Administrator
National Health
Funding Pool

Business rules for determining 2012-13 hospital services eligible for Commonwealth funding

Volume 2

Extended proof of concept

17 December 2013

Document Control Sheet

Document Information

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Approval

Title	Administrator of the National Health Funding Pool
Name	Bob Sendt
Signature	
Date	17 December 2013

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Contents

Preface

I am pleased to present volume two of the business rules for determining hospital services eligible for activity based funding (ABF) in 2012-13. I acknowledge and thank all jurisdictions for their continuing 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 or PBS claims.

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.

I acknowledge states' and territories' concerns about the level of evidence needed to determine that a hospital service is ineligible for Commonwealth funding from the National Health Funding Pool.

I have therefore decided that matching between hospital services and MBS or PBS claims will, as part of the full 2012-13 reconciliation between estimated and actual hospital service data, continue to be conducted on a 'proof of concept' basis. Any hospital services 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 2012 to June 2013 reconciliation period.

Outcomes from the initial 'proof of concept' matching based on volume one of the business rules have been provided to those states and territories that supplied the data necessary for the matching exercise to occur, and (in aggregate) to my Jurisdictional Advisory Committee. These outcomes represent an initial work in progress, and this extended 'proof of concept' will be an opportunity for all stakeholders to continue to participate in and be able to establish confidence in the data matching process. Any revision of these business rules or other changes to the reconciliation process identified from this extended 'proof of concept' will be implemented as part of data matching for future reconciliations. 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.

On 26 November 2013 I released my *Data Privacy, Secrecy and Security Policy* which deals with the collection, use, storage and disclosure of data provided to me under my data plan for the purposes of reconciliation and matching. It outlines the systems and processes for the collection and storage of data and the measures in place to ensure secrecy and patient confidentiality. This policy is in operation and I continue to work with jurisdictions to ensure that the processes surrounding the collection and use of the required data are as rigorous and transparent as possible. I am also progressing with jurisdictions the development of agreed practices for the provision of information back to jurisdictions and any dissemination of information more broadly.

Bob Sendt

RJ Sendt
Administrator
National Health Funding Pool

1 Introduction

These 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 13.5 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 separately 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 or PBS.
- **Data preparation** (sections 3 to 5) details what is needed to prepare the data for matching.
- **Merge hospital service with MBS claims, and separately with PBS claims** (section 6) merges hospital and MBS or PBS services using the common Medicare PIN unique to each person to set up for a progressive and 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 11) provides a 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) illustrate 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) 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 11.

1.3 Data matching considerations

Data matching approach

The overall approach with data matching is to arrange for suitable data to be available to enable the Administrator to determine if any hospital service which is otherwise in scope for ABF funding is ineligible for funding because it is established that there was a claim for an MBS or PBS service which should have been provided as part of the hospital service. No other commonwealth programs have been identified for matching to hospital services other than MBS and PBS.

In accordance with clause A6 of the Agreement, patient identified data provided by states and territories, will be compared to patient identified data on MBS or PBS services based on Medicare PINs (de-identified Medicare numbers). Where there is a match (after applying the matching rules specified in this document), these services will be reviewed to determine whether they remain eligible for Commonwealth NHR 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 or PBS 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 incorporated into the reconciliation and adjustment process for National Health Reform Commonwealth activity based funding.

Phase 1 outcomes and learnings for Phase 2

Outcomes from the initial Phase 1 July to December 2012 ‘proof of concept’ data matching, based on volume one of the business rules, have been provided to states and territories and to the Administrator’s Jurisdictional Advisory Committee. These Phase 1 outcomes represent an important work in progress, and the proof of concept has now been extended to Phase 2, covering the full 2012-13 financial year. This extended proof of concept includes learnings from Phase 1, including jurisdiction feedback, and is an opportunity for all stakeholders to continue to participate in and be able to establish confidence in the data matching process.

Learning from Phase 1, Phase 2 will provide a more flexible and detailed approach to data matching analysis.

In Phase 1, in scope hospital services were immediately *excluded from eligibility* for Commonwealth funding (on a 'proof of concept' basis) once they were flagged as being matched by any one of the business rules.

In Phase 2, in scope hospital services will initially *remain eligible* for Commonwealth funding. Each business rule (including each alternative scenario) will be then be evaluated in turn against each service, with the result from each business rule recorded as a separate 'eligibility flag' (*eligible or ineligible)* against the service.

At the end of the business rule evaluation process, the in scope service will be assessed according to each of its business rule 'eligibility flags', with alternative outcomes compared and further analysed, and a 'proof of concept' determination made as to an overall eligibility outcome for that service.

This Phase 2 approach will:

- enable more flexible analysis of all component business rules, so that the effect of each individual business rule and alternative scenario can be independently assessed.
- allow for easier application and evaluation of further refinements to the business rules following analysis of interim results.

Key challenges and opportunities

A number of key challenges exist in successfully conducting data matching for each period. Some of these challenges prevent a particular MBS or PBS claim being clearly established as part of the funding for a hospital service. This may mean that a number of hospital services incorrectly remain eligible for funding.

The Administrator will work with stakeholders on approaches to overcome these challenges.

Table 1 – Data matching - key challenges and opportunities

Key challenges	Opportunities
1. **Hospital services reported at an aggregate level** Nationally in 2012-13, some non-admitted and emergency department services were reported at the patient level, with the remainder reported at an aggregate level due to issues with the readiness of some hospital data collection and reporting systems to fully report patient level data. Any aggregate level data provided by states and territories cannot be used for data matching purposes. Only patient level data gives the required level of detail to enable matching to MBS or PBS claims.	The Administrator will work with jurisdictions in relevant forums to encourage state and territory commitment to an increasing percentage of patient level data for non-admitted and emergency services, and a commitment to achieving 100% of reporting at patient level for these services as soon as practicable.

Key challenges	Opportunities
2. **Lack of suitable data to clearly establish whether a particular MBS or PBS claim was part of the funding for a hospital service** There are many challenges to the accurate matching of hospital services to MBS or PBS claims. For example: a. **Matching on conditions:** For the 2012-13 period there is insufficient information to reliably match hospital diagnoses and conditions to relevant MBS conditions or PBS drugs. b. **Matching on provider:** Matching provider numbers between hospital services and MBS is a potential strategy to assist the matching process. However the suitability of the data for provider matching is not yet established. c. **Matching on time of day:** When matching hospital services to MBS or PBS services, time of day is only captured for emergency department hospital services. There is no time of day recorded for admitted or non-admitted hospital services, or MBS or PBS claims. This presents a matching challenge when a hospital service occurs on the same day as an MBS or PBS claim.	The Administrator will discuss opportunities and participate in initiatives with states and territories and the Commonwealth regarding suitability of data for matching, and to enable the capture and reporting of improved fit for purpose data for more accurate matching of hospital services to MBS or PBS claims.
3. Medicare numbers not reported for some patient services For some patient level hospital services reported by states and territories in 2012-13, a Medicare number is not reported at all, is not reported in a valid format, or is not itself a valid Medicare number. This prevents a Medicare PIN for the hospital service being derived, and so prevents any matching to MBS or PBS based on a common Medicare PIN.	The Administrator will work with states and territories to encourage state and territory commitment to an increasing proportion of valid Medicare numbers in submitted patient level data. The Administrator acknowledges that there will always be a certain percentage of services without a Medicare number, due to the fact that it is not compulsory for a patient to supply a Medicare number in order to receive a public hospital service.
4. Data submissions late or not to specification “Submission B” Medicare number components of hospital service data submissions provided to the Administrator by states and territories have in some cases been late, have not been provided according to specification, or have not been matched as required with “Submission A” The data matching effort has been delayed by these factors.	The Administrator will work with states and territories to improve the accuracy and timeliness of hospital data submissions.

Key challenges	Opportunities
5. Coding time lag affecting on-time data collection For many states and territories, a material percentage of hospital activity data is not coded in time and is therefore not included in the initial collection of data for a reconciliation period. For those states and territories requiring it, a window is currently held open for around six weeks following the deadline for activity data submission to allow a sufficient percentage of late coded activity data to be included in an updated submission of hospital activity data.	The Administrator will work with jurisdictions to encourage improvements in systems and practices to reduce the lag in coding affecting on time collection of hospital service data.
6. Timing of "switching on" data matching The Administrator will consider all existing data matching challenges in electing when to implement data matching. This includes ensuring there is appropriate notification to jurisdictions prior to implementation, and understanding of the impact of the business rules.	The Administrator will work with jurisdictions to encourage a detailed understanding of the data matching process prior to an election to implement. Appropriate notice will be given of the timing and approach in operationalising the data matching process.
7. Issuance of a public interest certificate to release matched MBS and PBS records Where MBS or PBS claims have been matched to hospital services, states and territories should be given sufficient information to allow them to investigate matched records.	The Administrator has requested a suitable public interest certificate from the Commonwealth Department of Health.

