

Acute Health Services

Form S9: Acute Non-Admitted Patient
Services—VACS Funded Hospitals

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Reporting Requirements

Form S9_111 is completed by hospitals that have had their specialist and allied health outpatient clinics assigned by the VACS Clinical Panel and approved by the Department of Human Services. Hospital staff make the initial assignment of proposed VACS clinics to the categories defined under the classification system, throughout the financial year (see VACS website: <http://www.health.vic.gov.au/vacs/>). These assignments are then evaluated once a year by the VACS Clinical Panel, which is comprised of eminent senior clinicians from a range of specialties (including Medical, Nursing and Allied Health professionals). Hospital staff are required to submit data to AIMS for clinics that have been approved and those pending formal approval from the VACS Clinical Panel. In the event of a clinic not being approved by the VACS Clinical Panel, hospitals are required to remove data already submitted under the VACS approved clinic categories for that financial year and resubmit the activity under the 'Other Clinics' categories.

Return of Forms

Hospitals are to submit data to the Department via the Health Collect website by the 15th day following the end of the month. A tick in the *Completed* field indicates to the Department that the form is complete with all validation rules satisfied and appropriate approvals for release obtained.

Printouts of the original signed forms must be retained by the hospital and be available to officers of the Department upon request.

Correction of Forms

Where an error is detected for any data item previously submitted to the Department, then a correction must be submitted. A correction can be made at any time during the reporting period.

Definitions

Non-Admitted Patient

A patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: emergency department patient, outpatient, and other non-admitted patient (treated by hospital employees off the hospital site—includes community/outreach services). The term *non-admitted patient* is synonymous with the term *non-inpatient*.

Patients admitted under the designated 'Hospital in the Home' program are admitted patients and services provided to them should not to be reported on Form S9_111.

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VACS Encounter

Encounters refer to a visit to a clinic assigned to one of the 35 VACS categories. For funding, resource weights have been developed that incorporate encounters based not only on the clinic visit but associated ancillary services provided to a patient over a defined period. The period over which bundling occurs is a 'window' of thirty (30) days either side of the visit. Activity reported on the S9_111 form for VACS approved clinics or clinics pending approval should be unweighted actual encounters.

In VACS, specialist clinic patients must have a one-on-one encounter with a doctor (specialist/physician) at each visit. The only exception is for VACS 402 where patients may see a midwife (performing equivalent duties) instead of a doctor.

If a patient has more than one booked appointment, each appointment will be counted as one encounter. For example, three booked appointments on a single day will be counted as three encounters (although in most instances, patients are unlikely to attend more than two clinic visits per day).

Where a patient receives multidisciplinary care, within one booked appointment, one encounter shall be recorded, regardless of the number of care types provided. The encounter record should be attributed to the clinic type associated with the booked appointment.

For further information on VACS Encounters see the VACS Brochure:

<http://www.health.vic.gov.au/vacs/vacs.pdf>

MBS Encounter

MBS encounters occur where the specialist/physician bills the MBS for the visit, regardless of any other ancillary services provided to the patient. As with VACS encounters, MBS encounters should be assigned to the relevant clinic type and must have a one-on-one encounter with a doctor (specialist/physician) at each visit. A single MBS encounter is recorded for any clinic regardless of the number of doctors (specialists/physicians) seen by an individual patient, or the number of MBS items billed for any individual patient. *Include MBS bulk billed clinics only. Do not report MBS-billed services which involve a co-payment.* Include MBS-billed allied health occasions of service in allied health section.

For further information on MBS-billed specialist clinics see:

<http://www.health.vic.gov.au/outpatients/resources>.

Occasion of Service

An occasion of service is any examination(s), consultation(s), treatment(s) or other direct care provided to a non-admitted patient in *each functional unit* of a health service establishment on each occasion such service(s) is (are) provided.

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A VACS occasion of service refers to a visit to a clinic assigned to one of the 11 allied health VACS categories. For reporting purposes, an occasion of service is counted once, irrespective of the number of allied health professionals who attend to the patient during the single clinic visit, or the number of patients within an allied health clinic group (e.g. Diabetes education class) – see definition of ‘Group Sessions’ below.

