NT Health Services Fees and Charges Register

NORTHERN TERRITORY GOVERNMENT

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Version	Date	Author	Changes made
1.0	20/03/2021	Maja Van Bruggen	Updated Fees and Charges Register onto new template design
2.0	01/07/2021	Matthew Jong	Updated revised Fees and Charges, including introduction to new fees
3.0	20/09/2021	Matthew Jong	Update Nursing Home Type Patient fees
4.0	20/03/2022	Matthew Jong	Update Nursing Home Type Patient fees
5.0	21/07/2022	Matthew Jong	Updated revised Fees and Charges, including introduction to new fees
6.0	20/09/2022	Matthew Jong	Update Nursing Home Type Patient fees
7.0	01/03/2024	Matthew Jong	Introduction of hydrotherapy pool fees
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10.0	30/08/2024	Matthew Jong	Update Nursing Home Type Patient fees
11.0	20/03/2024	Matthew Jong	Update Nursing Home Type Patient and respite fees, removal of private patient excess and renaming of triage categories
12.0	01/07/2024	Matthew Jong	Update revised Fees and Charges,

Contents

1. Introduction

1.1. Purpose

The Northern Territory Health Services **Fees and Charges Register** (this Register) provides a reference for NT Health staff and consumers on applicable fees and charges for diagnosis, treatment, accommodation, transport and products required by patients and delivered by Northern Territory public Health Services.

This Register does not replace statutory law and should not be regarded as a legal document, however it does make reference to legislation.

1.2. Version control

This Register is a live document and amendments are made regularly. Notification of amendments is by Circular sent by email to relevant staff and available on the intranet. If you wish to receive Circular information contact Finance Support Services on 8999 2895 or email **healthservicescharges.doh@nt.gov.au**.

It is the responsibility of each user of the Register to ensure they are using the current version. The current version is:

Fees and Charges Register	1 July 2024
Changes to latest version	Revision
Gazetted fee schedules	1 July 2024
Prostheses list	1 July 2024

1.3. Accessing the Register

This Register is available online as per the links below:

Intranet site at:
http://internal.health.nt.gov.au/services/finance/health-services-fees-charges/Pages/default.aspx

Internet site at:
https://nt.gov.au/wellbeing/hospitals-health-services/hospital-fees-and-charges

1.4. Calendar of updates

The fees and charges in this Register are updated regularly throughout the year as follows:

Fee	Annual review dates	Reason for update
Prostheses	March/July/November	Australian government Prostheses List updated
Nursing Home Type Accommodation	20 March / 20 September	Australian government Nursing Home Type Patient fee indexation
Respite Care Accommodation	January/ March / July/ September	Australian government Respite Care fee indexation
Same day band rates and overnight accommodation for Private Patients	1 July	Australian government private patient fee indexation and NT government annual general fees indexation
Accommodation and other fees for patients (excluding. Private patients)	1 July	Revision in line with costing reports and wages indexation and introduction of
Miscellaneous updates may also occur throughout the year to reflect any policy amendments, ad-hoc fee changes or clarification of information in the Register.		

1.5. Icons

For your convenience this Register has the following icons:

There is a ***form*** related to this information.

There is a web link with more detail.

1.6. Supporting Documents

NT Government Gazette

Pursuant to section 6(4) of the *Medical Services Act 1982 a*nd with reference to section 43 of the *Interpretation Act 1978*, the Northern Territory Minister for Health can amend the determination of charges for medical services. These charges are set by notice in the Northern Territory Government Gazette.

The Gazette is available at:
www.nt.gov.au/ntg/gazette.shtml

The Medical Services Act is available at:
https://legislation.nt.gov.au/Legislation/MEDICAL-SERVICES-ACT-1982

1.7. Private Health Insurance Circulars

The Private Health Insurance Branch of the Australian Government Department of Health produces Private Health Insurance (PHI) circulars. The circulars contain important information related to Australian Commonwealth Government legislation which governs the operation of private health insurance. These circulars announce changes to private patient band rates and nursing home type patient rates.

