SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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KEY TERMS	VMO, VMoney, Claims
SUMMARY	This procedure is provided to assist Visiting Medical Officers (VMOs) when submitting VMoney Claims, and to assist sites in the checking and auditing.

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Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

1. POLICY STATEMENT

Payment of claims is to be made in accordance with the requirements of NSW Health Guideline (November 2015) on VMO Claims management.

2. BACKGROUND

This procedure is provided to assist Visiting Medical Officers (VMOs) when submitting claims for agreed remunerable services and support claims checking, approvals and compliance monitoring following the NSW Health Policy Directives and Guidelines.

3. RESPONSIBILITIES:

3.1 Employees will: check claims and communicate with VMOs and VDOs in accordance with this procedure. Escalate concerns to a supervisor as required.

3.2 Line Managers of checking staff will: ensure that VMO and VDO claims are assessed in accordance with this procedure. Ensure that a timely, reliable and sustainable system for the checking of claims is implemented and embedded within the organisation.

3.3 General Managers will: Ensure compliance with this procedure. Have systems and processes in place to ensure adequate numbers of appropriately trained checkers are available to meet timelines for payment processing. Have processes in place to identify and escalate concerns regarding systemic non-compliance with this and other relevant policies and procedures. Ensure a regular schedule of auditing of claims is conducted, and that late claims are discounted in accordance with this procedure.

3.4 VMOs and VDOs will: Submit complete, accurate VMoney claims in a timely manner. Comply with all reasonable requests for further information in a timely manner. Comply with this procedure.

4. PROCEDURE

4.1 Implementation

Implementation will be achieved through:

- Dissemination of this guideline to VMOs currently appointed to SESLHD facilities.
- Establishment of a management structure that ensures:
  - Communication to VMOs and checkers;
  - Review, audit and reporting; and
  - Feedback to facility Medical Department Heads and Directors Medical Services.
- Inclusion of this document with contracts for new and reappointed VMOs and other relevant staff

4.2 Sources of verification of claims

Relevant reports and resources should be used to check the validity of the claims. VMOs must have made an appropriate notation identifying services to be paid in the Medical Record. It is acceptable for the notation to have been made by a member of the junior medical staff on behalf

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of the VMO, but it must identify with sufficient precision the senior medical officer and date and nature of the service provided. Relevant records, that can authenticate VMO claims include:

- eMR (Electronic Medical Record);
- PAS (Patient Administration system);
- PMI (Patient Master Index);
- Approved Committee lists, attendance records, minutes and action lists;
- Records of Non-Standard Arrangements approved by the Ministry of Health;
- Applicable Service Plans;
- Call Back Registers;
- VMoney Web;
- Surginet; and/or
- rosters.

4.3 Checking VMO Claims

The SESLHD facility must have in place the structure by which VMO claims are checked prior to a payment being processed. This should include designated staff with responsibility for each stage of the checking process.

VMoney Web is programmed to request particulars for each aspect of a claim. Checkers must assess each line of the claim against existing records. The facility Directors Medical Services should review local checking processes to ensure enough information is being routinely provided or is otherwise available to enable claims to be validated.

There is a designated Checker for each VMO, who is responsible for the initial review of the VMO claim. This role may be assigned to administrative staff in the medical workforce departments or other designated departments.

After the Checker has reviewed, the VMO claim it is then forwarded to the designated staff for approval. If further information is required at this time, the Approver will refer this to the Checker and/or the VMO. Once approved, the claim is then processed by the VMoney system.

4.4 V Money Web Check Points

The VMoney Web System automatically identifies any entries where there is an overlap in times (for example, a meeting from 7.00-8.00am and surgery starting at 7.30am on the same day.

These will be flagged in Orange or Red.

- Claim lines with Orange flags that are forwarded for approval should have further information entered by the checker with an explanation of why the claim should be approved. Claims marked with Red flags are not routinely approved.
- Each claim under the “Miscellaneous” tab requires manual checking.
- Checkers will also ensure that the correct cost centre is provided and seek authorisation to make changes where required.