‘Other Clinic’ occasions of service are reported on Form S9_111 for outpatient clinics outside the scope of VACS, allied health clinics, emergency medicine, other non-admitted activity such as outreach services and ancillary services. An occasion of service is equivalent to an encounter for VACS approved clinics.

Counting Occasions of Service

An occasion of service occurs when one or more services are provided to a non-admitted patient by a particular functional unit or department of a hospital. Each set of related diagnostic tests or services for the one patient on one occasion, consists of one occasion of service. For example, three blood tests performed for the one patient on one visit to a hospital would count as one occasion of service.

Services provided by different departments in the hospital represent different occasions of service; thus, if a patient receives radiology and pathology tests to assist with diagnosis of the same problem, this would count as two occasions of service.

If a patient has more than one booked appointment, each appointment will be counted as one occasion of service. For example, three booked appointments on a single day will be counted as three occasions of service.

Where a patient receives multidisciplinary care, within one booked appointment, one occasion of service shall be recorded, regardless of the number of care types provided. The occasion of service record should be attributed to the clinic type associated with the booked appointment.

Telephone calls or telemedicine contacts with, or about, the patient, are not included in the definition of an occasion of service and are not to be counted/reported to AIMS. These are counted in the VACS base grant in VACS funded hospitals.

Occasions of service may occur on campus or off campus. Services provided to non-admitted patients of another hospital, such as pathology or allied health services, should only be counted if the hospital is not reimbursed for these services by the other hospital. Outreach clinic services should be counted at the facility where the patient medical record is held.

Services provided to non-admitted patients by medical practitioners or other health professionals on a private basis should not be counted. Services provided on a private basis involve patients being charged directly by the private practitioner or in the private practitioner’s name; this includes all services, which attract Medicare benefits, and services provided to compensable patients.

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DVA Patients

Non-admitted patient services provided to eligible veterans and war widow(er)s are to be reported on non-admitted patient returns. Only one-on-one occasions of service need to be reported for DVA patients. DVA patients attending group sessions do not need to be reported.

Business Units and Privatised Services

'Privatised services' refers to services provided by a separately incorporated body, which may or may not be owned by the hospital/network.

The term 'business unit' refers to a unit which:

- is not a separate legal entity and is under the control of the hospital Board of Management;
- maintains a separate identity within the hospital and a separate set of accounts;
- does not (directly) receive any income from the Department of Human Services; and
- is reimbursed by the hospital from the Operating Fund for any services 'purchased' for public patients.

It is anticipated that business units and privatised services will provide services to private patients on a fee-for-service basis, or to public patients referred by the hospital. Services provided to privately referred non-admitted patients on a fee-for-service basis should not be counted.

Where a public non-admitted patient is referred to a business unit or privatised service by the hospital, these services should be counted as occasions of service by the hospital. The hospital would pay for the service provided to the referred public patient and no claims should be made for Medicare or Veterans' Affairs benefits. Payment by the hospital should be based on an agreed fee-for-service, such as the rates provided in the CMBS Schedule. Where payment for services by the hospital is in kind, such as by provision of accommodation, power, cleaning services, administrative services, etc., the value of the in kind services should be made explicit, and the transfer of chargings between Operating and Specific Purpose Accounts should occur at the end of each month.

Group Session

A service provided to a group of non-admitted patients or clients rather than to individuals. Each group session is to be counted *once only*, irrespective of the number of patients/clients in the group or the number of staff providing services.

For VACS funding purposes, group sessions (as defined above) are reported under the 'VACS Approved Clinics, Individual Sessions, Occasions of Service Public' column in Form S9_111.

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Although not required for VACS funding, separate reporting of the number of group sessions is also required under the 'Group Sessions' columns to enable the Department to comply with its reporting obligations under various Commonwealth State agreements. This information was previously reported on Form S2_111.

Group attendances

The number of patients/clients participating in the group session.