Private Health Insurance Circulars are available at:
www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars.htm

2. Contacts

If you have specific questions about the application of fees and charges, you may wish to contact one of the resources below for specialised assistance:

Need	Expert source	Contact details
Medicare Benefits Schedule eligibility details and rules	**Medicare**	132 011 (General Enquires) 132 150 or askMBS@health.gov.au (MBS schedule interpretation)
Motor Accidents Compensation (MAC) Scheme in the Northern Territory	**Territory Insurance Office**	1300 493 506 or mac@tiofi.com.au
Nursing home type patient deductions from Centrelink payments	**Centrelink**	1800 044 063
Pharmaceutical Benefits Scheme rules	**PBS**	1800 020 613 (PBS Information Line)
Veterans Affairs eligibility	**Department of Veterans Affairs**	1800 550 457
Australian Defence Force (ADF) Personnel eligibility	**Bupa ADF Health Services**	1800 316 915 or ADFhscproviders@bupa.com.au
Workers compensation rights and responsibilities in the Northern Territory	**NT Worksafe**	1800 250 713
Internal policy advice on the application of fees and charges in this Register	**Revenue Unit, Department of Health**	Phone (08) 8999 2895 or email **healthservicescharges.doh@nt.gov.au**

3. Development of fees

Principles

Although the fees charged for services provided to Compensable, Medicare ineligible and other chargeable patients form a small portion of the overall funding to NT Health in the Northern Territory (NT), they are important for the sustainability of these services. This Register has been developed with the following principles in mind:

- Transparency
- Equity and Efficiency
- Authority
- Rights and Responsibilities of the Health Service *and* Patients

Transparency

The Register endeavours to clearly articulate the application of fees in terms of who is chargeable, the amount to be charged and for which goods and services.

Equity and Efficiency

Fees are determined based on a balance between access to sustainable health services and the costs of providing those services. Fees are reviewed annually against the latest published costing data, specific to the NT, and aggregated to categories based on characteristics of the patient or location where services are delivered, in a framework that reflects an equitable recovery of costs in the most administratively efficient means.

Authority

Fees published in this Register are underpinned by national and Northern Territory legislation and approved and gazetted by the NT Minister for Health under the NT Medical Services Act.

Rights and Responsibilities

NT Health is committed to the rights and needs of individuals in the public health system under the Public Hospital Charter. Health services where charges apply must be paid in full by the responsible party. NT Health will always provide access to emergency health care, regardless of the financial category of the patient or capacity to pay.

3.1. Application of fees

Under the *Medical Services Act*, the fees in this Register are to be charged in full for all applicable services. Only the Minister for Health and the Chief Executive of NT Health are able to remit these charges. NT Health staff do not have the authority to manually amend charges and should not be asked to do so.

If a patient becomes subject to financial charges as a result of receiving treatment in a location or ward which is not standard hospital procedure (due to managing hospital patient flow or other once off events), then those charges will not apply. Standard accommodation rates will apply.

4. Admitted patient fees

4.1. Public

A public patient is an individual, eligible for Medicare, who on admission to a public hospital elects to be treated as a public patient. A public patient will be treated by doctors nominated by the hospital and cannot choose a specific doctor to provide their care. All patients need to complete the ***Patient Election Form***, at the time of admission or as soon as practical after this. Patients should be classified as public until such a time a valid election can be made.

Go to *4.3 Compensable* for more information.

Where a Medicare eligible patient is entitled to claim from a third party (e.g. workers compensation or motor accident compensation), they need to submit a claim. If their claim is rejected, they are able to elect to be public or private.

Public patients are entitled to receive care and treatment as an admitted patient without charge (with the exception of accommodation for long stay nursing home type care, maintenance type care, and accommodation at the Lorraine Brennan Centre (Royal Darwin Hospital (RDH) only). They may be admitted as an overnight stay or same day patient. After 35 days of continuous hospitalisation they may be reclassified as either a long stay acute or long stay nursing home type patient or other maintenance care.

Go to *17.1 Maintenance Care* for more information.

Charges should be raised for public patients classified as a long stay nursing home type patient.

Table 1.1 A Public patient	Fee per day	Date effective	Review date
Nursing home type patient*	$75.55	20 March 2024	20 Sept 2024

*Patients receiving convalescent and nursing home type care

After 35 days where a nursing home type patient takes **approved leave**, any approved leave period will **not** be charged (i.e. greater than 1 day will not be charged, less than 1 day will still be charged).

If after 35 days a nursing home type patient takes **unapproved leave** (i.e. without notice or informed decision), the patient ***will*** be charged according to the admission and discharge data recorded in the hospitals patient management system.

