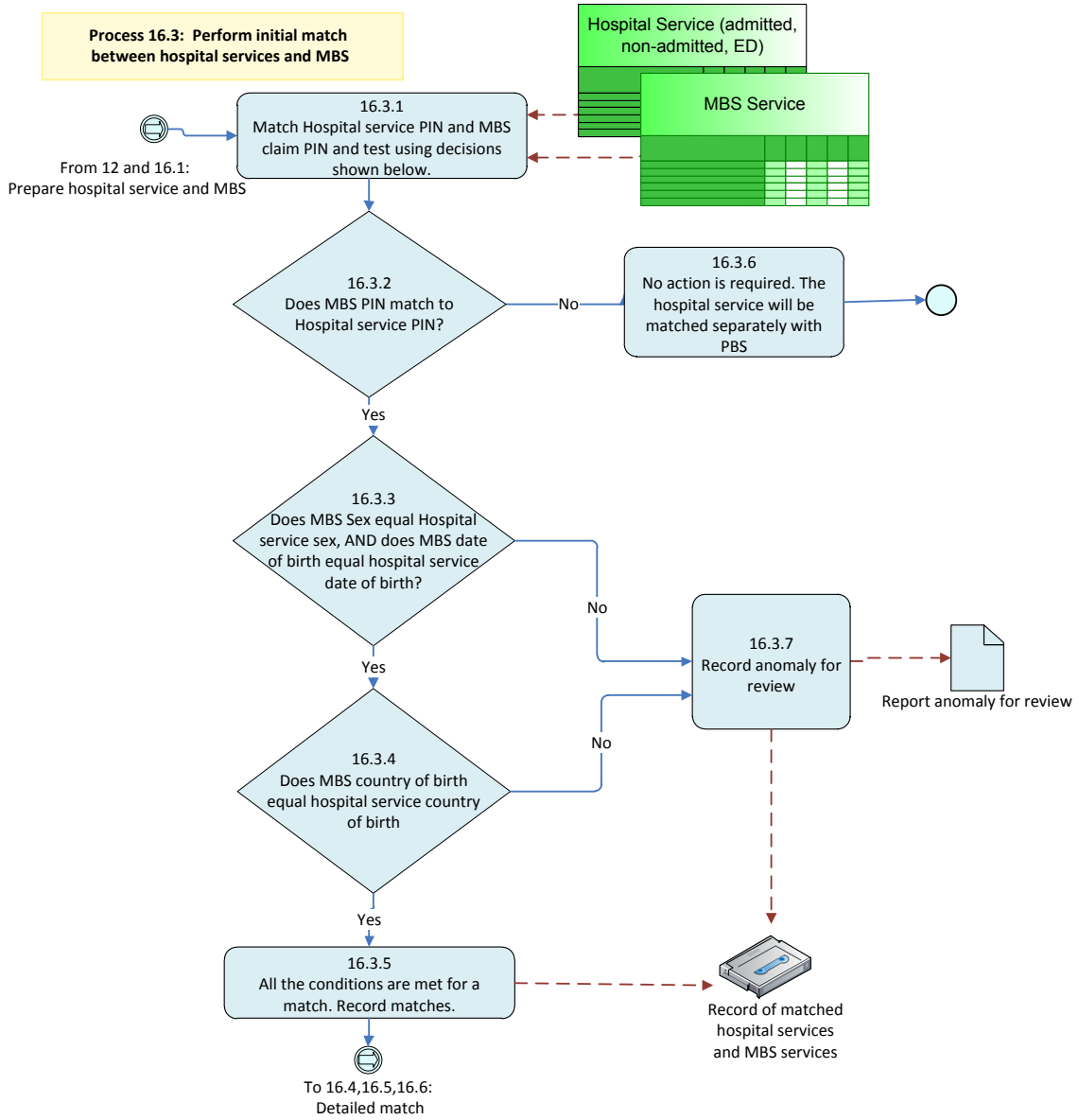
Rows from the PBS claims data where the following are all true:

- The date the script was written is greater than or equal to 1 July 2012, and less than or equal to 31 December 2012.
- The PBS service was prescribed or dispensed in hospital (using hospital ID for public patients, or Pharmacy ID where the pharmacy is in a hospital where public patients are treated).

6 Perform initial match to patient level service data

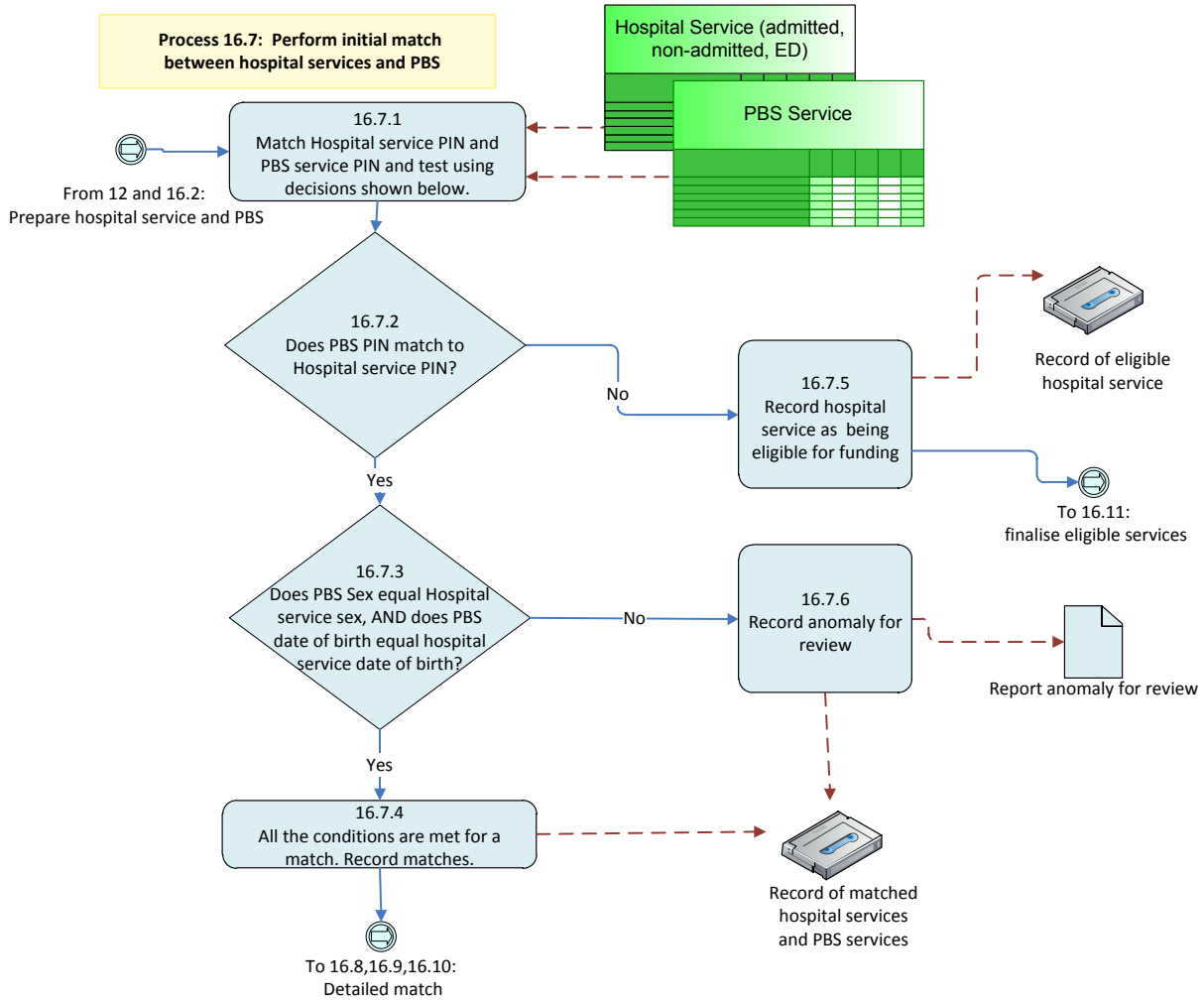
This process performs an initial level of matching which sets up for an iterative and more detailed matching process to follow.

6.1 Perform initial match between patient level service and MBS



In process 16.3.7, any anomalies are recorded for review. The volume and type of these anomalies will be analysed to form a view as to whether (for example) they stem from incomplete or bad data (eg incorrect recording of date of birth or gender) or from other causes (eg technical issues or data limitations with the PIN matching process).