Although not required for VACS funding, separate reporting of the total number of attendances is required to enable the Department to comply with its reporting obligations under various Commonwealth State agreements. This information was previously reported on Form S2_111. Note: Department of Veterans' Affairs patients attending group sessions do not need to be reported.

Section 1: Outpatient, Emergency and Allied Health Clinics

VACS Approved Clinics

The Victorian Ambulatory Classification System identifies hospital specific clinics, which are assigned to one of 47 VACS categories [35 weighted (Medical/ Surgical/ Dental/ Orthopaedic/ Psychiatric Related Services/ Obstetrics & Gynaecology/ Paediatric), 11 unweighted (Allied Health) and 1 Emergency Medicine]. Prior to submitting data on the S9_111 form, hospitals must first have identified and classified all their non-admitted patient services to the VACS clinical categories.

In the case of a new clinic commencing during the year or changes to existing clinics, assignment to a VACS category will be made by the hospital. The hospital will be required to advise the Department of any changes occurring during the year on the Notification of Clinic Changes Form (<http://www.health.vic.gov.au/vacs/form.pdf>). An annual review by the VACS Clinical Panel will assess for approval the assignment of all new and reviewed clinics for clinical appropriateness for inclusion in VACS.

For further information on VACS approved clinics, including frequently asked questions, see the VACS website at <http://www.health.vic.gov.au/vacs/>

550 Emergency Medicine

The number of occasions of service for

- *patients who, at the time of treatment, have not been admitted and who receive treatment in designated emergency (or 'casualty') departments within the hospital (including patients treated in such departments before admission as admitted patients);*

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- *non-admitted patients provided with unplanned or emergency care in areas of the hospital other than designated emergency departments.*

Unplanned care generally means that patients have not been booked into the hospital for an appointment prior to receiving treatment.

Other Clinics

It is known that there are sometimes extra outpatient activity or allied health activity, funded by Acute Health, that are outside the scope of VACS, such as Hospital Demand one off activity, which would previously have been reported on the S2_111 form but not on the S9_111 form. An 'Other Clinics' category has therefore been included to allow for reporting these, if and when they occur. They must be public patient services funded by Acute Health Services.

Exclude activity funded by other sources such as Medicare (this data is collected by the Commonwealth directly through Medicare); prisoners (funded by Department of Justice); sub-acute or other DHS programs.

Section 2: Other Non-Admitted Services (Acute Health)

Radiotherapy

This includes all occasions of service to non-admitted patients given in functional units primarily providing radiotherapy services.

Radiotherapy involves the use of ionising radiation (usually x-rays or electrons, or more rarely other subatomic particles and nuclei such as neutrons or protons) to kill tumour cells. All radiotherapy occasions of service provided to non-admitted patients should be reported under this category except superficial radiotherapy for the treatment of non-melanoma skin cancer, which should be reported under Medical (Item 5).

Hospitals providing radiotherapy occasions of service must also complete AIMS Form S8_111.

Domiciliary Postnatal Services

This includes all postnatal occasions of service to non-admitted patients where a nursing service is provided in the patient's home or other non-hospital site.

Each visit to the patient should be counted as an occasion of service. All postnatal visits should be reported regardless of whether these services are provided directly by the hospital or whether they are purchased from another health service agency such as district nursing service, community health, maternal and child health services or private midwifery services.

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This item relates to the Variable Maternity Services Grant (VMSG) for the provision of maternity domiciliary care across both rural and metropolitan areas. Each visit to the patient should be counted as an occasion of service. Postnatal visits should be reported regardless of whether these services are provided directly by the hospital or whether they are purchased from another health service or health service agency such as district nursing service, community health, maternal and child health services or private midwifery services.

For more information on reporting and funding under the VMSG, see the document *Information Regarding Funding and Health Service Responsibilities under the Variable Maternity Services Grant (VMSG)* on the website www.health.vic.gov.au/maternitycare/funding2.htm

Note: When a mother is discharged home following the birth of a baby, provision of domiciliary postnatal services is the responsibility of the birth hospital. However, for item 13 of Form S2_111, the hospital purchasing the service records the occasion of service.