Go to *17.1 Maintenance Care* for more information.

Charges should be raised for public patients classified as a respite care patient in Gove District Hospital (GDH).

Table 1.1 B Public patient	Fee per day	Date effective	Last gazetted change	Review date
Respite Care	$63.02	1 March 2024	S62 2024	1 July 2024

Go to *13.2 Reciprocal Health Care Agreements (RHCA)* for more information.

Residents of countries with which Australia has a Reciprocal Health Care Agreement (RHCA) ***may*** be eligible for treatment as a public patient at no charge.

4.2. Private

A private patient is a person who is eligible for Medicare, who on admission to a public hospital, or as soon as possible thereafter, ***elects*** to be treated as a private patient. Private patients are entitled to be treated by a doctor of their choice (provided that doctor has the right of private practice at that hospital and it is operationally possible). **Patients should be advised that this election will remain for the patient's total hospital stay unless there are unforeseen circumstances**. Private patients need to complete the ***Patient Election Form*** as well as the ***National private patient hospital claim form***.

Go to ***17.8 Change of election*** for more information.

The hospital will raise an account for accommodation, doctors' fees for medical services including diagnostic services and surgically implanted prostheses, directly to the patient's insurer and Medicare for settlement, where it is has been delivered by NT Health.

Where a service is provided by a third party (eg radiology imaging) to a patient who elects to be private, the third party may **invoice that patient directly** and normal private health insurance claim processes may apply.

Go to ***17.1 Maintenance Care*** for more information.

Private patients may be admitted as an overnight stay or same day patient **in a hospital**. After 35 days of continuous hospitalisation they may be reclassified as either a long stay acute or long stay nursing home type patient.

Table 1.2 A Private patient – Shared Ward Accommodation	Fee per day	Date effective	Last gazetted change	Review date
Overnight stay (includes long stay acute)*	$436	1 July 2024	S62 2024	1 July 2025
Same day band 1	$316	1 July 2024	S62 2024	1 July 2025
Same day band 2	$363	1 July 2024	S62 2024	1 July 2025
Same day band 3	$418	1 July 2024	S62 2024	1 July 2025
Same day band 4	$436	1 July 2024	S62 2024	1 July 2025
Nursing home type patient contribution (from patient)	$75.55	20 March 2025		20 Sept 2025
Nursing home type patient default benefit (from insurer)	$147.19	20 March 2025		20 Sept 2025

Table 1.2 B Private patient – Medical Services	Fee per day	Date effective	Last gazetted change	Review date
* *Note: Private long stay nursing home type patients are to be charged both the Patient Contribution and the Patient Default Benefits amounts for each overnight stay.*				
Specialist fees (including surgery)	100% MBS			
Diagnostics** (pathology and radiology including MRI, CT, nuclear medicine)	100% MBS			
Surgically implanted prostheses	As per Private insurance - Prostheses List			

Go to *8 Surgically implanted prostheses fees* for more information.

** Hospital in the Home is not eligible for accommodation charging*
***Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

The following will be charged to private health insurers on behalf of patients who elect to be private for overnight or same day procedures:

- accommodation (as per Table 1.2 A);
- medical procedure fees (as determined by the applicable MBS item number); and
- surgically implanted prostheses.

As a guide, the Australian Government has four Bands within which same day patient treatment will occur:

- Band 1 – gastrointestinal endoscopies, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic.
- Band 2 – procedures (other than Band 1) carried out under local anaesthetic, no sedation.
- Band 3 – procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour.
- Band 4 - procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.

A definitive list of procedures for Band 1 has been issued with no flexibility for reclassification. With respect to Band 2, Bands 3 and Band 4, theatre time and anaesthetic type should be determined by the attending doctor.

In an effort to limit hospitals claiming same day benefits for procedures traditionally undertaken on a non-admitted basis, the Type C Exclusion list has been developed. However if the medical practitioner believes that a patient warrants admission, the completion of the Same Day Certificate component of the ***National private patient hospital claim form*** must be completed.