1.4 Privacy considerations

On 26 November 2013 the Administrator released the *Data privacy, secrecy and security policy v1.0* which deals with the collection, use, storage and disclosure of data, including data provided for the purposes of reconciliation and matching. It outlines the systems and processes for the collection and storage of data and the measures in place to ensure secrecy and patient confidentiality. This Policy is currently in operation.

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) and considerations for the collection, use, storage and disclosure of data provided for the purposes of reconciliation and matching.

- *Determination 03: Provision of actual 2012-13 hospital services data for reconciliation with estimated data*
- *2012-13 Reconciliation Framework*
- *Data privacy, secrecy and security policy v1.0*

This document is also intended to be consistent with the Administrator's rolling Three Year Data Plan and the Commonwealth contribution calculation methodology.

2 Principles for matching hospital visits to MBS/PBS

2.1 Principles for all hospital services to public patients

These principles apply to services provided to *public* patients in either *public* or *private* hospitals.

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:

- Matching will only be performed against patient level data on services provided in ABF hospitals. This includes contracted services, including services for notional contacted service LHNs.[1]
- 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.

2.2 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.

[1] Refer to the Administrator's *Determination 04: Notional contracted services,* issued on 17 June 2013

2.3 Treatment of non-admitted patient level services

The classification system for non-admitted care is known as Tier 2 Non-Admitted Care Services. Tier 2 categorises a hospital's non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service. The major categories and their treatment for matching are as shown in table 2.

Table 2 – Major Tier 2 categories and treatment for matching

Category	Description	Matching treatment
Category 10 - Procedures	Procedures provided by a surgeon or other medical specialist. For example a hospital outpatient clinic which performs endoscopies will be classified to a class in the procedures category.	These services are eligible for funding, subject to matching with MBS or PBS
Category 20 – Medical consultations	Medical consultations provided by a general physician or medical specialist. For example a clinic run by a doctor who sees patients for consultations will be classified to a class in the medical consultations category.	These services are eligible for funding, subject to matching with MBS or PBS
Category 30 – Stand-alone diagnostics	Diagnostic services, within a specific field of medicine or condition. For example, a clinic which performs computerised tomography (CT) scans will be classified to a class in the stand-alone diagnostics category.	These services have no IHPA price weight and therefore are NOT eligible for funding. They will not be matched to MBS or PBS
Category 40 – Allied Health and/or Clinical Nurse Specialist interventions	Services provided by an allied health professional or clinical nurse	As specified by IHPA, these services are NOT in scope for funding for 2012-13. Accordingly they will not be matched to MBS or PBS[2]

[2] Based on IHPA's specifications, Category 40 services become eligible for funding in 2013-14 and will be included in matching to MBS or PBS in that year.

2.4 Exemptions to MBS matching 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 3 – 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[3] 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

[3] Office for Aboriginal and Torres Strait Islander Health

2.5 Exemptions to PBS matching under the Pharmaceutical Reform Agreement (*National Health Act* s94 and NHRA clause A7c)

Pharmaceutical Reform Agreements have been signed between the Commonwealth and all states and territories, other than NSW and ACT. Individual public hospitals in each participating state and territory liaise with their state or territory health department prior to making an application to become an approved authority (a 'reform' hospital) under section 94 of the *National Health Act 1953*.

Pharmaceutical Reform Agreement principles

Pharmaceutical Reform PBS scripts, prescribed and dispensed to eligible outpatients and patients on discharge, are exempt from matching to hospital services under the following circumstances:

- The hospital must be a 'reform' hospital, and
- The hospital service must be for a day admitted patient, or non-admitted patient, or the script must have been provided on discharge by a doctor who has a prescriber number issued by Medicare Australia.

Doctors in approved reform hospitals who have a prescriber number issued by Medicare Australia can:

- Prescribe under the Pharmaceutical Benefits Scheme (PBS) for eligible outpatients and patients on discharge.
- Prescribe PBS s100 Efficient Funding of Chemotherapy (EFC) medicines (where relevant). [4]
- Prescribe PBS s100 Highly Specialised Drugs (HSD) (where relevant).

Hospital pharmacies can dispense these prescriptions and claim re-imbursement from the Commonwealth.

The cost of s100 PBS scripts issued under the HSD program and the EFC has been removed from the National Efficient Price (NEP) as advised in the *IHPA National Efficient Price Determination 2012-13* (consistent with NHRA B12e). This means they do not form part of Commonwealth NHR funding. Any hospital services potentially matched against PBS scripts of this nature will be therefore be free of any 'double dipping' implications and will remain eligible for funding.

2.6 Exemptions to PBS matching outside of the Pharmaceutical Reform Agreement (*National Health Act* s100 and NHRA B12e)

In addition to the drugs and medicinal preparations available under normal PBS arrangements, a number of drugs are also available as pharmaceutical benefits but are distributed under alternative arrangements where these are considered more appropriate.

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[4] Note that EFC medicines can *only* be prescribed in reform hospitals.

These alternative arrangements are provided for under section 100 (s100) of the *National Health Act 1953* (NH Act).

s100 HSD program background[5]

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 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 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 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.

s100 Highly Specialised Drugs (HSD) principles

s100 HSD PBS scripts are exempt from matching to hospital services under the following circumstances:

- The hospital must be approved to claim HSD drugs (note that reform hospitals are automatically approved to claim HSD drugs where required and do not need a separate HSD approval), and
- The hospital service must be for a day admitted patient, or non-admitted patient, or the script must have been provided on discharge by a doctor who has a prescriber number issued by Medicare Australia.

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

3 Prepare hospital service data for matching

3.1 Prepare in-scope patient level hospital service data

The Administrator's 2012-13 Reconciliation Framework specifies the steps for preparation of in-scope hospital service data (refer section 4.2, and for further detail, Appendix 2). These steps are summarised here.

Submission and validation

Activity data sets are to be provided by states and territories within the specified timeline, either via direct submission to the Administrator or through authorisation to utilise the relevant data sets provided by states and territories to IHPA. Upon provision, the data sets will be validated by IHPA's existing validation capability and validation rules.

Identify activity based funded hospitals

The list of agreed activity based funded hospitals for 2012-13 for each state and territory will be agreed with states and territories and used to identify the relevant national health reform in-scope hospitals that are eligible to receive Commonwealth activity based funding. This list is produced in consultation with states and territories.

See Appendix B (Section 13.5) for a list of the 2012-13 activity based hospitals by state/territory and LHN.

Select in-scope hospital services (as determined by IHPA)

The patient level services identified as belonging to in-scope hospitals will then be subject to determination of those activity based hospital services that are in-scope for Commonwealth funding under the Agreement, as determined by IHPA (clauses A9 to A26).

The list of 2012-13 activity based hospital services eligible for Commonwealth funding can be located on the IHPA website.[6]

3.2 From in-scope services data, prepare patient level hospital service data for matching

For this second phase of data matching covering the full 2012-13 year, the overall approach in using in-scope hospital services for matching is to:

- exclude those services which are not in scope for NHR funding as specified in IHPA's National Efficient Price (NEP) determination but remain in the in-scope list as zero NWAU services (refer point 1 below)

[6] http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nep-determination-2012-13.htm/$File/NEPDetermination2012-2013.pdf

- further ‘flag’ those in scope services with criteria which can be used to assist the determination of eligibility for funding. This provides a more flexible approach to matching, as instead of using a set of criteria to exclude services straight away from matching (as was the case with different rounds of matching in the phase one approach with the July to December 2012 data), these ‘flagged’ criteria can then be further evaluated during or at the end of the matching process. This allows the testing of different approaches to how Commonwealth funding eligibility is determined, and more easily allows further enhancements to business rules following analysis of interim results (refer point 2 below)

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. Where any hospitals reported in the aggregate data also exist in non-admitted patient level data, states and territories advise whether to use aggregate or patient level data, or a specified combination for calculation of NWAU and determination of eligibility for Commonwealth funding.

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

1. For non-admitted services, only include in the selection for matching those services where the tier 2 major category is 10 (procedure clinics) or 20 (medical consultation clinics)
2. For admitted services, flag the following criteria in the selected patient services data for matching:
    - Flag as “admitted service leave days greater than zero” services where the “admitted service leave days” is greater than zero (if there are any leave days, this may negate the ability to match with MBS or PBS claims).
    - Flag as “public patient service” 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)
3. Sort <category> patient services (Table 1) by state record identifier and establishment identifier.
4. Sort <category> submission B data received from states and territories via DHS (Table 2) by state record identifier and establishment identifier.
5. Merge Table 1 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 did not match to a Table1 row, and listing them in an exception report for follow up with the relevant state or territory.

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.

A full set of MBS claims where the date of service is greater than or equal to 1 July 2012, and less than or equal to 30 June 2013 will be used for preparation of MBS claims data for matching, using specific columns from the MBS claims data as identified in the attachment to the Administrator's Determination 03.