6.2 Perform initial match between patient level service and PBS

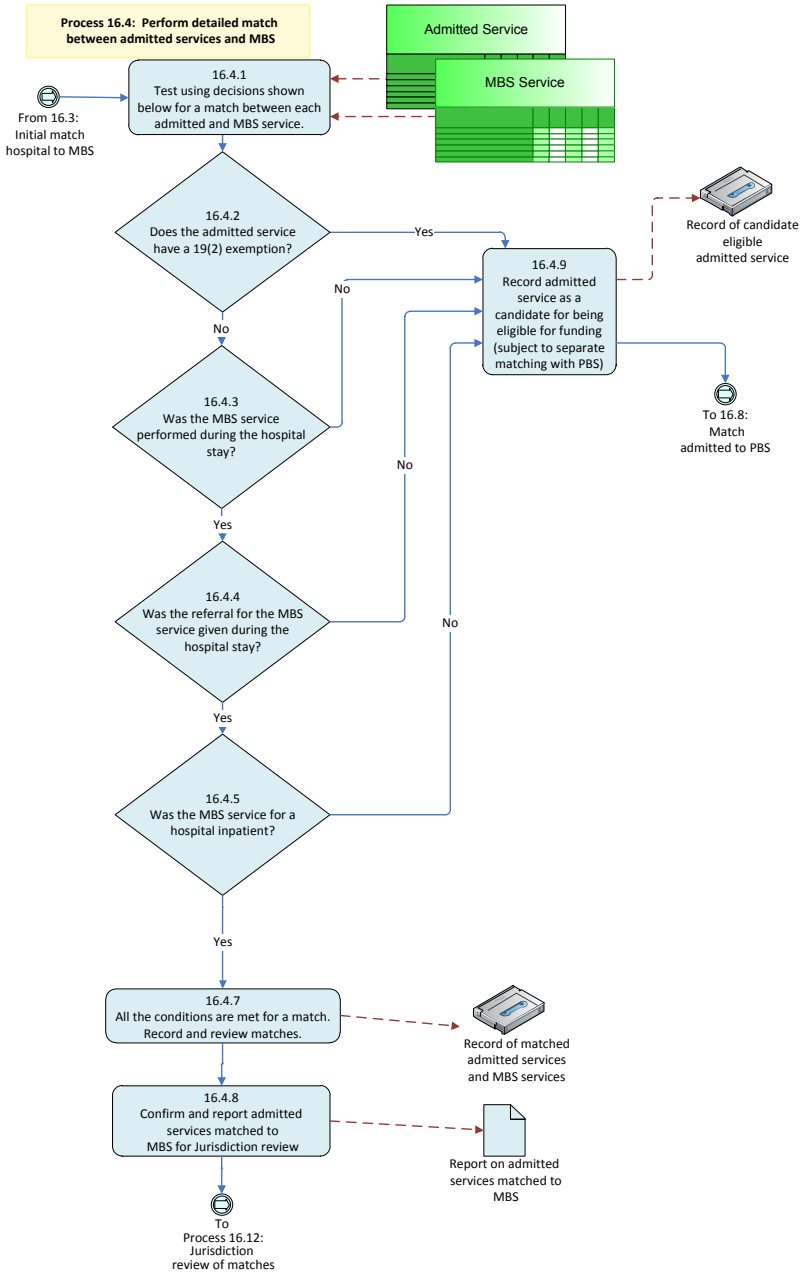


In process 16.7.6, any anomalies are recorded for review. The volume and type of these anomalies will be analysed to form a view as to whether (for example) they stem from incomplete or bad data (eg incorrect recording of date of birth or gender) or from other causes (eg technical issues or data limitations with the PIN matching process).

7 Establish eligible admitted services

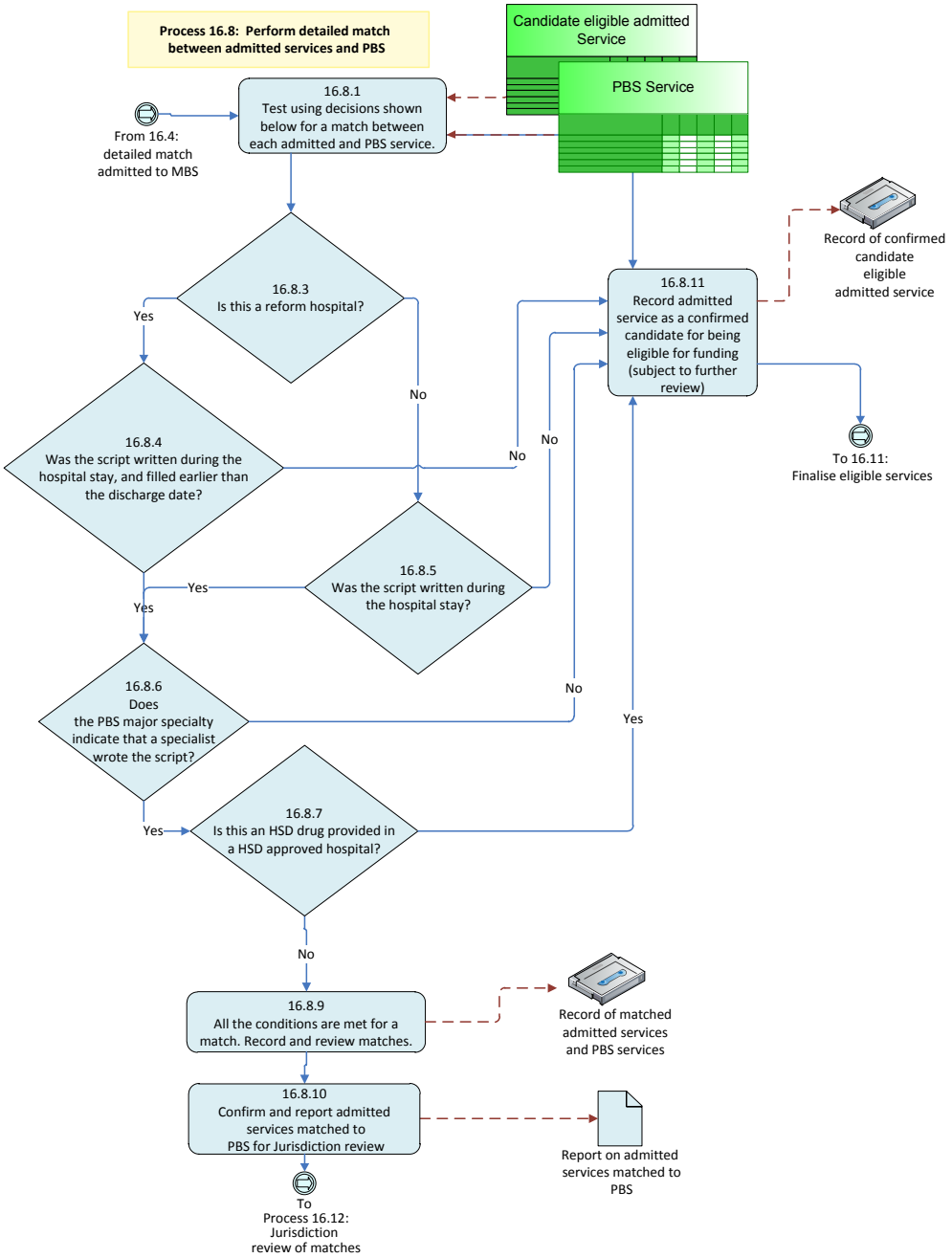
This process performs an iterative and more detailed matching process on the admitted data initially matched on MBS or PBS PIN and patient characteristics. It is designed to be an investigative process, informed by patterns and limitations observed in the actual data.

7.1 Perform detailed match between admitted services and MBS



As an alternative approach, the rule in 16.4.3 will be amended to say “Was the MBS service performed between the day after admission, and the day before discharge”. An analysis of the impact of this alternative rule will inform a policy decision on its use.

7.2 Perform detailed match between admitted services and PBS



As an alternative approach, amend the rule in:

1) 16.8.4 to say “Was the script written between the day after admission, and the day before discharge, and filled earlier than the discharge date?”

2) 16.8.5 to say “Was the script written between the day after admission, and the day before discharge?”