The Type C exclusions list and further information is contained in the Australian Government *Private Health Insurance (Benefit Requirements) Rules 2011* available from: https://www.legislation.gov.au/F2011L02160/2022-01-01/text

4.3. Compensable (excluding the NT Motor Accident Compensation (MAC) Scheme)

A compensable patient is a person whose care may be covered by a third party (eg workers compensation), ie they may be entitled under law that is or was in force in a State or Territory of the Australian Government, to the payment of damages or other benefits in respect of the injury, illness or disease for which they are receiving care and treatment. Compensable patients need to complete the ***Patient Election Form***. Should their compensation claim not be successful, patients who are Medicare eligible will be asked to elect if they wish to be private or public.

Under the *Health Insurance Act 1973*, patients to whom compensation has been made are not eligible for Medicare Benefits. Also under the National Health Reform Agreement (NHRA) 2020-25 these patients are not funded by the Commonwealth via activity based funding, and the onus is on States and Territories to raise charges for this patient category. Where there is reasonable evidence that a person would be entitled to claim for compensation or damages in respect to an injury, illness or disease e.g. Interstate Motor Vehicle, Public Liability, Workers Compensation, that person should be classified as "compensable' and accounts raised when a claim number is provided.

Compensable status takes precedence over all other financial categories *except* Medicare ineligible. Even where a Medicare ineligible patient is **able to claim** from a third party, the Medicare ineligible patient will be responsible for the fees until such time as evidence is provided to the hospital that the claim is accepted. Once a claim number has been received and the third party has accepted liability, the Medicare ineligible patient may be reclassified as a compensable patient.

Hospitals shall not raise charges for treatment of a person entitled to compensation under the *Motor Accidents Compensation Act 1979 (MACA)*, unless the patient is Medicare ineligible. Where a Medicare ineligible patient receives services as a result of a motor vehicle accident, that Medicare ineligible patient is financially responsible for those services until such a time as a guarantee of payment has been received from the appropriate insurer. If the Medicare ineligible patient does not have insurance, they may submit a claim under the Motor Accident Compensation (MAC) Scheme.

Go to *4.8 Motor Accident Compensation Act (MACA)* for more information.

Professional fees (including theatre procedures and specialist ward round attendances) for compensable patients are based on MBS item numbers as these include descriptions of the service. The fee will be invoiced at 120% of the applicable MBS item number/s.

Table 1.3A Compensable patient	Fee per day	Date effective	Last gazetted change	Review date
ICU*, SCN**, CCU***	$8,480	1 July 2024	S62 2024	1 July 2025
Overnight****	$3,655	1 July 2024	S62 2024	1 July 2025
Same day	$3,505	1 July 2024	S62 2024	1 July 2025
Hospital in the home (HITH)	$1,360	1 July 2024	S62 2024	1 July 2025
Professional fees	120% MBS			

* ICU - Intensive Care Unit
** SCN - Special Care Nursery
*** CCU - Coronary Care Unit
**** This rate includes all care types

Admitted patients

Table 1.3B Compensable patient	Fee			Date effective
Diagnostics (pathology and radiology including MRI, CT, nuclear medicine)*	120% MBS			
Surgically implanted prostheses	As per Private insurance - Prostheses List			
Medical transport	As per Medical transport fees	1 July 2024	S62 2024	1 July 2025

Go to *8 Surgically implanted prostheses fees* for more information.

Go to *10 Medical transport fees* for more information.

* *Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

4.4. Medicare ineligible

Go to *13.2 Reciprocal Health Care Agreements (RHCA)* for more information.

Medicare ineligible patients are persons who usually live outside Australia (overseas visitors and temporary visa holders) who are not citizens or permanent resident visa holders of any of the countries with which Australia has Reciprocal Health Care Agreements. Medicare ineligible patients are not entitled to medical treatment at public hospitals at no charge. Medicare ineligible patients need to complete the ***Overseas Patient Election Form***.

Where a Medicare ineligible person does not provide a written guarantee of payment or an eligible insurance policy at the point of arrival, they will be required to:

- either **pre pay** or establish a **payment plan** for their **hospital admission**
- **pre pay** for their specialist **outpatient appointments**
- **pay** the issued **invoice within 7** days, if there is no prepayment or no payment plan established.

Go to *13.3 Overseas students* for more information on overseas students.

For those persons on student and work visas it is a condition of their visa that they obtain and maintain the adequate insurance whilst in Australia. The Department of Home Affairs recommends overseas visitors seeking tourist visas should take out an appropriate level of health insurance prior to entry to Australia as it would be in their best interest.