The following rules will be applied as part of the matching rules when establishing eligible services in sections 7, 8 and 9 of this document:

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

- The requesting/referral reason is NOT in the following list:
  P – (possible self-determined, lost or emergency)
  L – (lost. *A replacement for a lost referral will be marked with an "L" requesting/referral reason. If a referral is lost and is replaced, and if the new replacement referral date is on the same date as an outpatient consult, this may cause a 'false positive' match)*
- The MBS service type is NOT in the following list: (*these need to be excluded from matching as they are duplicate records*)
  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")

Flag rows for evaluation and potential *inclusion* in the MBS claims data as follows

- Flag the claim as "MBS service performed in hospital" where the hospital indicator is "H" AND the benefit is 75% of the scheduled fee

  (Note: in the above rule, allow for the following situation: Where a medical practitioner performs multiple operations (eg removal of multiple skin cancers; plastic surgery involving multiple MBS items), the benefit is based on:
  - 100% of the scheduled fee for the item with the greatest scheduled fee
  - 50% of the scheduled fee with the next greatest scheduled fee
  - 25% of the scheduled fee for each other item

- Flag the claim as “MBS service can be performed by a non-GP” if the Category and Group for the claim is present in the table below of MBS Categories and Groups for MBS services which *can be* performed by specialists or other non-GP medical practitioners.

  The Administrator is examining the effect of only matching to those MBS claims which belong to the categories and groups which can be performed by specialists and other non-GP medical practitioners, on the basis that this will exclude the majority of GP consults and is likely to reduce 'false positive' matches between hospital services and MBS claims.

  For example, if a physician in a GP role provides a standard consult (item 23) under the MBS on the same day as that patient attends an outpatient clinic, then that consult will be potentially excluded from matching by this rule (Item 23 belongs to Category 1 and Group A01, which is not included in the below table).

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

  Table 4 – MBS Categories and Groups for services which *can be* performed by specialists and other non-GP medical practitioners

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

Category	Group	Item	Group name
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.

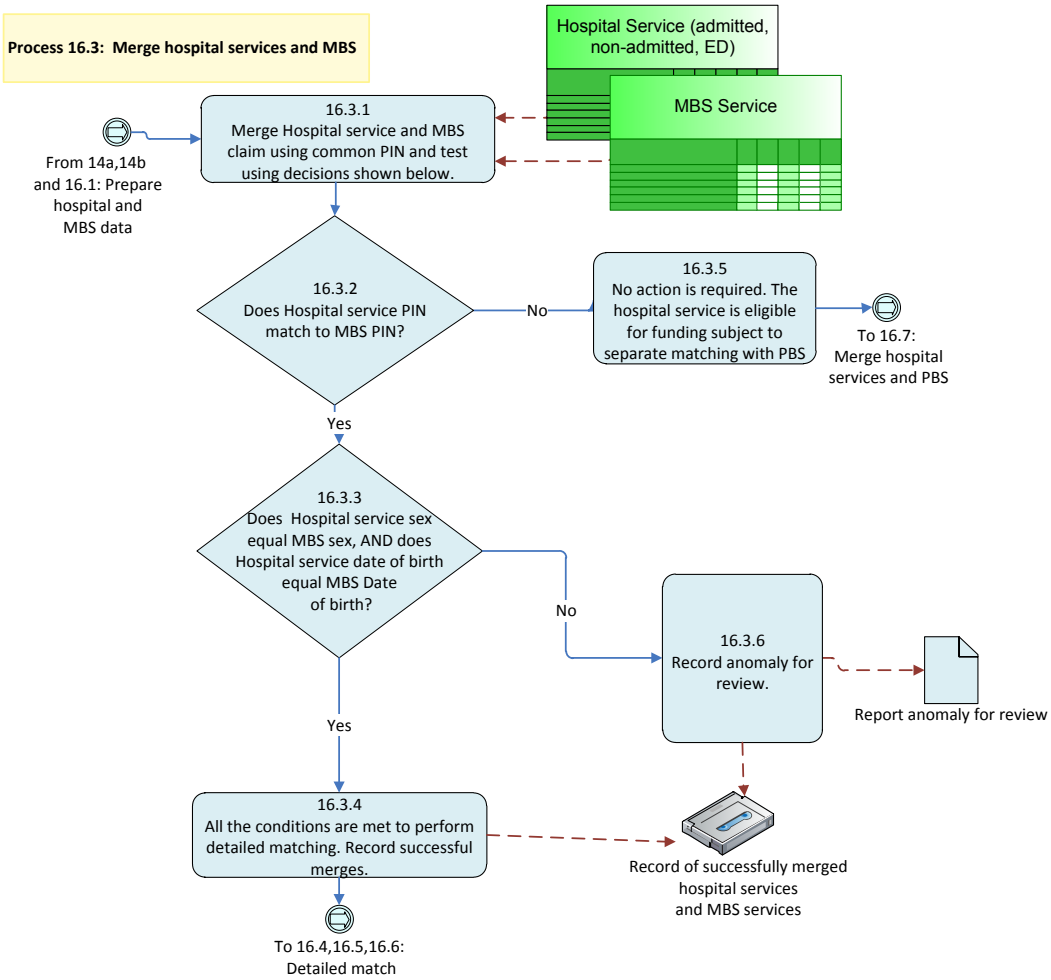
An extract of PBS claims data needs to be prepared that includes:

- 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 date the script was *written* is greater than or equal to 1 July 2012, and less than or equal to 30 June 2013.

6 Merge hospital service with MBS claims, and separately with PBS claims using common Medicare PIN

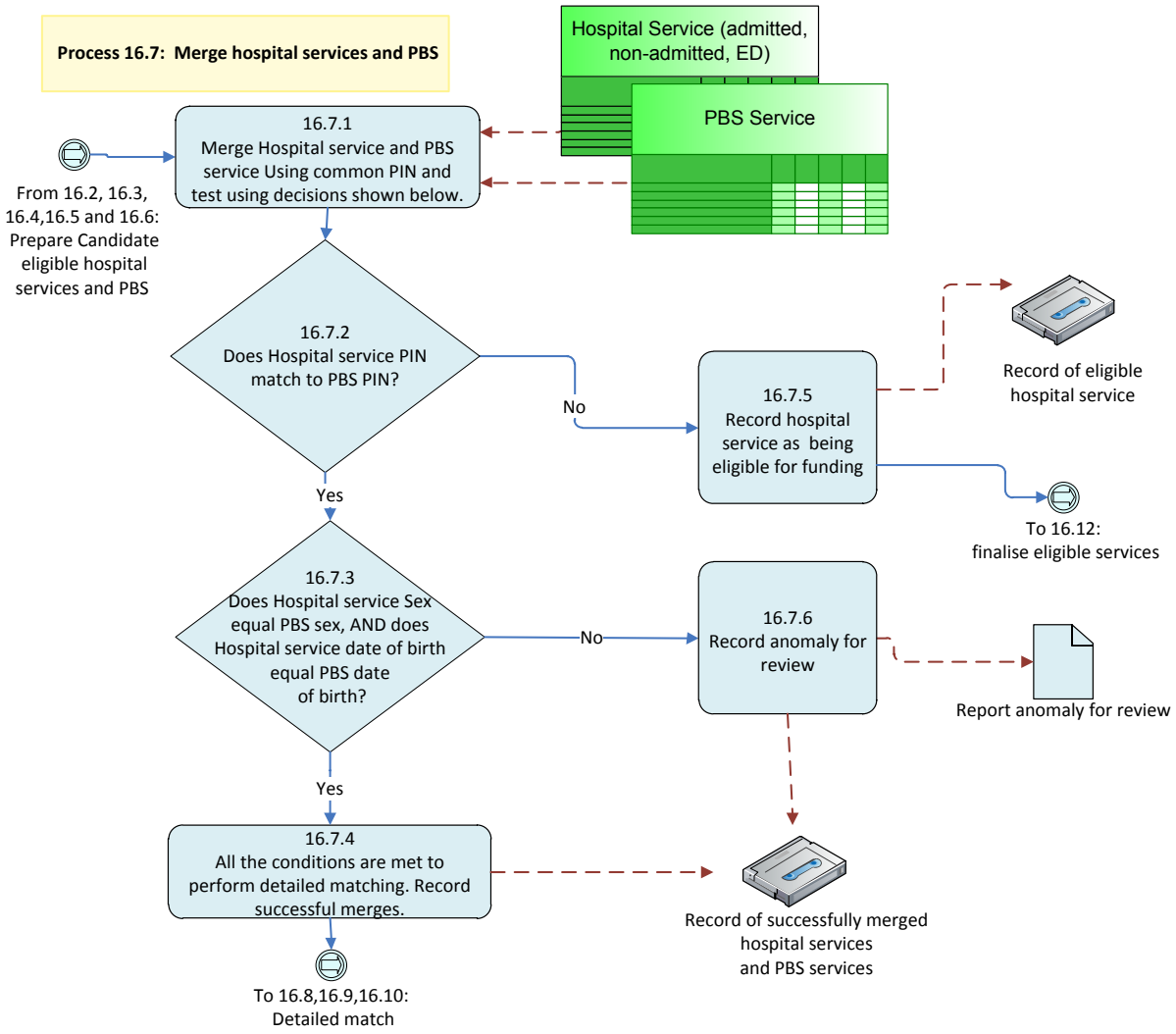
This process performs an initial merge which sets up for a progressive matching process to follow. Supporting process diagrams are shown, providing a further level of detail for the matching process overview shown in Appendix D.