4.5 Insufficient provision of information

- Where sufficient information is not provided in the VMO claim or where sufficient information ceases to be otherwise available from the medical records or the VMO personal records, then

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future payments to the VMO for a specified period will require the provision by the VMO of additional details.
- On a case by case basis, claims may be referred to the SESLHD facility Director of Medical Services for verification or advice before it is approved for payment without necessitating request for additional information from the VMO.
- A claim that cannot be verified from abovementioned sources or are not supported for payment by the SELSHD Director of Medical Services will be classified as "pending payment".
- A claim that is classified as "pending payment" will be communicated to the VMO in writing (electronically) at least five (5) calendar days prior to the due date for completion of checking and before forwarding to the authorised Approver. The VMO will need to provide further documentation and/or evidence from the VMOs personal records, of completion of the service for which the claim has been made in order to substantiate the claim.
- A standard communication template will be used for claims "pending payment" (Appendix A). Where these claim lines cannot be adequately verified by the due date for completion of checking, those claim lines shall be rejected for payment in the current pay period. Such claim lines should be re-submitted by the VMO as an adjustment in the VMOs next claim month with relevant supporting information for validation and subsequent payment.

4.6 VMO Claim Categories

4.6.1 Sessional Claims

Routine Hours

VMO's are contracted to provide agreed clinical services to the facility within their position description and delineated scope of clinical practice.

VMOs are required to submit their claims by the 15th of each calendar month and to maintain their own record of services rendered including start and finish times, patients name and medical record number, and the nature of the service provided of each public patient claimed.

The VMO should provide relevant details of patients who received the service, type of service and the date the service is provided. Following details are required;

- o The date, commencing and finishing times, full name and/or medical record number of the patient and nature of service;
- o Particulars of on-call periods;
- o For call-backs, the patient MRN and/or name and the name and designation of the person requesting the call-back, and appropriate entry by the VMO in the medical record of the relevant attendance and/or treatment;
- o Particulars of teaching, training and committee work
- o Particulars of any leave of absence.

- **Rounds and Consults:** VMOs are required to provide details of services rendered to each public patient claimed when requested by the Facility – VMoney Web will flag inconsistencies, noting that there can be considerable variation in time taken for clinical care depending on caseload and acuity of care.

- **Outpatient Hours:** VMO outpatient clinic rosters are to be used for cross reference by Checkers to verify claims submitted.

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- **Theatre Hours:** VMO theatre lists are to be used for cross reference by Checkers, to verify claims submitted. All non-eligible patients should be excluded from the claim by way of deduction of hours.

- **Cancelled Theatre Sessions:** The VMO is entitled to be paid for that portion of the cancelled time that is reasonably estimated would have involved the treatment of non-chargeable patients at the hourly rates, on the condition that the VMO attends the PHO to provide services for the relevant period in lieu of the cancelled theatre session, unless excused from such attendance by the PHO.

The payment should only apply in circumstances where a VMO has a pre-arranged operating theatre session cancelled by the PHO:

- less than 28 days' notice of such cancellation was provided to the anaesthetists;
- less than 14 days' notice of such cancellation was provided to a regional VMO who is not an anaesthetist;
- less than 7 day notice of such cancellation was provided to other VMOs.

For payment to be made, the following activities should be undertaken as requested by the PHO (in lieu of cancelled theatre sessions):

- undertaking training and education activities specified by the PHO;
- undertaking clinics or procedures within the scope of the VMO's clinical privileges;
- undertaking quality assurance or review activities specified by the PHO

Where a VMO cancels a pre-arranged operating theatre session, and the cancellation is not due to illness, the VMO is required to make up the cancelled time over the ensuing 14 day period at time/s of mutual convenience to the VMO and the PHO. If such mutually convenient time is unavailable, the VMO will cooperate with the PHO in examining the feasibility of alternate arrangements with another medical practitioner for the performance of operations or procedures upon non-chargeable patients affected by such cancellation.

- **On-Call Hours:** Departmental rosters are to be maintained and checked, confirming that the VMO was on call.

- **Call Back Hours**: VMOs are to provide details of the hospital officer who has requested the VMO's attendance to claim a call back. VMOs are entitled to claim a maximum of 20 minutes travel time to and 20 minutes home from the hospital. VMOs already on campus, who are requested to attend a call back, cannot claim travel time.

VMOs must only enter details of public call back patients attended, as the system has no provision for the deduction of private patient hours worked. This is unlike the 'Routine' part of the claim, which allows a VMO to enter the entire session time spent at the hospital and to also be able to deduct the private patient time component so as to pay the VMO the difference (the public patient component).

Where a VMO attends the hospital for a ward round as part of a period of oncall (such as on a weekend on public holiday) the VMO may claim the ward round as a sessional or part sessional payment rather than itemising all patients seen on the round. Only the actual time spent on the round should be claimed. Deductions should be made for any private or ineligible patients.