It is the policy of NT Health to report Medicare ineligible persons, who have made no effort to meet their financial obligations to the health system and have outstanding and unrecoverable debts, to the Department of Home Affairs. This may affect future visa applications.

Children born in Australia to overseas visitors on or after 20 August 1986 are not eligible for Medicare unless one parent is an Australian citizen or a permanent resident at the time of the child's birth.

Go to *17.2 New born babies* for more information on new-born qualification status.

No charges are raised for babies born to Medicare ineligible parents until such time that babies become qualified.

Medicare ineligible patients, regardless of whether their medical treatment is in connection to a compensable event, will be recorded and invoiced as a Medicare ineligible patient until such time a claim and liability is accepted.

Medicare ineligible patients will have their professional fees determined within the MBS framework. This means each charge is derived from the value of the applicable MBS item number for the service provided.

Go to *4.5 Immigration detainees (Royal Darwin Hospital or Palmerston Regional Hospital ONLY).* for more information.

Immigration detainees and illegal foreign fishers are charged under agreement with the Commonwealth Department of Home Affairs.

Table 1.4A Medicare ineligible patient	Fee per day	Date effective	Last gazetted change	Review date
ICU*, SCN** and CCU***	$6,280	1 July 2024	S62 2024	1 July 2025
Overnight****	$2,705	1 July 2024	S62 2024	1 July 2025
Same day	$2,010	1 July 2024	S62 2024	1 July 2025
Hospital in the home (HITH)	$1,360	1 July 2024	S62 2024	1 July 2025

* ICU – Intensive Care Unit
** SCN – Special Care Nursery
*** CCU – Coronary Care Unit
**** This rate includes all care types

Table 1.4B Medicare ineligible patient	Fee	Date effective	Last gazetted change	Review date
Dialysis	$860	1 July 2024	S62 2024	1 July 2025
Professional Fees	120% MBS			
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)*	120% MBS			
Surgically implanted prostheses	As per Private insurance - Prostheses List			
Medical transport	As per Medical transport fees	1 July 2024	S62 2024	1 July 2025

Go to *8 Surgically implanted prostheses fees* for more information.

Go to *10 Medical transport fees* for more information.

* *Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

Medicare ineligible patients admitted in a public hospital with approved leave for 24 hours or more, with their bed available to be used for other patients, will not be charged accommodation fees for this period. If the approved leave is for less than 24 hours then, normal accommodation charges will apply. In circumstances where leave is unapproved, accommodation will be charged as if the patient was in hospital for the duration of the leave period. If the Medicare ineligible patient has taken leave against medical advice and is not readmitted within seven days, then the patient is deemed to have been discharged.

Admitted patients

Charges will apply for the episode up to the discharge date recorded in the hospital system.

Some travel insurers will not pay for a patient's leave days. If leave is determined to be chargeable, then the patient will be personally financially liable for that portion of the stay not covered by their insurer.

Where a Medicare ineligible person does not provide a written guarantee of payment at the point of arrival, they are required to either **pre pay** or establish a **payment plan** for their hospital admission, otherwise they will be issued an invoice with 7 day payment terms.

Fees should not be raised for Medicare ineligible patients where the patient does not have insurance and:

- presents as a **victim of a violent crime** and the police are in attendance or have supplied an event number which confirms that the person is a victim of crime; or
- has an unexpectedly **high risk pregnancy** and is unlikely to access clinically necessary treatment based on the costs; or
- has been **admitted involuntarily** by a detention order because of mental illness or mental disturbance; or
- presents for certain **public health issues**; or
- has been determined a **potential organ donor** (only for ventilation required for organ and tissue retrieval and the process of organ and tissue retrieval regardless of success).

If a patient in any of the above circumstances has insurance which is able to cover the charges, then charges will be raised to the insurer to the extent that the insurance covers the charges i.e. no out of pocket expenses to the patient.

4.5. Immigration detainees (Royal Darwin Hospital and Palmerston Regional Hospital only)

Immigration detainees are Medicare ineligible, but whose charges for care and treatment will be met by the Australian Government Department of Home Affairs under an agreement with the Northern Territory Department of Health. Immigration detainees include asylum seekers and illegal foreign fishers and need to complete the ***Overseas Patient Election Form***.

Under the current agreement individual invoices are raised for each patient by the hospital and directed to the relevant immigration detention centre.