6.1 Merge patient level service data with MBS data using common Medicare PIN



In process 16.3.6, 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). For example, if there are different sex or date of birth values for MBS claims with the same PIN, then this represents a potential MBS data integrity issue and will be recorded for review by the Administrator.

6.2 Merge patient level service data with PBS data using common Medicare PIN

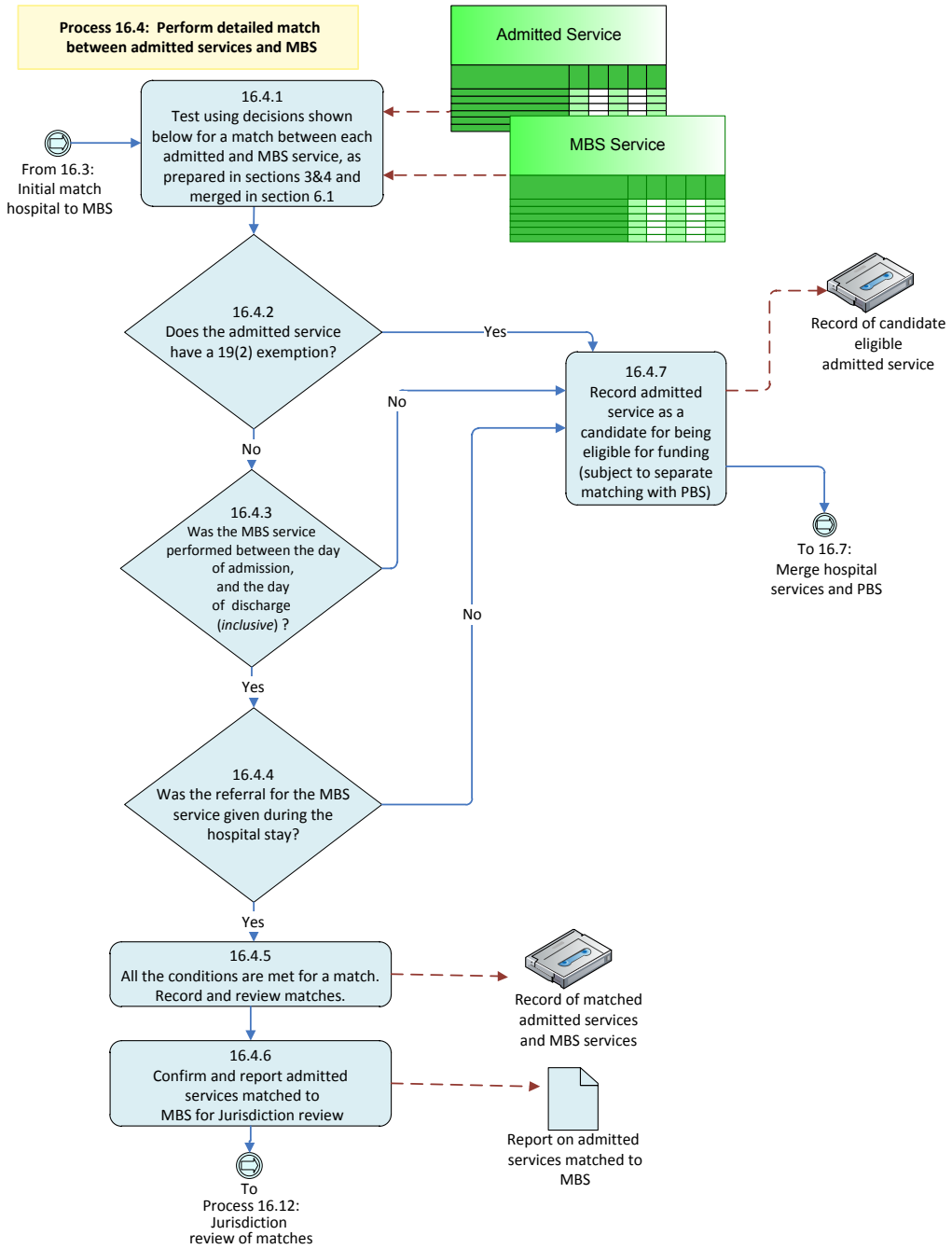


In process 16.7.6, any anomalies are recorded for review. The volume and type of these anomalies will be analysed to form a view as to whether (for example) they stem from incomplete or bad data (eg incorrect recording of date of birth or gender) or from other causes (eg technical issues or data limitations with the PIN matching process). For example, if there are different sex or date of birth values for PBS claims with the same PIN, then this represents a potential PBS data integrity issue and will be recorded for review by the Administrator.

7 Establish eligible admitted services

This process performs a progressive and more detailed matching process on the admitted data initially matched on PIN to MBS or PBS 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

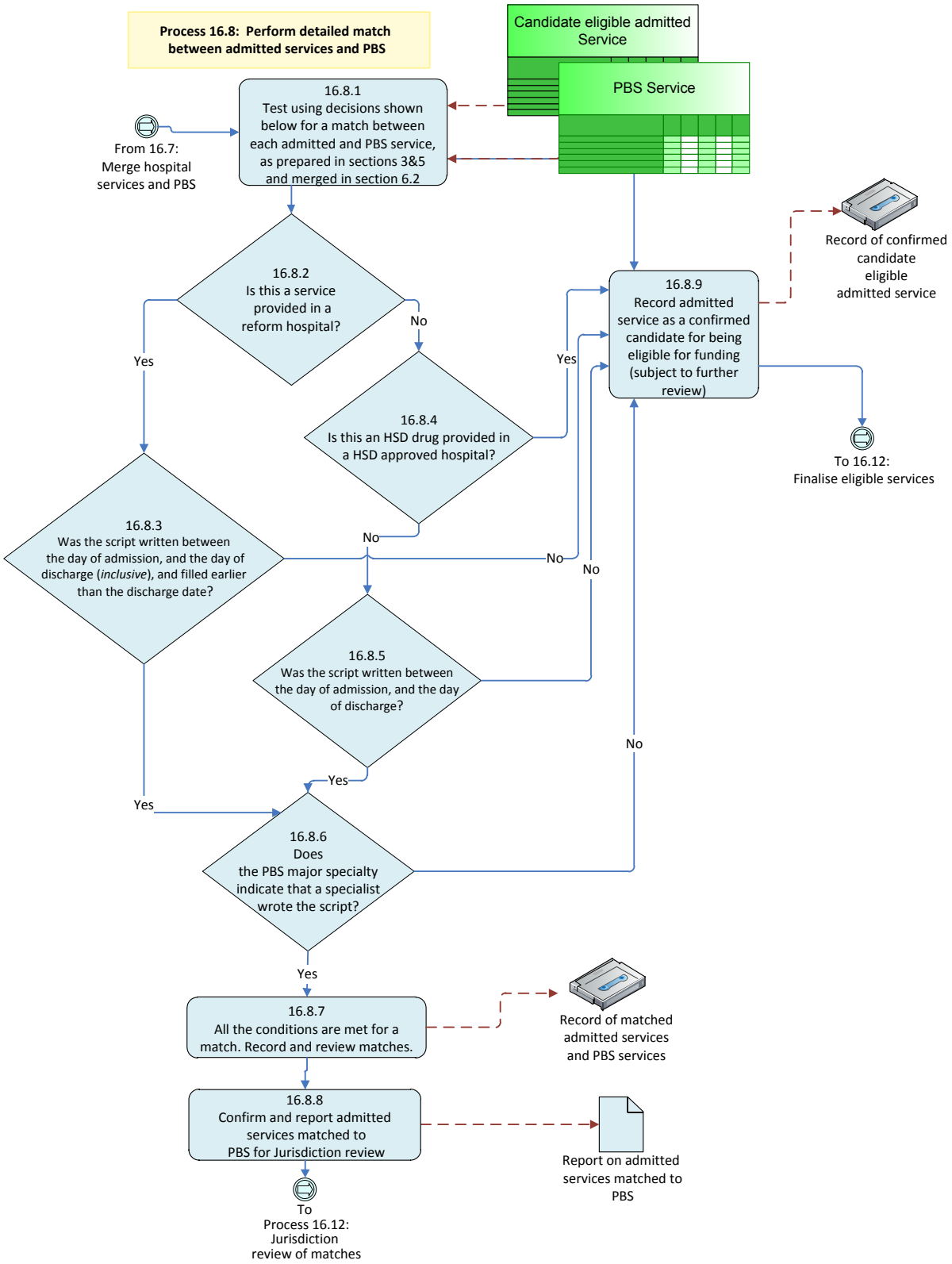


The NHFB will analyse the results of this matching process under the following alternative scenario:

- Amend the rule in 16.4.3 to state "Was the MBS service performed between the day *after* admission, and the day *before* discharge".