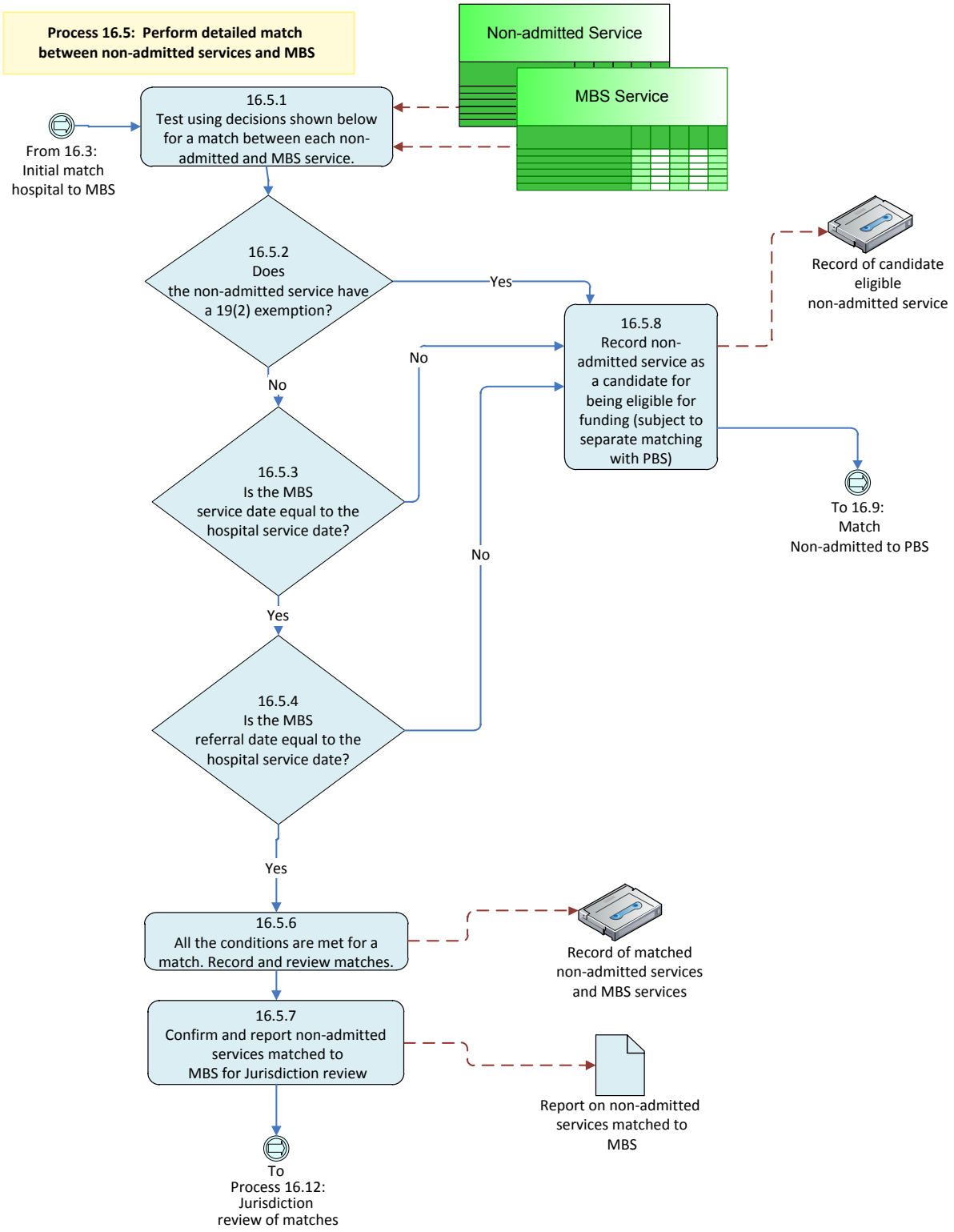
An analysis of the impact of these alternate rules will inform a policy decision on their use.

8 Establish eligible non-admitted services

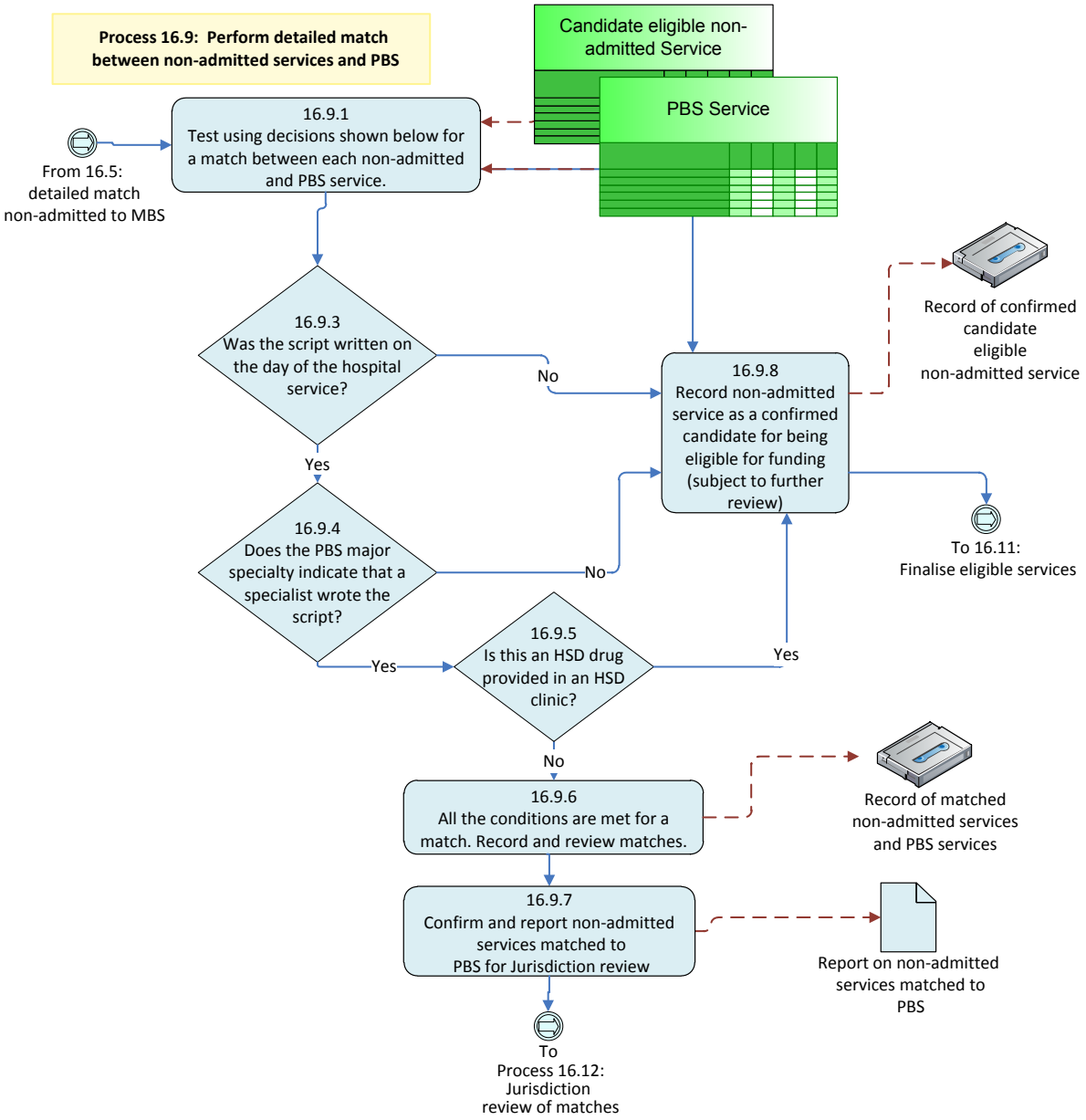
This process performs an iterative and more detailed matching process on the non-admitted data initially matched on MBS or PBS PIN and patient characteristics. It is designed to be an investigative process, informed by patterns and limitations observed in the actual data.

Note: The focus should be on matching non-admitted consultations with MBS imaging and pathology services. This is predicted to be the most likely area for ‘double dipping’. MBS schedule category for imaging is 5 and pathology is 6. The focus of analysis should also be on providers that have a derived specialty recorded.