4.6. Australian Defence Force (ADF)

ADF personnel are eligible persons under Medicare, but whose charges for care and treatment will be met by the ADF. A third party private health insurer, appointed by the Australian Government Department of Defence, co-ordinates the provision of health services to service personnel and active reservists within the ADF. ADF personnel may elect to be treated as a public or private patient. ADF patients need to complete the ***Patient Election Form***. ADF Personnel will be asked to elect if they wish to be private or public should the ADF decline responsibility.

Dependants of ADF personnel are not covered by the Department of Defence but may be covered by a Defence Force Health Funds, which are Private Health Funds. These patients will be asked to elect if they wish to be public or private.

Table 1.6A Australian Defence Force patient	Fee per day	Date effective	Last gazetted change	Review date
ICU*, SCN**, CCU***	$8,480	1 July 2025	S62 2024	1 July 2025
Overnight****	$3,655	1 July 2025	S62 2024	1 July 2025
Same day	$3,505	1 July 2025	S62 2024	1 July 2025
Hospital in the home (HITH)	$1,360	1 July 2025	S62 2024	1 July 2025
Professional fees	120% MBS			

* ICU - Intensive Care Unit
** SCN - Special Care Nursery
*** CCU - Coronary Care Unit
**** This rate includes all care types

Table 1.6B Australian Defence Force patient	Fee	Last gazetted change	Review date
Diagnostics (pathology and radiology including MRI, CT, nuclear medicine)*	120% MBS		
Surgically implanted prostheses	As per Private insurance - Prostheses List		
Medical transport	As per Medical transport fees	Last gazetted S62 2024	1 July 2025

* *Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.*

Go to *8 Surgically implanted prostheses fees* for more information.

Go to *10 Medical transport fees* for more information.

4.7. Department of Veterans Affairs (DVA)

The Repatriation Commission, Military Rehabilitation and Compensation Commission, the Australian Government and the Northern Territory Government have an agreement for providing hospital services to entitled veterans (entitled persons). Under the Agreement, entitled DVA patients are able to elect to be admitted to public hospitals as Veterans Affairs patients. Eligible veterans need to complete the ***Patient Election Form***.

Patients entitled to treatment through DVA have been issued with a treatment entitlement card indicating their eligibility status. Occasionally a patient may only have a written authorisation from DVA. Those veterans issued with a *Repatriation Health card – for all Conditions* (a gold card) have full entitlement to treatment. Holders of a *Repatriation Health Card – For Specific Conditions* (a white card) are only eligible for treatment for specific injuries or diseases for which DVA has accepted financial responsibility.

Entitled Persons will ***not*** be covered under this Arrangement if they:

Admitted patients

a) ***elect to be public patients*** under the National Health Reform Agreement 2020-25 (NHRA); or

b) are ***compensable*** patients; or

c) ***elect to be admitted under their private health insurance*** fund arrangements.

The DVA reimburses the Department of Health for the treatment of entitled veterans under the Agreement for all hospital services and eligible travel, excluding the patient contribution for nursing home type patients. This patient contribution should be charged at the rate in Table 1.1A for all DVA patients, except for ex-Prisoners of War or Victoria Cross recipients.

Table 1.7 Department of Veterans Affairs	Fee per day	Date effective	Review date
Nursing home type patient contribution	$75.55	20 March 2025	20 Sept 2025

4.8. Motor Accident Compensation (MAC) Scheme

The Northern Territory Government has a motor vehicle accident compensation scheme administered by the Territory Insurance Office (TIO). The Motor Accident Compensation (MAC) Scheme (the Scheme) covers persons injured or killed in a motor vehicle accident in the Territory, except where the:

- motor vehicle is unregistered or un-registerable (though passengers and pedestrians will still be covered); or
- used in a motorsport event or high speed time trial (includes drivers and passengers).

Certain other exclusions may apply. All types of road users are protected by the Scheme, including pedestrians, drivers, passengers, motorcyclists and cyclists. The Scheme is funded by motor vehicle owners through compulsory contributions paid when registering vehicles in the NT. MAC patients need to complete the ***Patient Election Form***, as well as a MAC claim form. Medicare eligible patients will also be asked to elect if they wish to be private or public should their claim not be successful.

The Motor Accidents Compensation Act is available from: https://legislation.nt.gov.au/Legislation/MOTOR-ACCIDENTS-COMPENSATION-ACT-1979

Where there is a shortfall between what is paid under a patient's travel insurance and the Scheme, the NT Health will invoice TIO the difference.