An analysis of the impact of this alternative scenario will inform a policy decision on its use by the Administrator.

7.2 Perform detailed match between admitted services and PBS



The NHFB will analyse the results of this matching process under the following alternative scenarios:

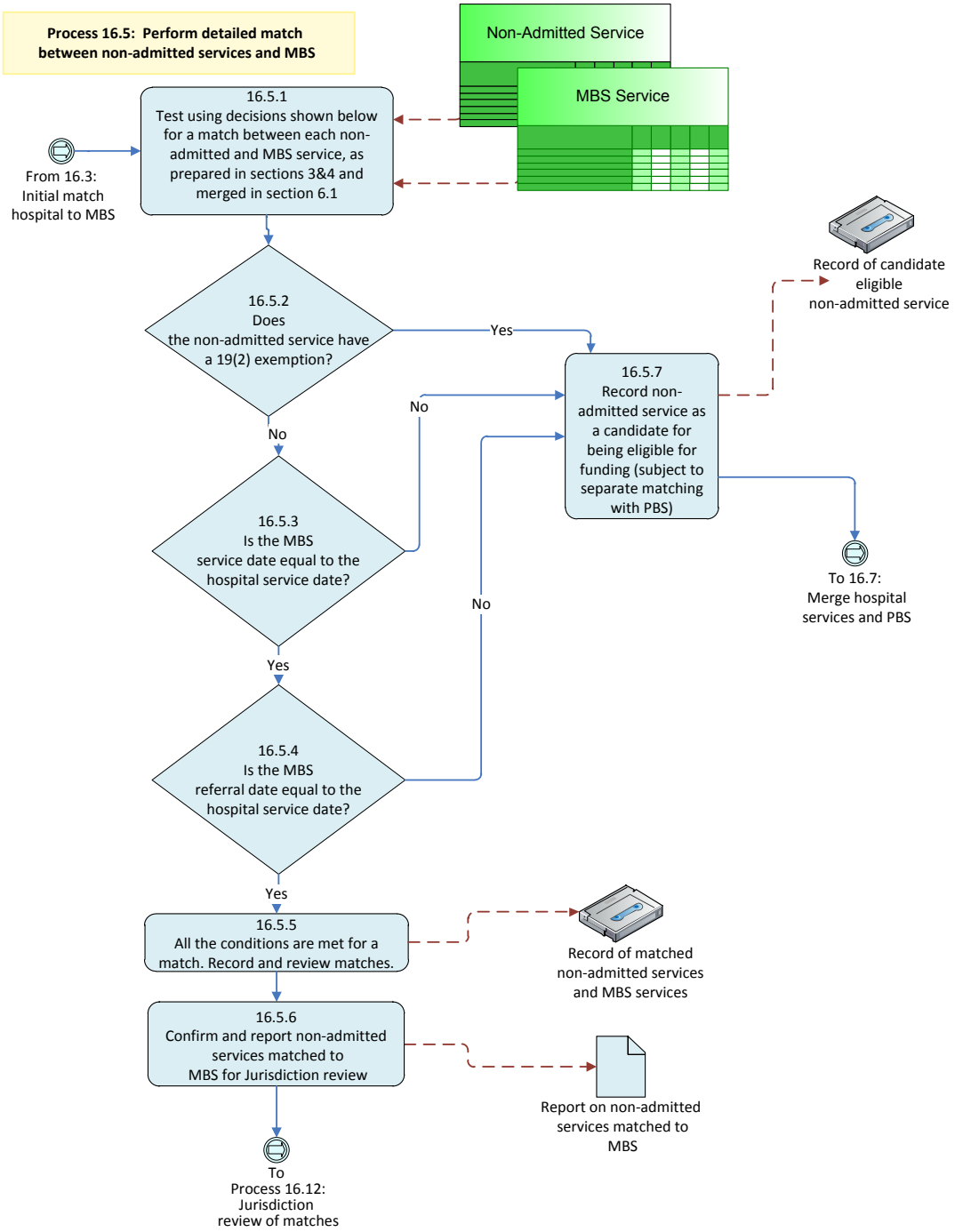
1. Include all matches from the above process.
2. Only include matches from the above process where the PBS service was prescribed and dispensed in hospital (using hospital ID for public patients, or Pharmacy ID where the pharmacy is in a hospital where public patients are treated).
3. Amend the rule in 16.8.3 to state "Was the script written between the day *after* admission, and the day *before* discharge, and filled earlier than the discharge date?" and amend the rule in 16.8.5 to state "Was the script written between the day *after* admission, and the day *before* discharge?"

Analysis of the impact of these alternative scenarios will inform a policy decision on their use by the Administrator.

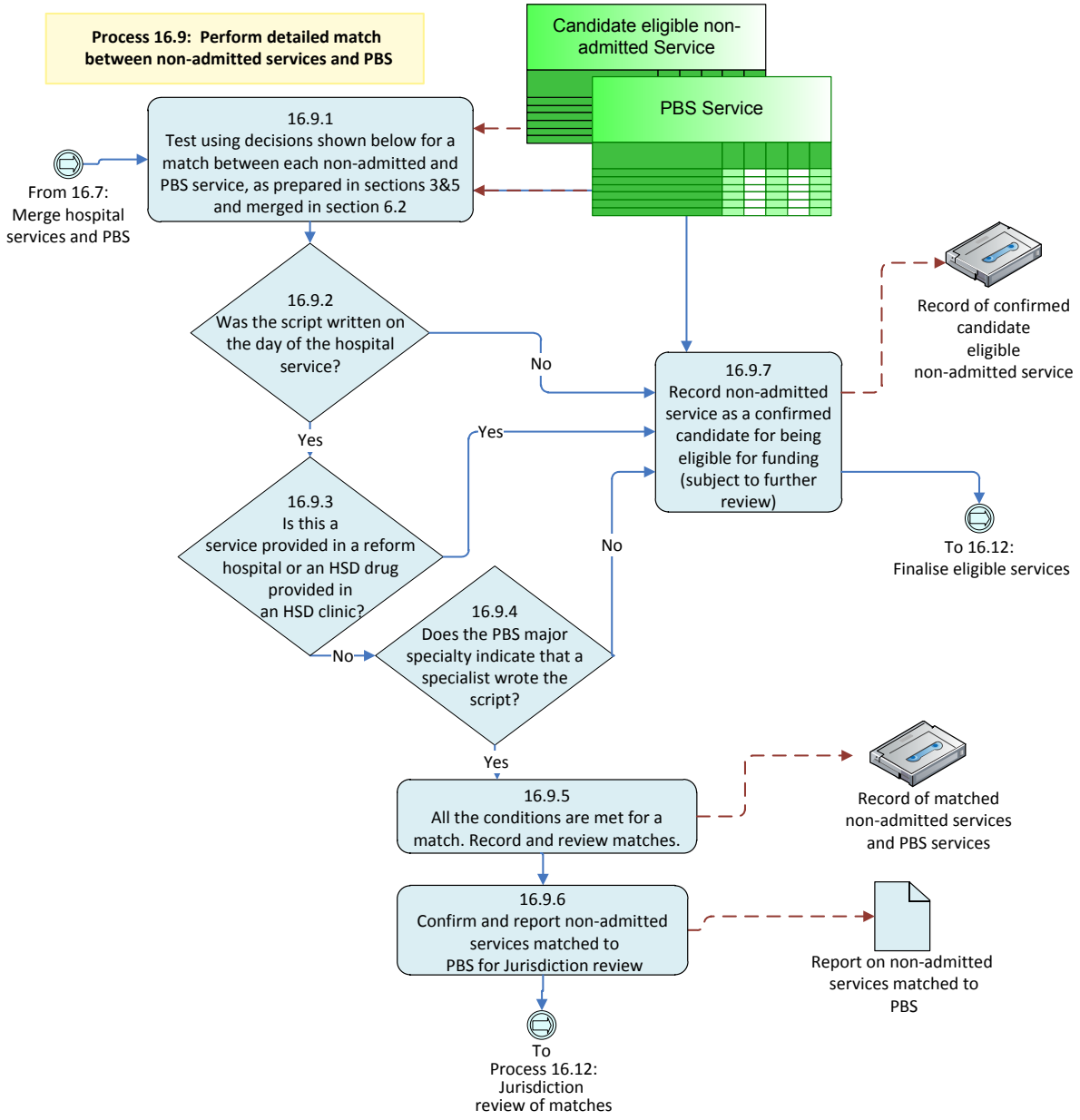
8 Establish eligible non-admitted services