8.1 Perform detailed match between non-admitted services and MBS



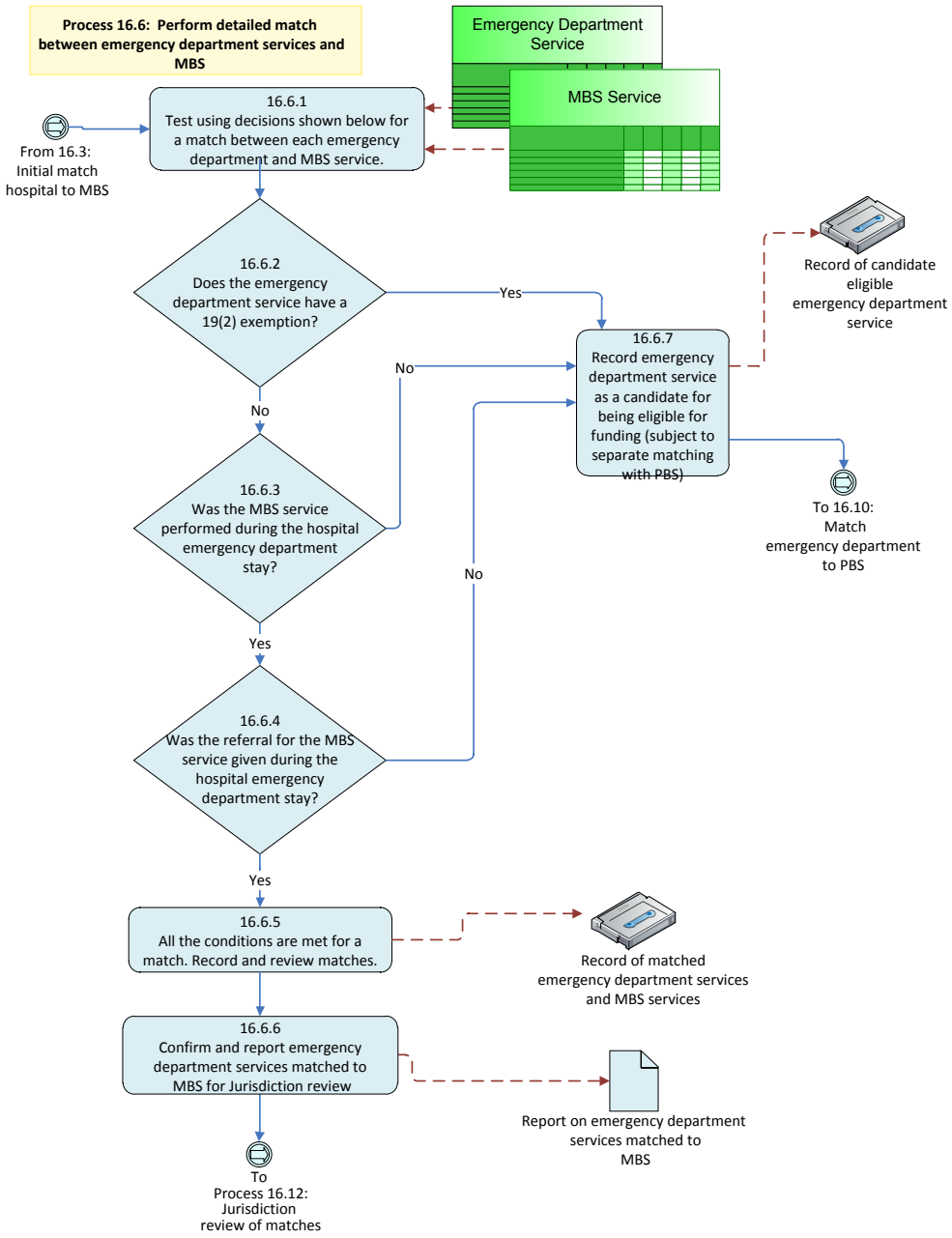
8.2 Perform detailed match between non-admitted services and PBS



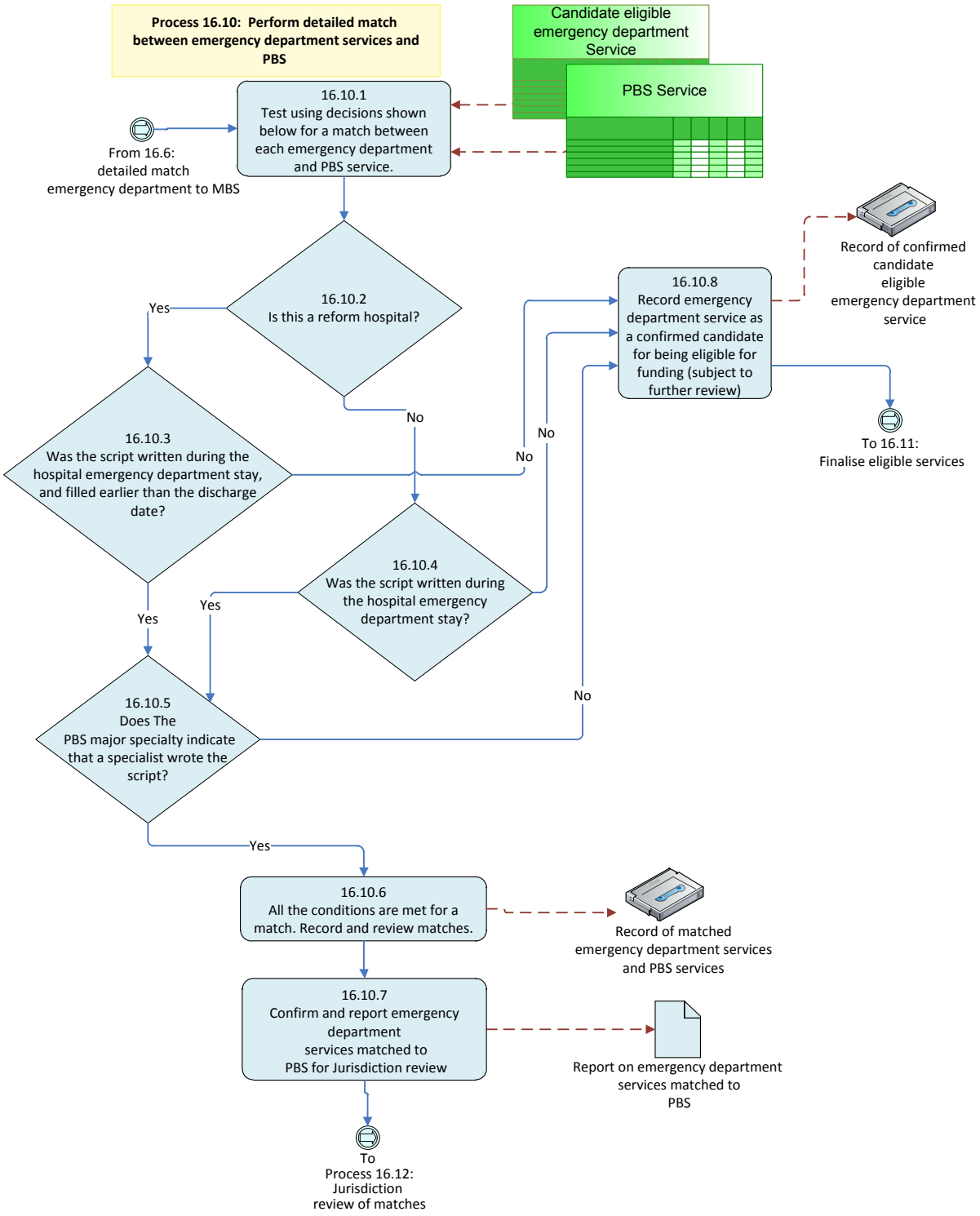
9 Establish eligible emergency department services

This process performs an iterative and more detailed matching process on the emergency department data initially matched on MBS or PBS PIN and patient characteristics. It is designed to be an investigative process, informed by patterns and limitations observed in the actual data.

9.1 Perform detailed match between emergency department services and MBS



9.2 Perform detailed match between emergency department services and PBS



10 Exception reporting requirements

10.1 Report data anomalies to states and territories for review

If hospital services data is inconsistent with either MBS or PBS data, then an exception report will be provided to states and territories. These anomalies may arise if the MBS or PBS pin matches, but the patient characteristics in the hospital services data do not match the characteristics in the MBS or PBS data.

10.2 Report matched services to states and territories for review[4]

The Administrator expects that hospital services which are matched to MBS or PBS and are identified as ineligible for funding will be provided to states and territories for their review in a "Hospital services matched to MBS/PBS" report. For each matched hospital service, the report is expected to provide, in CSV file format, the following details:

- The reconciliation period to which the match relates.
  eg for the first half of 2012-13: 2012-13H1
- The unique state record identifier provided by the jurisdiction, together with the category (admitted/non-admitted/emergency department) and establishment ID.
  This will provide a unique reference for the service so that the jurisdiction can identify the actual hospital service as submitted to the Administrator.
- A complete audit trail or "lineage" of the path this particular service took through the matching business rules as published in this document. This will take the form of a string of up to 15 comma delimited decision points based on the decision process tables provided in the scenarios documented in Appendix A of this document.
  eg 16.7.1,16.7.2,16.7.3,16.7.4,16.8.1,16.8.2,16.8.4,16.8.11,16.11
  The details able to provided in this lineage will be confirmed following clarification of legal constraints around privacy and secrecy. This lineage is intended to enable the reasons for matched hospital services to be readily identified to assist states and territories with establishing trends and patterns in the data.

As detailed in the matching process overview (see Appendix D), only services remaining eligible for funding after being matched with MBS, will be matched with PBS. This means that if a particular service appears on the "Hospital services matched to MBS/PBS" report, it will only have been matched to either a MBS or PBS claim, but not both MBS and PBS. Commonwealth legislation disallows any linkage between MBS and PBS data.