Other Domiciliary Nursing

This includes all other occasions of service to non-admitted patients where a nursing service is provided in the patient's home, place of work, or other non-hospital site excluding postnatal domiciliary services.

It should be noted that only those domiciliary nursing services funded by Acute Health Services should be reported under this item.

Patients who are admitted to the 'Hospital in the Home' program should be counted as admitted patients and services provided to them should not be reported on Form S9_111.

Domiciliary visits provided after a baby is discharged from the birth hospital or other hospital at a time separate from the mother, is the responsibility of the discharging hospital and should be recorded under this category.

Other Off Campus Health Professional Services

This includes all other occasions of service to non-admitted patients where a health professional service is provided in the patient's home, place of work, or other non-hospital site.

This category includes off campus services provided by a medical officer or an allied health professional such as home visits provided by an occupational therapist or a physiotherapist.

Section 3: Ancillary Services

The variable component of VACS funding comprises encounters (weighted) and occasions of services (unweighted). Encounters are defined as the clinic visit, plus all ancillary

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services (pathology, radiology and pharmacy) provided within the 30 days either side of the clinic visit. The 30-day window has been chosen to encompass the majority of services associated with a particular visit and to enable a reasonable and practical time period for reporting and funding. This approach more closely reflects patterns of clinical care and provides better resource utilisation and controls than the 'unbundled' fee-for-service or occasions of service systems.

For funding purposes, encounters are paid on the basis of the cost weight, which is derived from the annual Victorian Cost Weight Study, and incorporates the ancillary services. For more details on casemix funding, see:

<http://www.health.vic.gov.au/casemix/index.htm>.

For reporting purposes, only the clinic visit (encounter) needs to be reported as VACS clinic activity. Although not required for VACS funding, separate reporting of occasions of service are required for ancillary services to enable the Department to comply with its reporting obligations under various Commonwealth State agreements. This information was previously reported on Form S2_111.

As with VACS, separate reporting of occasions of service are required for ancillary services associated with MBS-billed specialist clinics, e.g. pathology, radiology and pharmacy.

Referrals to the ancillary services must have originated from or be required for an attendance at a specialist clinic. If ancillary service is funded under VACS then it is a public occasion of service, if claim is made under DVA it is DVA, and if the patient is MBS billed with no co-payment then they are coded as an MBS occasion of service.

MBS activity generated via the following referral pathways should NOT be reported as MBS occasions of service:

- Activity related to direct GP referrals with no associated specialist clinic referral.
- Activity related to private specialist referrals or specialist clinics that charge a co-payment.
- Activity related to referrals from external specialists—medical or allied health.
- Activity related to referrals from other hospital departments, for example, emergency departments.

Pathology

This includes all occasions of service to non-admitted patients given in the hospital's pathology department.

An occasion of service in pathology may involve a single diagnostic test or a related set of diagnostic tests. It is counted as one occasion of service if it is for the one patient on the one occasion, regardless of the number of tests involved.

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It should be noted that for purposes of counting occasions of service, the pathology department is generally treated as one single functional unit regardless of the number of subdivisions within the department. Large pathology departments may be subdivided into a number of units including haematology, microbiology, and biochemistry. It is counted as one occasion of service if tests are for the one patient on the one occasion, regardless of whether the tests are undertaken in separate subdivisions of the pathology department.

Pathology services provided to non-admitted patients of another hospital should only be included if the hospital is not reimbursed for these services by the other hospital.

Radiology

This includes all occasions of service to non-admitted patients given in radiology (x-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI).

An occasion of service in radiology may involve a single x-ray or a related set of x-rays. It is counted as one occasion of service if it is for the one patient on the one occasion, regardless of the number of x-rays involved.

Pharmacy

This includes all occasions of service to non-admitted patients given in the hospital's pharmacy department.

An occasion of service occurs when a non-admitted patient presents one or more prescriptions to a designated pharmacy department. Only one occasion of service is counted if it is for the one patient on the one occasion, regardless of the number of prescriptions filled.