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

8.1 Perform detailed match between non-admitted services and MBS



8.2 Perform detailed match between non-admitted services and PBS



The NHFB will analyse the results of this matching process under the following alternative scenarios:

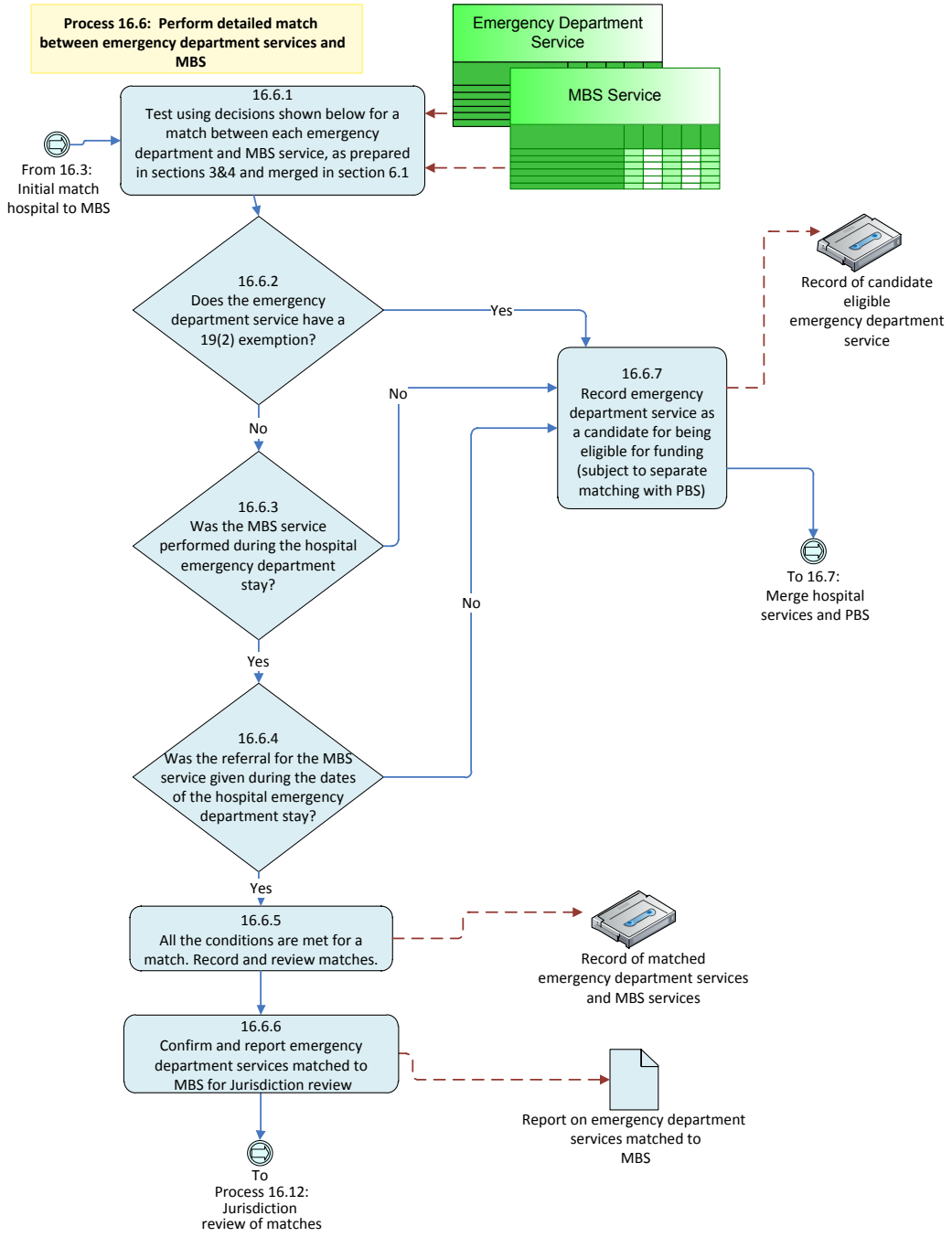
1. Include all matches from the above process.
2. Only include matches from the above process where the PBS service was prescribed and dispensed in hospital (using hospital ID for public patients, or Pharmacy ID where the pharmacy is in a hospital where public patients are treated).

Analysis of the impact of these alternative scenarios will inform a policy decision on their use by the Administrator.

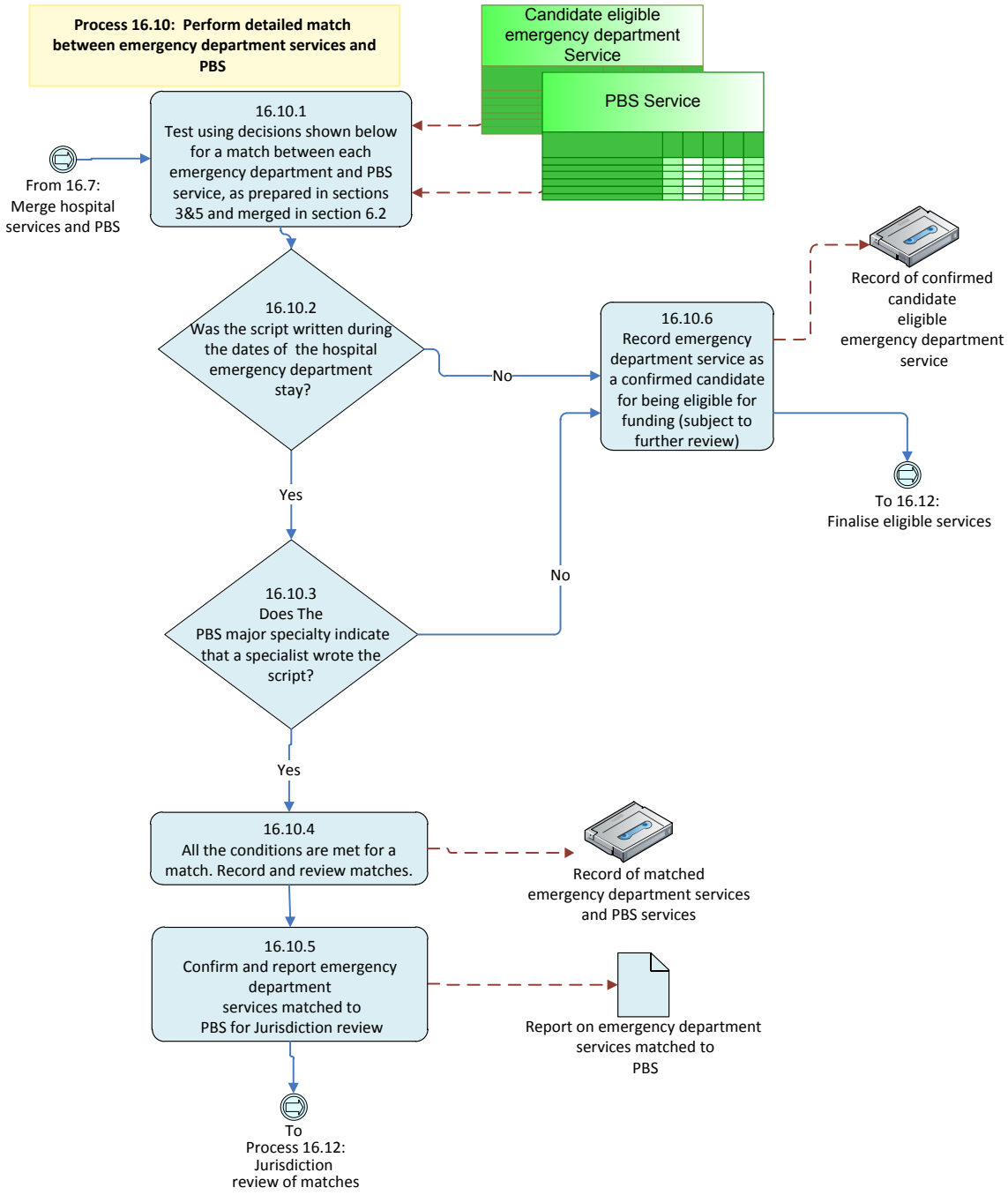
9 Establish eligible emergency department services

This process performs a progressive and more detailed matching process on the emergency department data initially matched on PIN to MBS or PBS 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



The NHFB will analyse the results of this matching process under the following alternative scenarios:

1. Include all matches from the above process.
2. Only include matches from the above process where the PBS service was prescribed and dispensed in hospital (using hospital ID for public patients, or Pharmacy ID where the pharmacy is in a hospital where public patients are treated).

Analysis of the impact of these alternative scenarios will inform a policy decision on their use by the Administrator.

10 Resolve the eligibility of same day hospital services

Across *all* service categories - admitted, non-admitted or emergency department - examine the set of services out of the detailed matching process which have been matched and are therefore *not eligible* for funding under the 'proof of concept'.