States and territories will be given a time-limited opportunity to review the "Hospital services matched to MBS/PBS" report and indicate to the Administrator, where appropriate, according to an agreed format and process, why these matched services should be eligible for funding.

[4] Refer section 7.2.3 of Determination 03

11 Appendix A – Scenarios

Disclaimer: Scenarios are intended to depict realistic situations, however all names and stories depicted in scenarios are fictitious and are for illustration purposes only.

Each scenario documented here illustrates a particular situation where a hospital service matches to MBS or PBS, together with an indication of whether in this situation the service would be eligible or ineligible for ABF funding and why.

Scenarios help to illustrate the intent of the business rules for business users. They are an easy to understand "completeness" check for what is eligible and ineligible for funding. Particular scenarios can be discussed and disputed, for example if a stakeholder doesn't believe that a scenario should make a service ineligible for funding.

It needs to be recognised that flexibility may need to be built in to the way the business rules are applied, due to limitations in the available data. Where data limitations exist, the principle will be adopted that such flexibility will generally be applied in favour of a service being declared eligible for funding. The Administrator will participate in data improvement initiatives to address data issues affecting the accuracy of the business rules.

11.1 Scenario 1: Admitted patient discharged with PBS script – pharmaceutical reform

Figure 1 – Scenario 1 timeline

Scenario: Jack is leaving hospital today. He had coronary artery bypass surgery last week as a public patient at his local public hospital in Melbourne. It went well, and his wife and teenage daughter have come in to pick him up. The surgeon has given him a script for Lipitor to help keep his cholesterol levels down, and he fills it at the hospital's pharmacy on the way out.

Outcome: The admitted service is eligible for funding. The PBS script is not considered for matching to the admitted service (and is eligible), as the hospital is a reform hospital in Victoria, so under the Pharmaceutical Reform Agreement, the script Jack filled on discharge is not treated as 'double-dipping'. If the script was filled before the day of discharge then this service would be considered for matching and be ineligible for funding.

If a similar situation had occurred in a hospital in NSW or ACT, or another hospital that has not enrolled under the Pharmaceutical Reform Agreement, then the admitted service would be matched and ineligible for funding.

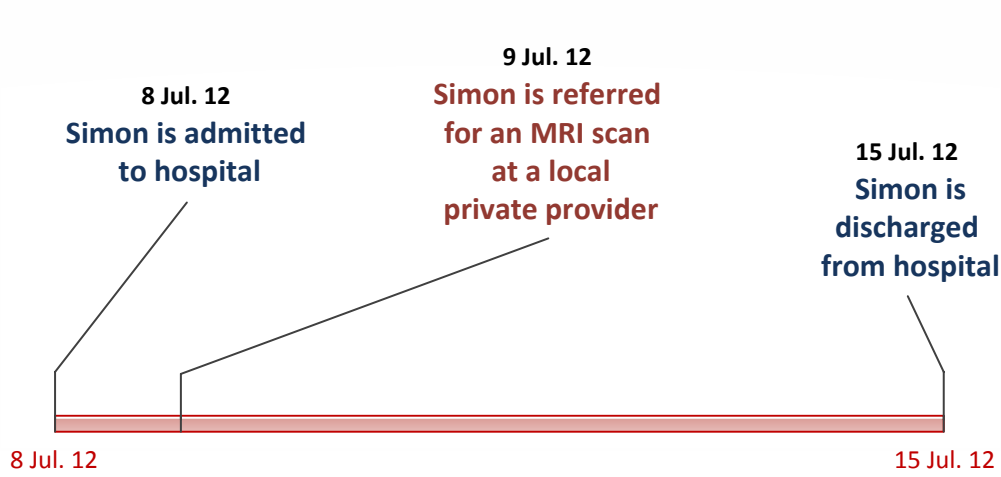
The decision process for this scenario is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 7.2 and 8.2, in the context of the Appendix D process overview.

Table 3 – Scenario 1 decision process

Decision Point	Question	Answer	Action
16.7.1	Perform initial match between hospital services and PBS.		
16.7.2	Does PBS PIN match to hospital service PIN?	Yes	Go to 16.7.3
16.7.3	Does PBS sex equal hospital service sex, and does PBS date of birth equal hospital service date of birth?	Yes	Go to 16.7.4
16.7.4	All the conditions are met for a match. Record Jack's record in the following datasets: • admitted patient matched with PBS • PBS matched with admitted patient		Go to 16.8
16.8.1	Evaluate specified conditions for a match between each admitted and PBS service		Go to 16.8.3
16.8.3	Is this a reform hospital?	Yes	Go to 16.8.4
16.8.4	Was the script written during the hospital stay, and filled earlier than the discharge date?	No	Go to 16.8.11
16.8.11	Record admitted service as a confirmed candidate for being eligible for funding.		Go to 16.11
16.11	Finalise eligible services.		

11.2 Scenario 2: Admitted patient with MBS service

Figure 2 – Scenario 2 timeline



Scenario: Simon has just left his local hospital in Sydney. He is lucky to be alive. He was admitted to hospital from the emergency department, unconscious, with head trauma needing ongoing assessment and management. The hospital took him to the private MRI provider across the road on an MBS referral from a hospital specialist to get a head scan to assess his injuries. After being unconscious for 24 hours Simon woke up and now after some bed rest, and treatment of his lacerations, does not appear to have any ongoing signs of brain injury.

Outcome: The admitted service is not eligible for funding. The MRI scan was an MBS service provided on referral from a hospital specialist, and was matched to the admitted service. The entire admitted service becomes ineligible for funding through the use of a private MRI service provider.

The decision process for this scenario is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 7.1 and 8.1, in the context of the Appendix D process overview.

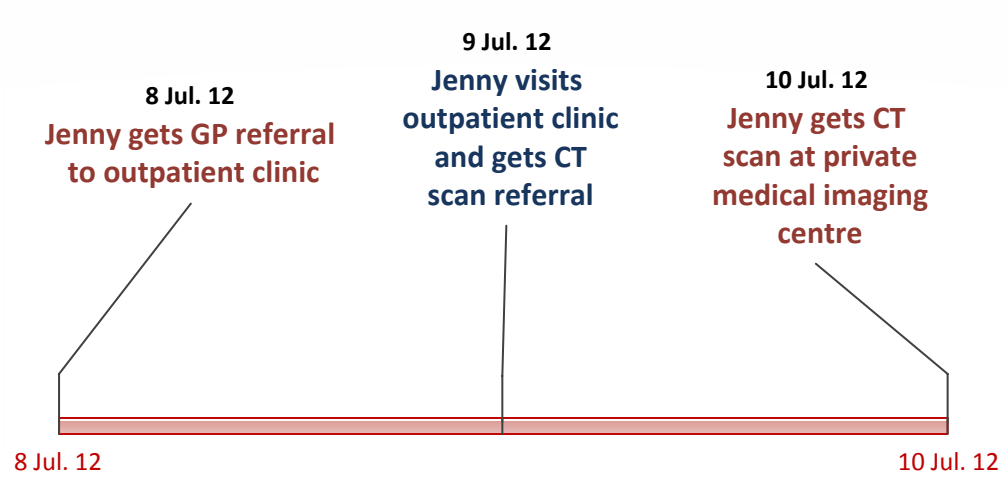
Table 4 - Scenario 2 decision process

Decision Point	Question	Answer	Action
16.3.1	Evaluate specified conditions for a match between each admitted and MBS service.		
16.3.2	Does MBS PIN match to hospital service PIN?	Yes	Go to 16.3.3
16.3.3	Does MBS sex equal hospital service sex, and does MBS date of birth equal hospital service date of birth?	Yes	Go to 16.3.4
16.3.4	Does MBS country of birth equal hospital service country of birth?	Yes	Go to 16.3.5
16.3.5	All the conditions are met for a match. Record Simon's record in the following datasets: • admitted patient matched with MBS • MBS matched with admitted patient		Go to 16.4
16.4.1	Evaluate specified conditions for a match between each admitted and MBS service.		Go to 16.4.2

16.4.2	Is this a private patient, or does the admitted service have a 19(2) exemption?	No	Go to 16.4.3
16.4.3	Was the MBS service performed during the hospital stay?	Yes	Go to 16.4.4
16.4.4	Was the MBS service referral date during to the hospital stay?	Yes	Go to 16.4.5
16.4.5	Was the MBS service for a hospital inpatient?	Yes	Go to 16.4.7
16.4.7	All the conditions are met for a match. Record and review matches.		Go to 16.4.8
16.4.8	Confirm and report admitted service matched to MBS for jurisdiction review, with the service being ineligible for ABF funding.		Go to 16.12
16.12	Jurisdiction review of matches.		