Go to *10 Medical transport fees* for more information.

The Scheme pays for transport and associated accommodation costs for MAC patients (within the NT and interstate), including inter-hospital transfers, repatriation and follow up care.

5. Non-admitted patient fees

5.1. Private

Emergency Department

Under the National Health Care Agreement, any person who is eligible for Medicare is to receive Emergency Department services at no charge. This includes patients who would elect to be treated as private if admitted.

Outpatients

A Medicare eligible person who is referred to a specialist medical practitioner from a general practitioner, district medical officer or an appropriate clinician is able to be treated in a public hospital as a private outpatient under Medicare. Referrals must also contain the name and either practice address or provider number of the referring practitioner, date of referral and period of referral. A private primary care referred patient will be bulk-billed to Medicare (with no patient contribution required) for non-admitted consultations, radiology and pathology services where the service provider is a public Northern Territory Health.

Go to *9 Prosthetic and Orthotic fees* for more information.

General explanatory notes on referrals can be found on the Australian Government MBS Online site at:
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.6.16&qt=noteID

5.2. Compensable (excluding the NT Motor Accident Compensation (MAC) Scheme)

Defined in *4.3 Compensable*

Services for compensable patients will be charged at the non-admitted rates below:

Table 2.2A Compensable patient – Emergency Department services	Fee*	Date effective	Last gazetted change	Review date
ATS 1	$2,550	1 July 2024	S62 2024	1 July 2025
ATS 2	$1,465	1 July 2024	S62 2024	1 July 2025
ATS 3	$1, 175	1 July 2024	S62 2024	1 July 2025
ATS 4	$680	1 July 2024	S62 2024	1 July 2025
ATS 5	$445	1 July 2024	S62 2024	1 July 2025
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)**	120% MBS			

ATS: Australasian Triage Scale

* Where a patient is transferred to another NT public hospital and is admitted to that hospital through the Emergency Department, no triage fee will be raised for the second episode.

** Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.

The initial triage assessment will be basis for the fee charged. Where there is a differing subsequent assessment of the triage category it will not result in a change of the amount originally determined to be invoiced.

Table 2.2B Compensable patient – non-admitted services	Fee	Date effective	Last gazetted change	Review date
Medical Practitioner	$555	1 July 2024	S62 2024	1 July 2025
Telehealth – Medical Practitioner	$355	1 July 2024	S62 2024	1 July 2025
Allied Health or Nurse	$350	1 July 2024	S62 2024	1 July 2025
Telehealth – Allied Health or Nurse	$200	1 July 2024	S62 2024	1 July 2025
Hyperbaric unit	$2,645	1 July 2024	S62 2024	1 July 2025
Minor operations	$1,000	1 July 2024	S62 2024	1 July 2025
Chemotherapy	$1,360	1 July 2024	S62 2024	1 July 2025
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)*	120% MBS			

* Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.

Go to *4.4 Medicare Ineligible* for a definition of Medicare ineligible patient.

5.3. Medicare ineligible

Services for Medicare ineligible patients will be charged at the non-admitted rates below:

Table 2.3A Ineligible patient – Emergency Department services	Fee	Date effective	Last gazetted change	Review date
ATS 1	$2,550	1 July 2024	S62 2024	1 July 2025
ATS 2	$1,465	1 July 2024	S62 2024	1 July 2025
ATS 3	$1,175	1 July 2024	S62 2024	1 July 2025
ATS 4	$680	1 July 2024	S62 2024	1 July 2025
ATS 5	$445	1 July 2024	S62 2024	1 July 2025
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)*	120% MBS			

ATS: Australasian Triage Scale

* Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.

Where a patient is transferred to another NT public hospital and is admitted to that hospital through the Emergency Department for continuation of treatment, no triage fee will be raised for the second episode.

Treatment of Medicare ineligible persons should *not* be delayed because of financial considerations.

Non-admitted patients

The initial triage assessment will be basis for the fee charged. Where there is a differing subsequent assessment of the triage category it will not result in a change of the amount originally determined to be invoiced.