If there are multiple hospital services in this set of matched services which have been provided on the same day[7] to the same patient, then these services must be changed to *remain eligible* for funding as it would not be possible to determine to which of these multiple hospital services any MBS or PBS claim related.

[7] Note that the 'same day' business rule applied here by the Administrator examines the remaining patient level same day services reported by states and territories after taking into account the IHPA business rules for appropriately amalgamating same day non-admitted services. Refer to IHPA's *Tier 2 Non-admitted Services Compendium 2013–2014*, Section 6: "Multiple services on the same day".

11 Exception reporting requirements

11.1 Report data anomalies to states and territories for review

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

11.2 Report matched services to states and territories for review[8]

The Administrator intends 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 full 2012-13 financial year: 2012-13H2[9]
- The unique state record identifier provided by the jurisdiction, together with the service 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 be 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 a format and process to be discussed, why these matched services should be eligible for funding.

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[8] Refer section 7.2.3 of Determination 03
[9] H2 denotes "half two"

12 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 as per the Administrator's business rules, together with the reasons 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, and are designed to encourage stakeholder discussion.

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.

12.1 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 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.

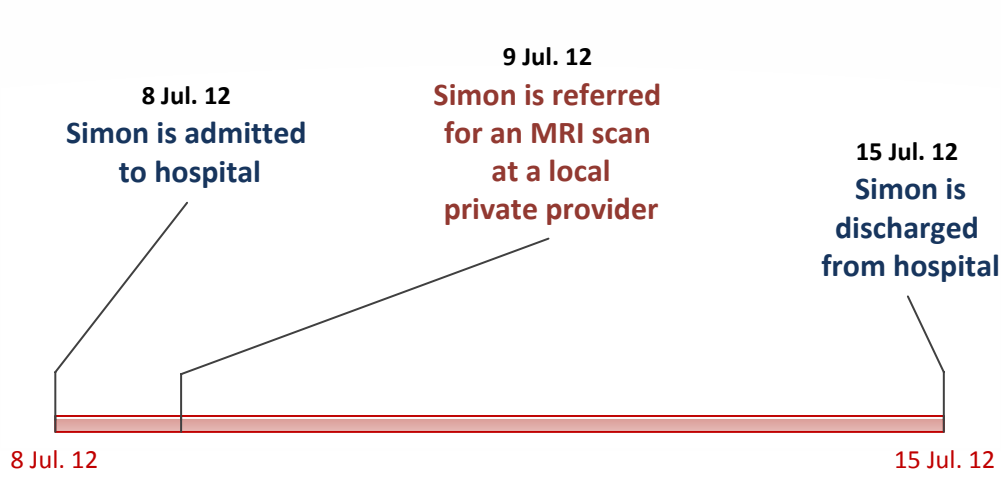
The decision process for this scenario is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 6.2 and 7.2, in the context of the Appendix D process overview.

Table 5 – Scenario 1 decision process

Decision Point	Question	Answer	Action	Page number
16.7.1	Merge hospital services and PBS and test using decisions below			
16.7.2	Does hospital service PIN match to PBS PIN?	Yes	Go to 16.7.3	24
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	24
16.7.4	All the conditions are met for a match. Record this row in the following datasets: • admitted patient matched with PBS • PBS matched with admitted patient		Go to 16.8	27
16.8.1	Evaluate specified conditions for a match between each admitted and PBS service		Go to 16.8.2	27
16.8.2	Is this a reform hospital?	Yes	Go to 16.8.3	27
16.8.3	Was the script written during the hospital stay, and filled earlier than the discharge date?	No	Go to 16.8.9	27
16.8.9	Record admitted service as a confirmed candidate for being eligible for funding.		Go to 16.12	33
16.12	Finalise eligible services.			

12.2 Scenario 2: Admitted patient with MBS service

Figure 2 – Scenario 2 timeline



Scenario: Simon has just left his local hospital in Sydney. 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 6.1 and 7.1, in the context of the Appendix D process overview.

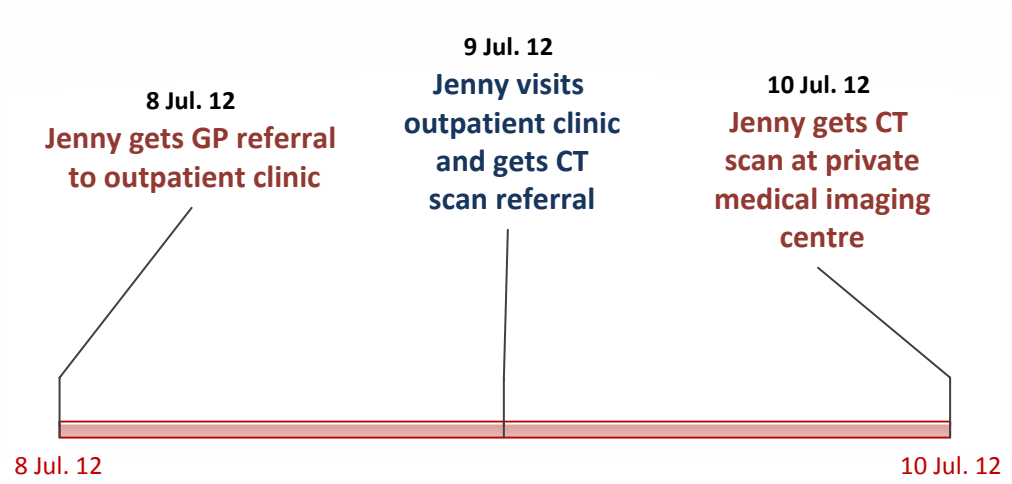
Table 6 - Scenario 2 decision process

Decision Point	Question	Answer	Action	Page number
16.3.1	Merge each admitted and MBS service and test using decisions below.			
16.3.2	Does MBS PIN match to hospital service PIN?	Yes	Go to 16.3.3	23
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	23
16.3.4	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 16.4.1	25
16.4.1	Evaluate specified conditions for a match between each admitted and MBS service.		Go to 16.4.2	25
16.4.2	Does the admitted service have a 19(2) exemption?	No	Go to 16.4.3	25

Decision Point	Question	Answer	Action	Page number
16.4.3	Was the MBS service performed during the hospital stay?	Yes	Go to 16.4.4	25
16.4.4	Was the MBS service referral date during the hospital stay?	Yes	Go to 16.4.5	25
16.4.5	All the conditions are met for a match. Record and review matches.		Go to 16.4.6	25
16.4.6	Confirm and report admitted service matched to MBS for jurisdiction review, with the service being ineligible for ABF funding.		Go to 16.11	34
16.11	Jurisdiction review of matches.			

12.3 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.

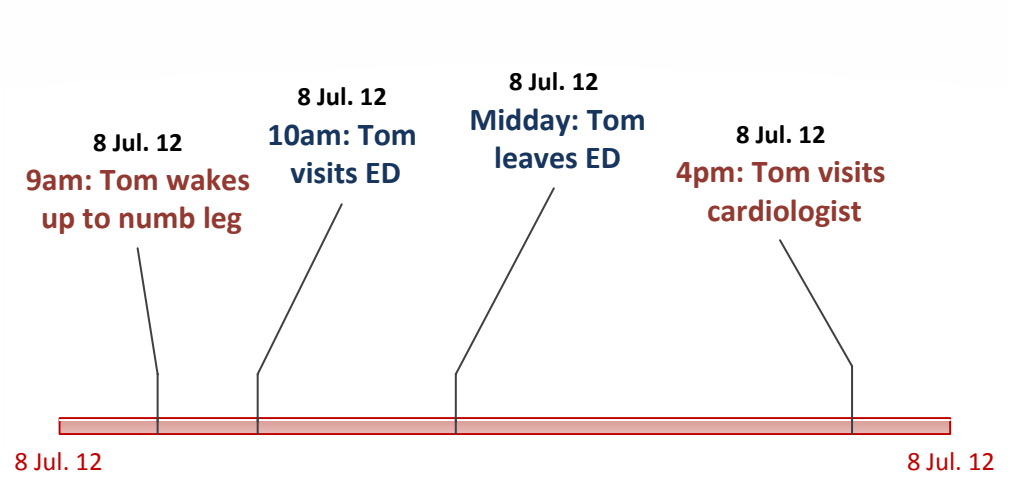
The decision process is illustrated in detail in the table below, showing the path including decision points and actions, that this scenario takes through the detailed process flows in sections 6.1 and 8.1, in the context of the Appendix D process overview.

Table 7 - Scenario 3 decision process

Decision Point	Question	Answer	Action	Page number
16.3.1	Merge each non-admitted and MBS service and test using decisions below.			
16.3.2	Does MBS PIN match to hospital service PIN?	Yes	Go to 16.3.3	23
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 16.3.5	23
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 16.5.1	29
16.5.1	Evaluate specified conditions for a match between each non-admitted and MBS service.		Go to 16.5.2	29
16.5.2	Does the non-admitted service have a 19(2) exemption?	Yes	Go to 16.5.7	29
16.5.7	Record non-admitted service as a candidate for being eligible (subject to separate matching with PBS).		Go to 16.7	24
16.7	If no match to the PBS is found, then the service is eligible for funding.			