11.3 Scenario 3: Non-admitted service with MBS imaging, but with 19(2) exemption

Figure 3 – Scenario 3 timeline



Scenario: Jenny is visiting her local hospital's outpatient clinic. She has been referred there by her GP to see a specialist to assess her sore hip which the GP thinks might be a candidate for a hip replacement. Dr Johns greets Jenny, interviews her regarding her medical history, and refers her for a CT scan the next day to help him assess Jenny's condition and suitability for surgery. Due to an equipment breakdown at the hospital clinic, the only CT scanner available is at the local private medical imaging centre. Jenny visits the centre on referral from Dr Johns, and has a scan which is billed through MBS.

Outcome: The non-admitted service is eligible for funding. Ordinarily this service would be ineligible due to the MBS CT scan. However, the hospital is specified as a location for one of the COAG directions under ss19(2) of the *Health Insurance Act* 1973, so all of its services are eligible for funding.

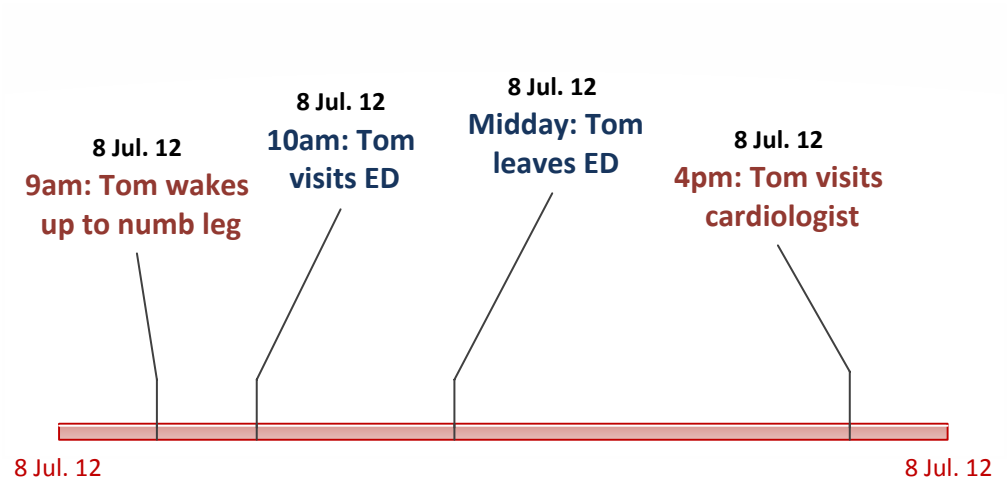
The decision process is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 7.1 and 9.1, in the context of the Appendix D process overview.

Table 5 - Scenario 3 decision process

Decision Point	Question	Answer	Action
16.3.1	Evaluate specified conditions for a match between each non-admitted and MBS service.		
16.3.2	Does MBS PIN match to hospital service PIN?	Yes	Go to 16.3.3
16.3.3	Does MBS sex equal hospital service sex, and does MBS date of birth equal hospital service date of birth?	Yes	Go to 16.3.4
16.3.4	Does MBS country of birth equal hospital service country of birth?	Yes	Go to 16.3.5
16.3.5	All the conditions are met for a match. Record Jenny's record in the following datasets: • non-admitted patient matched with MBS • MBS matched with non-admitted patient		Go to 16.5
16.5.1	Evaluate specified conditions for a match between each non-admitted and MBS service.		Go to 16.5.2
16.5.2	Does the non-admitted service have a 19(2) exemption?	Yes	Go to 16.5.8
16.5.8	Record non-admitted service as a candidate for being eligible (subject to separate matching with PBS).		Go to 16.9
16.9	If no match to the PBS is found, then the service is eligible for funding.		

11.4 Scenario 4: Emergency department with MBS consult

Figure 4 – Scenario 4 timeline



Scenario: Tom wakes up in his bed at home concerned that his whole leg has gone numb. He is increasingly worried as the leg is still numb after getting dressed and having breakfast. He gets Brett, his partner, to drive him to the local emergency department, where he is assessed and given the all clear, after the numbness had gone away. He knows he is visiting his cardiologist, Dr Tranh, at 4pm for his regular 6 monthly check up, and he tells Dr Tranh about it when he sees him.

Outcome: The emergency department (ED) service is eligible for funding. There is a data match between the cardiologist consult and the ED visit as they occurred on the same day. However because the date of referral to the specialist was prior to the ED visit, the ED service is eligible for funding.

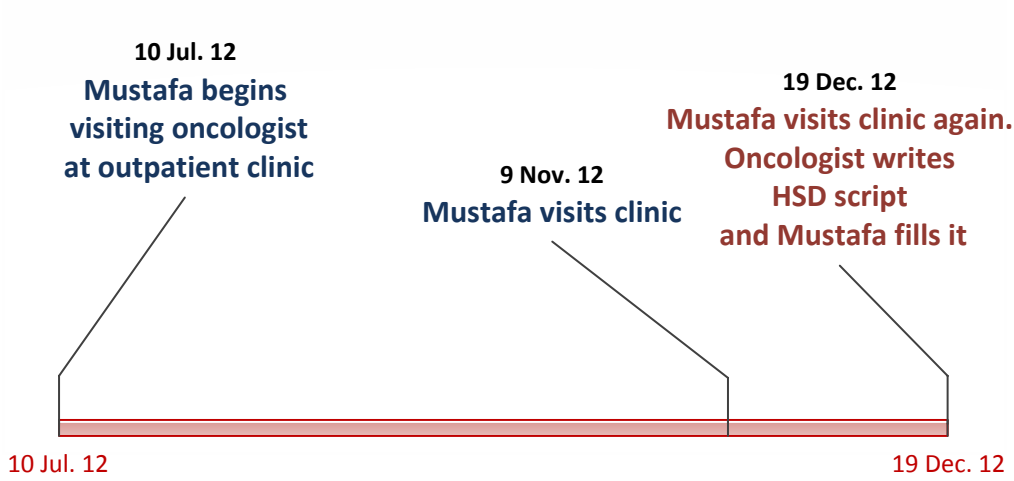
The decision process for this scenario is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 7.1 and 10.1, in the context of the Appendix D process overview.

Table 6 - Scenario 4 decision process

Decision Point	Question	Answer	Action
16.3.1	Evaluate specified conditions for a match between each emergency department and MBS service.		
16.3.2	Does MBS PIN match to hospital service PIN?	Yes	Go to 16.3.3
16.3.3	Does MBS sex equal hospital service sex, and does MBS date of birth equal hospital service date of birth?	Yes	Go to 16.3.4
16.3.4	Does MBS country of birth equal hospital service country of birth?	Yes	Go to 16.3.5
16.3.5	All the conditions are met for a match. Record Tom's record in the following datasets: • Emergency department patient matched with MBS • MBS matched with emergency department patient		Go to 16.6
16.6.1	Evaluate specified conditions for a match between each emergency department and MBS service.		Go to 16.6.2
16.6.2	Is this a private patient, or does the emergency department service have a 19(2) exemption?	No	Go to 16.6.3
16.6.3	Was the MBS service performed during the emergency department stay?	Yes	Go to 16.6.4
16.6.4	Was the MBS service referral date during the emergency department stay?	No	Go to 16.6.7
16.6.7	Record emergency department service as a candidate for being eligible (subject to separate matching with PBS).		Go to 16.10
16.10	If no match to the PBS is found, then the service is eligible for funding.		

11.5 Scenario 5: Non-admitted service with Highly Specialised Drug prescription

Figure 5 – Scenario 5 timeline



Scenario: Mustafa has been diagnosed with multiple myeloma (cancer of the blood), and has been seeing an oncologist, Dr Grant, at the local hospital's outpatient clinic. After another treatment was unsuccessful, Dr Grant has assessed him as eligible for the Section 100 highly specialised drug (HSD) Lenalidomide, which she prescribes to him on the same day as his consult.

Outcome: If the hospital is HSD approved, the non-admitted service is not considered for matching with PBS and is eligible for funding.

If the same drug was prescribed on the day of discharge from an admitted service at a HSD approved hospital, then this would also be eligible for funding. However, if the drug was prescribed from a non-HSD approved hospital, or earlier in the hospital admission, then the hospital service would be considered for matching and potentially ineligible for funding (i.e. no different from another PBS script).

The decision process for this scenario is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 7.2 and 9.2, in the context of the Appendix D process overview.