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- **Ineligible Patient Classifications**: Sessional claims may include private patients or otherwise chargeable patient details as a record of services. However the VMO will need to deduct any time for services provided to such patients. Where the VMO has not deducted such time, the delegated checker will need to deduct that time from the claim by modifying the claim line or rejecting the entire claim line if it relates solely to such patients VMOs wishing to claim ineligible patient classifications can do so by entering the call back claim as an 'Outpatient' rather than an 'Inpatient'. These claims require an explanation in the comments as to why an ineligible patient classification is being claimed. This process will be carefully monitored, to ensure no unwarranted claims are being submitted for payment.

- **Teaching and Training:** VMOs can claim for teaching and training of postgraduate medical officers as may reasonably be required. Sufficient details will need to be provided by the VMOs regarding the teaching and/or training sessions.

- **Meetings:** A VMO shall participate in committees expressly established or authorised by the PHO to which the officer is appointed where reasonably required by the PHO for the proper and efficient functioning of the hospital or hospitals concerned. Claimable meetings for the SESLHD facility will include the following and the claimable hours of the meeting agreed beforehand
- Morbidity and Mortality meetings and other designated routine or ad- hoc clinical audit meetings.
- Peer review meetings, including; Multi-Disciplinary Team meetings, Radiology and Pathology Review meetings.
- Hospital/district meetings where the VMO is appointed as a clinical delegate, including but not limited to Clinical Council, Quality and Risk Committee, Ethics and Research Committee, Heads of Department and formal Departmental Meetings and Preliminary Risk Assessment (PRA) meetings
- Medical Educational Meetings (if presenting or facilitating)
- Interview panels
- Mandatory training
- Other meetings required by the SESLHD facility

The following meetings shall not be claimed:

- Board meetings
- Medical Staff Council Meetings;
- Education meetings for the benefit of the VMO;
- Public relations type meetings where the VMO may be invited and attends by their own choice (e.g. opening ceremonies, meetings with dignitaries)

There should be outputs from meetings such as an attendance record, and minutes or actions lists as applicable. Claims for attendances at "Agreed meetings" will be checked against minutes of meetings and/ or meeting attendance records maintained by the relevant Clinical Service.

Where claims are submitted for attendance at meetings other than those routinely held within the service, checkers should ensure that the meeting for which reimbursement is being sought has been approved by checking with the relevant facility Department Head and if indicated, Director Medical Services before submitting for approval.

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4.6.2 Fee for Service Claims

Fee for Service claims are VMO procedure item claims. VMOs are required to enter the medical record number of the patient attended, together with the date and the procedure item to be claimed. The patient status will be checked to confirm it is non-chargeable via iPM and against the Surginet report.

Services provided to private patients or otherwise classified as a chargeable patients should not be included in Fee for Services claims. Claims will be checked to exclude private patients before being approved for payment.

4.7 Late Claims

In line with section 14.8 of the Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2014 and Section 8.8 of the Public Hospitals (Visiting Medical Officers Fee for Service Contracts) Determination 2014, late claims made by VMOs will be discounted or disallowed if the claim dates are too old. The current practice is as follows:

- Claims for services provided more than 12 months before the date the claim is submitted will be paid 50% of the rate that would otherwise apply.
- No payment will be made for any claim for any services provided more than 24 months before the claim was submitted.

4.8 Zero Hours/Nil Activity Claims

If in any month a VMO does not undertake any clinical practice a zero hours or nil activity claim should be submitted indicating that there are no clinical hours requiring remuneration in that period.

4.9 Patient Financial Classifications eligible for payment from 23 March 2021

- Public Patient (MNW) as of the 23/03/21
- Reciprocal- Public (RW)
- NSW MA- No Claim Public (V10)
- Asylum/ROMAC- Single (ARS)
- Asylum/ROMAC- Shared (ARW)
- Asylum/ROMAC- S/D1-4 (ARD)
- Asylum/ROMAC- Critical (ARC)
- Unqualified Newborn (UQ)

4.10 Financial Consent

If the VMO is charging a medical gap to a chargeable patient, they must provide adequate informed financial consent to this patient. If the patient does not pay the medical gap, under no circumstances can a claim then be made against the hospital. This process will be carefully monitored, to ensure no unwarranted claims are being submitted for payment.

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4.11 Claims related to ineligible patients

4.11.1 Overseas visitors

Overseas patients are treated as private patients, other than overseas patients from countries which have reciprocal arrangements with Australia.

An exception applies under NSW Ministry of Health Policy Directive PD2021_025 - Scale of Fees for Hospital and Other Health Services, where the VMO is required by the Public Health Organisation to treat an ineligible patient under their service contract as a public patient in a public hospital, the VMO is paid by the Public Health Organisation at the appropriate VMO rate.