12.4 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 6.1 and 9.1, in the context of the Appendix D process overview.

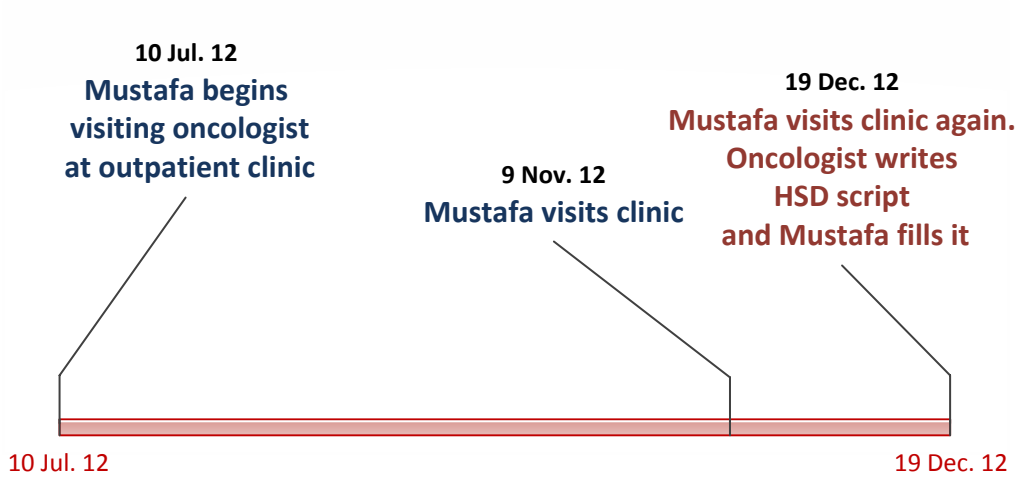
Table 8 - Scenario 4 decision process

Decision Point	Question	Answer	Action	Page number
16.3.1	Merge each emergency department and MBS service and test using decisions below.			
16.3.2	Does MBS PIN match to hospital service PIN?	Yes	Go to 16.3.3	23
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	23
16.3.4	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	31
16.6.1	Evaluate specified conditions for a match between each emergency department and MBS service.		Go to 16.6.2	31

Decision Point	Question	Answer	Action	Page number
16.6.2	Does the emergency department service have a 19(2) exemption?	No	Go to 16.6.3	31
16.6.3	Was the MBS service performed during the emergency department stay?	Yes	Go to 16.6.4	31
16.6.4	Was the MBS service referral given during the dates of the emergency department stay?	No	Go to 16.6.7	31
16.6.7	Record emergency department service as a candidate for being eligible (subject to separate matching with PBS).		Go to 16.7	24
16.7	If no match to the PBS is found, then the service is eligible for funding.			

12.5 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 any other 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 6.2 and 8.2, in the context of the Appendix D process overview.

Table 9 - Scenario 5 decision process

Decision Point	Question	Answer	Action	Page number
16.7.1	Merge hospital services and PBS and test using decisions below.			
16.7.2	Does hospital service PIN match to PBS PIN?	Yes	Go to 16.7.3	24
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	24
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 16.9.1	30
16.9.1	Evaluate specified conditions for a match between each non-admitted and PBS service.		Go to 16.9.2	30
16.9.2	Was the script written on the day of the hospital service?	Yes	Go to 16.9.3	30
16.9.3	Is this a reform hospital or an HSD drug provided in an HSD clinic?	Yes	Go to 16.9.7	30
16.9.7	Record non-admitted service as a confirmed candidate for being eligible for funding.		Go to 16.12	33
16.12	Finalise eligible services.			

13 Appendix B - Reference data

The Administrator will work with the Commonwealth Department of Health and other jurisdictions to establish required reference data.

13.1 Hospital (aka facility or establishment) list

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

- Hospital ID
- Hospital Name
- State/territory
- 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 *National Health Act* which will allow them to supply PBS medicine.
- Should non-admitted services for this hospital be funded using patient level data, aggregate level data or both? (Patient level/Aggregate level/Both)

13.2 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” (Yes/No)

13.3 Prescriber number list

A prescriber list is required, specifying:

- Prescriber number
- Provider number

13.4 Pharmacy list

A pharmacy list is required, specifying:

- Pharmacy number
- Whether the pharmacy is in hospital or not (Yes/No)

13.5 List of ABF hospitals for 2012-13

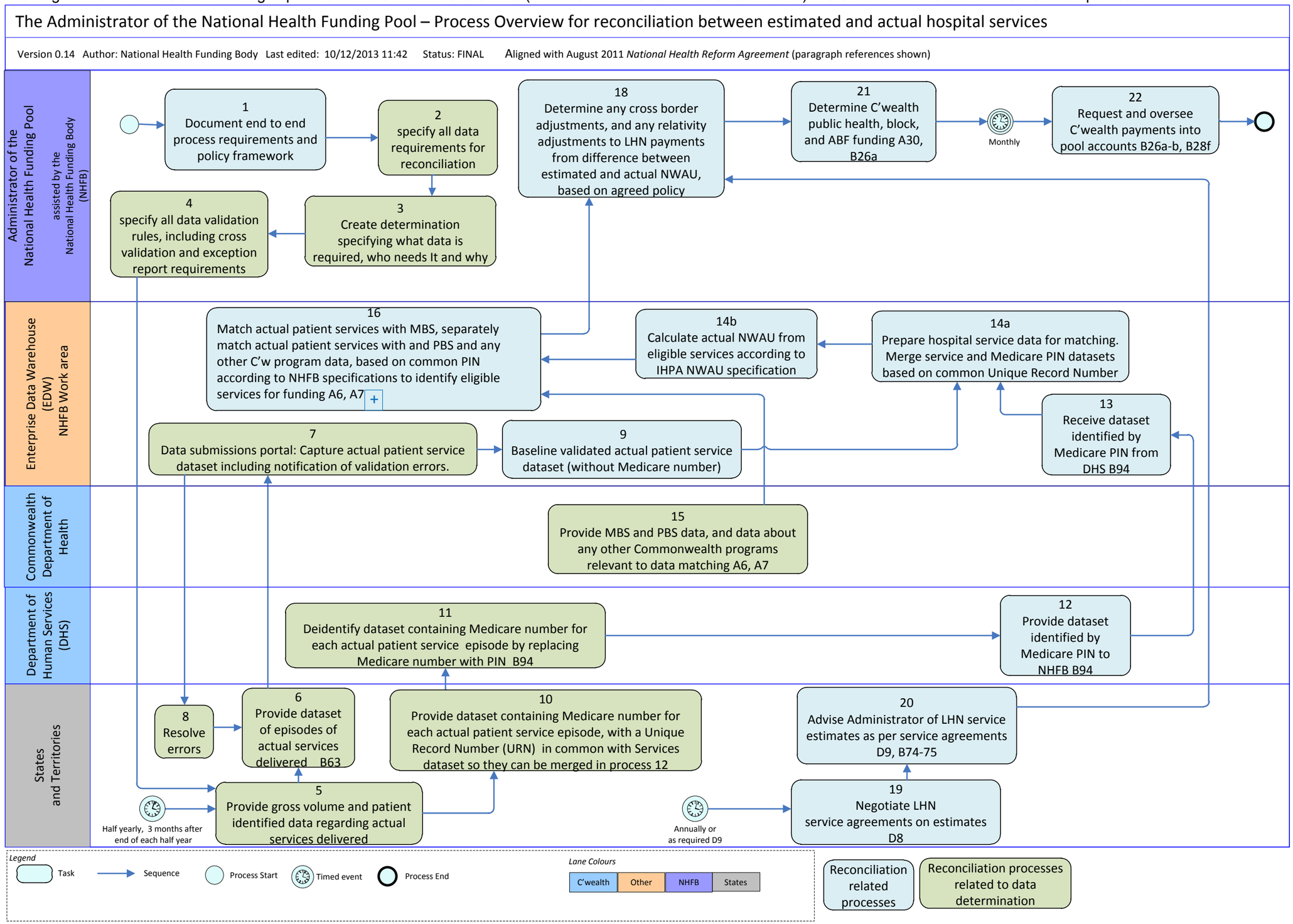
The list of activity based hospitals by state or territory and by LHN for 2012-13 is as advised by each state and territory to the Administrator.

13.6 Postcodes that span states/territories

Refer to the *Administrator's 2012-13 Reconciliation Framework* for a table outlining the postcodes that span more than one state/territory including a determination of which state or territory patients with that postcode will be assigned to.

14 Appendix C – Reconciliation process overview

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



15 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.