Table 7 - Scenario 5 decision process

Decision Point	Question	Answer	Action
16.7.1	Perform initial match between hospital services and PBS.		
16.7.2	Does PBS PIN match to hospital service PIN?	Yes	Go to 16.7.3
16.7.3	Does PBS sex equal hospital service sex, and does PBS date of birth equal hospital service date of birth?	Yes	Go to 16.7.4
16.7.4	All the conditions are met for a match. Record Mustafa's record in the following datasets: • non-admitted patient matched with PBS • PBS matched with non-admitted patient		Go to 16.9
16.9.1	Evaluate specified conditions for a match between each non-admitted and PBS service.		Go to 16.9.3
16.9.3	Was the script written on the day of the hospital service?	Yes	Go to 16.9.4
16.9.4	Does the PBS major specialty indicate that a specialist wrote the script?	Yes	Go to 16.9.5
16.9.5	Is this an HSD drug provided an HSD clinic?	Yes	Go to 16.9.8
16.9.8	Record non-admitted service as a confirmed candidate for being eligible for funding.		Go to 16.11
16.11	Finalised eligible services.		

12 Appendix B - Reference data

The Administrator will work with DoHA and other jurisdictions to establish required reference data.

12.1 Hospital (aka facility or establishment) list

A complete hospital (campus) list is required including the following data:

- Hospital ID
- Hospital Name
- State
- Is this hospital activity based funded for 2012-13 or not (ABF/NOT ABF).
- Is this a public hospital/private hospital
- Does this hospital have a 19(2) exemption at the hospital level (Yes/No). A facility (hospital) may have a 19(2) exemption. If it does, then all MBS claims at that facility are exempt from matching.
- Does this hospital participate in the pharmaceutical reform agreement (Yes/No). Hospitals participating in the pharmaceutical reform agreement have access to the PBS, for non-admitted and admitted patients on discharge as well as a Commonwealth subsidised list of pharmaceuticals for same-day admitted patients requiring chemotherapy.
  Note: All states except NSW and ACT have signed up to the pharmaceutical reform agreement. However within states that have signed up, not all hospitals are participating, hence the need to record this attribute at hospital level.
- Is this hospital approved to claim HSD drugs (Yes/No). Public hospitals that want to claim HSD under the HSD program need a section 94 (s94) approval (or section 100 in the case of non-dispensing public hospitals) under the *NH Act* which will allow them to supply PBS medicine.

12.2 Tier 2 Outpatient clinic definitions

Reference is required to the list of Tier 2 Outpatient Clinics shown on the IHPA website. These identify the following:

- 10 series – Procedure clinics – These services are potentially eligible for funding, depending on matching to MBS or PBS
- 20 series – Medical Consultation clinics - These services are potentially eligible for funding, depending on matching to MBS or PBS
- 30 series – Stand-alone Diagnostic clinics - no price weight – These services will NOT be eligible for funding
- 40 series – Allied Health &/or Clinical Nurse Specialist interventions clinics - These services are potentially eligible for funding, depending on matching to MBS or PBS

12.3 Provider number list

A provider list is required, specifying:

- Provider number
- Whether or not the provider is a “medical practitioner not in a GP role”

12.4 Prescriber number list

A prescriber list is required, specifying:

- Prescriber number
- Provider number

12.5 Pharmacy list

A pharmacy list is required, specifying:

- Pharmacy number
- Whether the pharmacy is in hospital or not

12.6 List of ABF hospitals for 2012-13

Table 8 below outlines the list of the 2012-13 activity based hospitals by state/territory and LHN.

Table 8: 2012-13 activity based hospitals by state/territory and LHN

State / Territory	Local Hospital Network	Hospital
NSW	Central Coast (NSW)	Gosford Hospital
		Wyong Hospital
	Far West NSW	Broken Hill Base Hospital
	Hunter New England	Belmont Hospital
		John Hunter Hospital Royal Newcastle Centre
		Manning Rural Referral Hospital (Taree)
		Tamworth Rural Referral Hospital
		The Maitland Hospital
		Armidale Hospital
		Calvary Mater Newcastle Hospital
	Illawarra Shoalhaven	Iahs Mental Health Services
		Shellharbour Hospital
		Shoalhaven Hospital
		Wollongong Hospital
	Mid North Coast (NSW)	Coffs Harbour Base Hospital
		Kempsey District Hospital
		Port Macquarie Base Hospital
	Murrumbidgee	Griffith Hospital
		Wagga Wagga Hospital

State / Territory	Local Hospital Network	Hospital
	Nepean Blue Mountains	Hawkesbury Hospital
		Nepean Hospital
		Blue Mountains District Hospital
		Tresillian Nepean Family Care Centre -Kingswood
	Northern NSW	Grafton Base Hospital
		The Tweed Hospital
		Lismore Hospital
		Murwillumbah Hospital
	Northern Sydney	Hornsby Ku-Ring-Gai Hospital
		Manly Hospital
		Mona Vale Hospital
		Royal North Shore Hospital
		Ryde Hospital
	South Eastern Sydney	Prince Of Wales Hospital
		Royal Hospital For Women
		St George Hospital
		Sydney Hospital And Sydney Eye Hospital
		Sutherland Hospital
	South Western Sydney	Bankstown-Lidcombe Hospital
		Bowral Hospital
		Campbelltown Hospital
		Fairfield Hospital
		Liverpool Hospital
	Southern NSW	Bega Hospital
		Goulburn Hospital
		Moruya Hospital
		Queanbeyan Hospital
	St Vincent's Health Network (NSW)	St Vincent'S Hospital
	Sydney	Canterbury Hospital
		Royal Prince Alfred Hospital
		RPAH Institute Of Rheumatology & Orthopaedics
		Tresillian Family Care Centre - Canterbury
		Concord Hospital
	Sydney Children's Hospital Network	Sydney Children'S Hospital
		Children's Hospital At Westmead
	Western NSW	Orange Health Service
		Dubbo Hospital
		Bathurst Hospital
	Western Sydney	Blacktown Hospital
		Mount Druitt Hospital
		Westmead Hospital
		Auburn Hospital
VIC	Albury Wodonga Health	Albury Wodonga Health - Wodonga Campus

State / Territory	Local Hospital Network	Hospital
	Alfred Health (Vic)	Caulfield Hospital
		Sandringham Hospital
		The Alfred
	Austin Health (Vic)	Austin Hospital
		Heidelberg Repatriation Hospital
	Bairnsdale Regional Health Service	Bairnsdale Regional Health Service
	Ballarat Health Services	Ballarat Base Hospital
	Barwon Health	Geelong Hospital
	Bass Coast Regional Health	Bass Coast Regional Health
	Benalla and District Memorial Hospital	Benalla Health
	Bendigo Health Care Group	The Bendigo Hospital
	Castlemaine Health	Castlemaine Health
	Central Gippsland Health Service	Central Gippsland Health Service (Sale)
	Colac Area Health	Colac Area Health
	Djerriwarrh Health Service (Vic)	Djerriwarrh Health Service - Bacchus Marsh
	East Grampians Health Service	Ararat And District Hospital
		Willaura Health Care
	Eastern Health (Vic)	Angliss Hospital
		Box Hill Hospital
		Maroondah Hospital
		The Peter James Centre
	Echuca Regional Health	Echuca Regional Health
	Gippsland Southern Health Service	Gippsland Southern Health Service - Korumburra
		Gippsland Southern Health Service - Leongatha
	Goulburn Valley Health	Goulburn Valley Health - Shepparton
	Kyabram and District Health Service	Kyabram & District Health Services
	Latrobe Regional Hospital	Latrobe Regional Hospital
	Maryborough District Health Service	Maryborough District Health Service (Dunolly)
		Maryborough District Health Service (Maryborough)
	Melbourne Health	Royal Melbourne Hospital - Parkville
	Mercy Public Hospital Inc. (Vic)	Mercy Hospital For Women
		Mercy Public Hospital - Werribee
	MTAA Superannuation Fund (Mildura Base Hospital)	Mildura Base Hospital
	Northeast Health Wangaratta	Northeast Health Wangaratta
	Northern Health (Vic)	Broadmeadows Health Service
		The Northern Hospital - Epping
	Peninsula Health (Vic)	Frankston Hospital
		Rosebud Hospital
	Peter MacCallum Cancer Institute (Vic)	Peter Maccallum Cancer Institute