4.12 Checking and auditing VMO claims

NSW Ministry of Health Information Bulletin IB2013_055 - Visiting Medical Officer (VMO) Claims Auditing outlines the arrangements that will facilitate more effective scrutiny of VMO claims, to ensure that they are appropriate to be paid.

The process for auditing VMO claims is dependent on whether the VMO's contract is Sessional - Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2014 or Fee for Service - Public Hospitals (Visiting Medical Officers Fee-For-Service Contracts) Determination 2014.

4.13 Definitions

"Call-back" means called to attend a hospital-, whether or not rostered on-call, at a time when the VMO would not otherwise have attended the hospital, in response to a request from the relevant hospital or public health organisation (PHO) to attend for the purpose of providing services.

"Clinical privileges" means the clinical privileges as defined in the Health Services Act 1997;

"Fee-for-service contract" means a fee-for-service contract as defined in the Health Services Act 1997;

"Hospital" means a hospital as defined in the Health Services Act 1997;

"Medical practitioner" means a person registered for the time being under the Medical Practice Act 1992;

"On-call" means rostered to be available to attend public patients pursuant to an on-call roster prepared by a public health organisation in consultation with the relevant clinical department;

"Private patient" means a patient who is not a public patient;

"Public health organization PHO" is as defined in Chapter 2 of the Health Services Act 1997;

"Public patient" means a patient in respect of whom the public health organisation provides comprehensive care, including all necessary medical, nursing and diagnostic services, by means of its own staff or by other agreed arrangements;

"Services" means medical services provided to a public patient by a visiting medical officer under a fee-for-service contract, including teaching, training and participation on

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committees, but excluding attendance at meetings of a medical staff council (howsoever called);

"Service contract" means a service contract as defined in the Health Services Act 1997;

"Sessional contract" means a sessional contract as defined in the Health Services Act 1997;

"Visiting medical officer" means a visiting medical officer as defined in the Health Services Act 1997 who provides services under a service contract, but excluding a pathologist and a radiologist.

"Visiting practitioner" means a medical practitioner or dentist who is appointed, otherwise than as an employee, to practise as a medical practitioner or dentist in accordance with the conditions of appointment (including Visiting Medical Officers and Honorary Medical Officers) The term can be applied to visiting practitioners appointed otherwise than under a service contract (i.e. who are not VMOs or HMOs).

"Nil Activity Claim" means a VMO who has a contract with a SESLHD facility and has not provided services within that month should submit a Nil Activity claim.

5.0 DOCUMENTATION

TEMPLATE: Notification to Visiting Medical Officer seeking additional information forpurpose of verifying claims for services provided

Send to < Dr's Email Address >

Priority < High Importance >

Email Subject < ACTION REQUIRED - PENDING CLAIM- >

Dear Dr…< Name >…………

Your claim for services provided during <month> <year> has been reviewed.

The following claims have not been able to be verified and approved to process for payment and have been withheld as "Pending claims" to offer you an opportunity to provide the additional information which is required to verify and approve the claims

Date of service	Type of service provided/claimed	Information required by VMO to verify claim

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The information requested should be provided to < name of VMO claims checker> by < duedate > for claims to be substantiated and processed for payment during the current pay period.

If the information is not received by the due date, payment for the pending claim lines will be rejected in the VMoney system for the current pay period. You are advised to resubmit outstanding claims with required evidence as an adjustment in your next claim month.

Please contact <Name> <contact number><email> if you require any further information or assistance.

Yours sincerely,

6. AUDIT

Refer to Section 4.12.

7. REFERENCES

NSW Ministry of Health Policy Directive PD2021_025 – Scale of Fees for Hospital and Other Health Services

NSW Ministry of Health Information Bulletin IB2019_026 - Remuneration Under Fee for Service Contracts for Visiting Medical Officers

NSW Ministry of Health Information Bulletin IB2019_033 - Remuneration Rates for Sessional Visiting Medical Officers

NSW Ministry of Health Information Bulletin IB2013_055 - Visiting Medical Officer (VMO) Claims Auditing

Visiting Medical Officer (VMO) Claims Management Audit Tool Guideline

Public Hospitals (Visiting Medical Officers Sessional Contracts)Determination 2014

Public Hospitals (Visiting Medical Officers Fee-For-Service Contracts) Determination 2014

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
September 2021	1	Approved by Executive Sponsor, following development and consultation period.
October 2021	1	Approved at September 2021 Executive Council meeting.

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