State / Territory	Local Hospital Network	Hospital
	Portland District Health	Portland District Health
	Royal Children's Hospital (Melbourne	The Royal Childrens Hospital
	Royal Victorian Eye and Ear Hospital	The Royal Victorian Eye And Ear Hospital
	Royal Women's Hospital (Melbourne)	The Royal Women'S Hospital
	South West Healthcare (Vic)	Warrnambool Base Hospital
	Southern Health (Vic)	Casey Hospital
		Cranbourne Integrated Care Centre
		Monash Medical Centre - Clayton
		Monash Medical Centre - Moorabbin
		Dandenong Campus
	St Vincent's Hospital (Melbourne) Limited	St Vincent'S Hospital (Melbourne)
	Stawell Regional Health	Stawell Regional Health
	Swan Hill District Health	Swan Hill District Hospital
	West Gippsland Healthcare Group	West Gippsland Healthcare Group
	Western District Health Service (Vic)	Hamilton Base Hospital
	Western Health (Vic)	Sunshine Hospital
		Williamstown Hospital
		Western Hospital (Footscray)
	Wimmera Health Care Group	Wimmera Base Hospital - Horsham
QLD	Cairns and Hinterland	Cairns Base Hospital
	Central Queensland	Gladstone Hospital
		Rockhampton Hospital
	Children's Health Queensland	Royal Children'S Hospital
	Darling Downs	Toowoomba Hospital
	Gold Coast	Gold Coast Hospital
	Mackay	Mackay Base Hospital
	Mater Misericordiae Health Services Brisbane	Mater Adult Hospital
		Mater Children'S Hospital
		Mater Mother'S Hospital
	Metro North (Qld)	Caboolture Hospital
		Redcliffe Hospital
		Royal Brisbane & Womens Hospital
		Prince Charles Hospital
	Metro South (Qld)	Logan Hospital
		Princess Alexandra Hospital
		Queen Elizabeth Ii Jubilee Hospital
		Redland Hospital
	North West (Qld)	Mount Isa Hospital
	Sunshine Coast	Caloundra Hospital

State / Territory	Local Hospital Network	Hospital
		Gympie Hospital
		Nambour Hospital
	Townsville	Townsville Hospital
	West Moreton	Ipswich Hospital
	Wide Bay	Bundaberg Hospital
		Hervey Bay Hospital
WA	Child Adolescent Health Service (WA)	Princess Margaret Hospital For Children
	North Metropolitan Health Service (WA)	Joondalup Health Campus
		Osborne Park Hospital
		Sir Charles Gairdner Hospital
		Swan Districts Hospital
		King Edward Memorial Hospital For Women
	South Metropolitan Health Service (WA)	Armadale Kelmscott Memorial Hospital
		Fremantle Hospital And Health Service
		Hedland Health Campus
		Peel Health Campus
		Rockingham General Hospital
		Royal Perth (Rehab) Hospital
		Royal Perth Hospital
		Bentley Hospital
	WA Country Health Service	Albany Hospital
		Bunbury Hospital
		Fremantle-Kaleeya Hospital
		Geraldton Hospital
		Kalgoorlie Hospital
SA	Central Adelaide	The Queen Elizabeth Hospital
		Royal Adelaide Hospital
	Country Health SA	Gawler Health Service
		Mount Gambier And Districts Health Service
		Port Pirie Regional Health Service
		Port Augusta Hospital And Regional Health Service
		Whyalla Hospital And Health Service
	Northern Adelaide	Lyell Mcewin Hospital
		Modbury Hospital
	Southern Adelaide	Flinders Medical Centre
		Repatriation General Hospital
		Noarlunga Public Hospital
	Women's and Children's Health Network (SA)	Womens And Childrens Hospital
TAS	Tasmanian Health Organisation - North	Launceston General Hospital

State / Territory	Local Hospital Network	Hospital
	Tasmanian Health Organisation - North West	Mersey Community Hospital
		North West Regional Hospital
	Tasmanian Health Organisation - South	Royal Hobart Hospital
ACT	Australian Capital Territory	The Canberra Hospital
		Calvary Hospital
NT	Central Australia (NT)	Alice Springs Hospital
	Top End (NT)	Katherine Hospital
		Royal Darwin Hospital

12.7 Postcodes that span states/territories

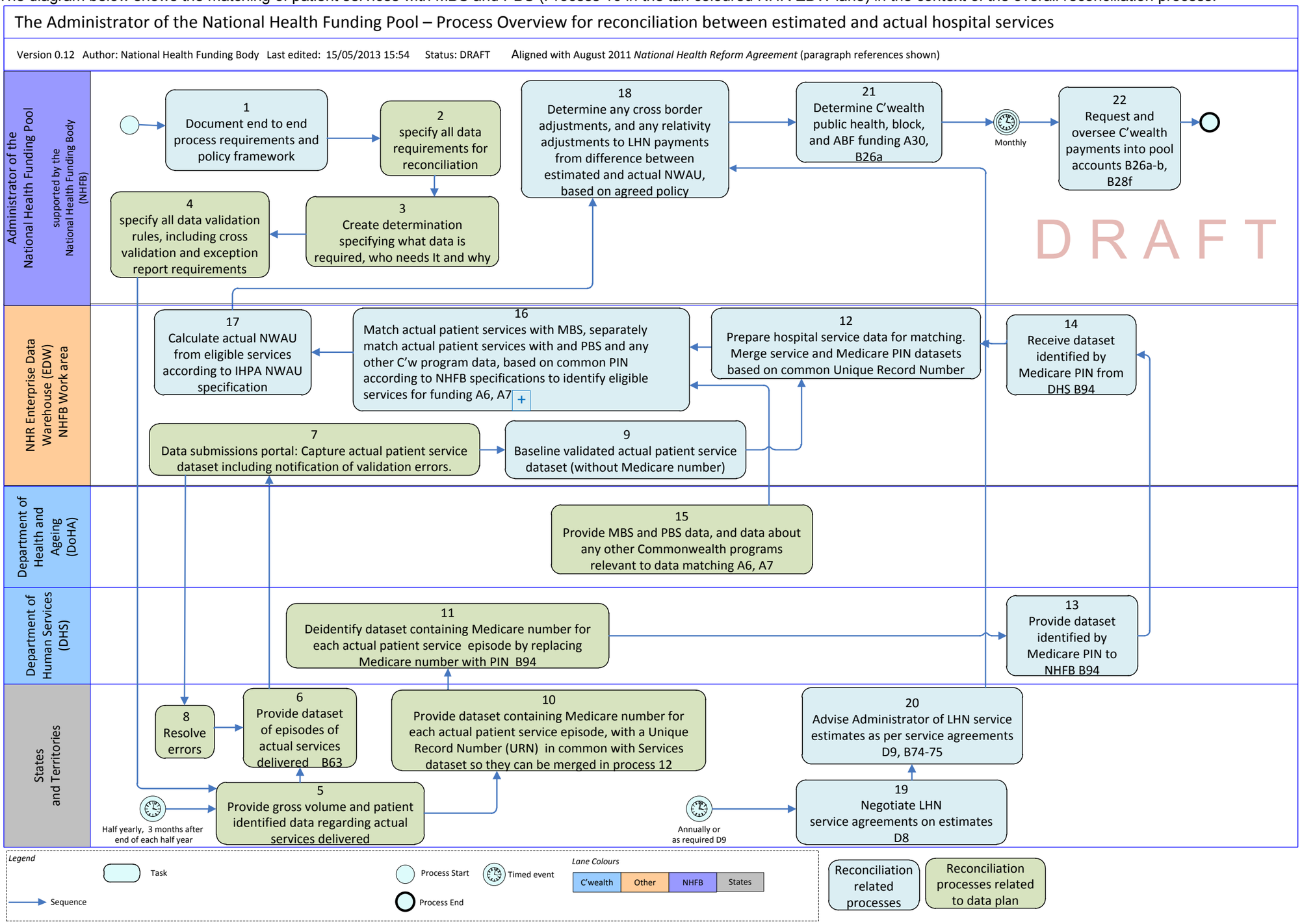
Table 9 below outlines the 15 postcodes that span more than one state/territory and determination of which state or territory that patients with that postcode will be assigned to (based on the largest population proportion of the applicable states/territories).

Table 9: Postcodes that span over more than one state/territory

Postcode	State/Territory postcode spans	S/T with largest population proportion	Population proportion of largest S/T
872	NT, SA and WA	NT	80%
2406	NSW and QLD	NSW	84%
2540	ACT and NSW	NSW	99%
2611	ACT and NSW	ACT	100%
2618	ACT and NSW	NSW	76%
2620	ACT and NSW	NSW	98%
3644	NSW and VIC	VIC	80%
3691	NSW and VIC	VIC	100%
3707	NSW and VIC	VIC	96%
4375	NSW and QLD	QLD	100%
4377	NSW and QLD	QLD	100%
4380	NSW and QLD	QLD	100%
4383	NSW and QLD	QLD	71%
4385	NSW and QLD	QLD	93%
4825	NT and QLD	QLD	98%

13 Appendix C – Reconciliation process overview

The diagram below shows the matching of patient services with MBS and PBS (Process 16 in the tan coloured NHR EDW lane) in the context of the overall reconciliation process.



14 Appendix D – Matching process overview

Process 16 is further broken down in the following data matching process. Each process is further detailed in document sections.