Table 2.3B Ineligible patient – Non-admitted services	Fee	Date effective	**Last gazetted change**	**Review date**
Medical Practitioner	$555	1 July 2024	S62 2024	1 July 2025
Telehealth - Medical Practitioner	$355	1 July 2024	S62 2024	1 July 2025
Allied Health or Nurse	$350	1 July 2024	S62 2024	1 July 2025
Allied Health or Nurse (Education only) – excluding Rehabilitation	$80	1 July 2024	S62 2024	1 July 2025
Telehealth - Allied Health or Nurse	$200	1 July 2024	S62 2024	1 July 2025
Hyperbaric Unit	$2,645	1 July 2024	S62 2024	1 July 2025
Minor Operations	$1,000	1 July 2024	S62 2024	1 July 2025
Chemotherapy	$1,360	1 July 2024	S62 2024	1 July 2025
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)*	120% MBS			

* Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.

Where a Medicare ineligible person does not provide a written guarantee of payment at the point of arrival, they need to **pre pay** for their emergency treatment and their specialist outpatient appointments, otherwise they will be provided with an invoice with 7 day payment terms. A deposit may be sought for some inpatient admissions.

Fees should not be raised for Medicare ineligible patients where the patient does not have insurance and:

- presents as a **victim of a violent crime** and the police are in attendance or have supplied an event number which confirms that the person is a victim of crime; or
- has an unexpectedly **high risk pregnancy** and is unlikely to access clinically necessary treatment based on the costs; or
- presents for certain **public health issues**.

If a patient in any of the above circumstances has insurance which is able to cover the charges, then charges will be raised to the insurer to the extent that the insurance covers the charges i.e. no out of pocket expenses to the patient.

5.4. Public

Emergency Department

Under the National Health Reform Agreement, any person who is Medicare eligible is to receive Emergency Department services at no charge.

Outpatients

A public outpatient is a person who receives health care from public hospital staff or receives health care at a public hospital without being admitted, or after discharge. Treatment may be provided by health professionals, such as a medical practitioner, allied health professional or nurse.

Public patients are entitled to receive non-admitted patient services and supplies at no charge, with the following exceptions for which charges can be raised:

- Dental Services;
- Spectacles and hearing aids;
- Surgical supplies;
- External breast prostheses funded by the National External Breast Prostheses Reimbursement Program; and
- Aids, appliances and home modifications
- Enteral feeding supplies
- Medi-hotel type accommodation

5.5. Immigration detainees (Royal Darwin Hospital and Palmerston Regional Hospital only)

The Agreement with the Department of Home Affairs sets out the non-admitted rates.

5.6. Australia Defence Force Personnel (ADF)

The following rates for non-admitted services apply for Australian Defence Force personnel.

Table 2.6A Australian Defence Force personnel - Emergency Department services	Fee*	Date effective	Last gazetted change	Review date
ATS 1	$2,550	1 July 2024	S62 2024	1 July 2025
ATS 2	$1,465	1 July 2024	S62 2024	1 July 2025
ATS 3	$1,175	1 July 2024	S62 2024	1 July 2025
ATS 4	$680	1 July 2024	S62 2024	1 July 2025
ATS 5	$445	1 July 2024	S62 2024	1 July 2025
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)**	120% MBS			

ATS: Australasian Triage Scale

The initial triage assessment will be basis for the fee charged. Where there is a differing subsequent assessment of the triage category it will not result in a change of the amount originally determined to be invoiced.

Table 2.6B Australian Defence Force personnel – Non-admitted services	Fee	Date effective	Last gazetted change	Review date
Medical Practitioner	$555	1 July 2024	S62 2024	1 July 2025
Telehealth – Medical Practitioner	$355	1 July 2024	S62 2024	1 July 2025
Allied Health or Nurse	$350	1 July 2024	S62 2024	1 July 2025
Telehealth – Allied Health or Nurse	$200	1 July 2024	S62 2024	1 July 2025
Hyperbaric unit	$2,645	1 July 2024	S62 2024	1 July 2025
Minor operations	$1,000	1 July 2024	S62 2024	1 July 2025
Chemotherapy	$1,360	1 July 2024	S62 2024	1 July 2025
Diagnostics (pathology and radiology including MRI, CT, Nuclear Medicine)**	120% MBS			

** Fees for diagnostic services undertaken on private facilities will be determined by the service provider and invoiced directly by that service provider.

Where a patient is transferred to another NT public hospital and is admitted to that hospital through the Emergency Department, no triage fee will be raised for the second episode.

5.7. Department of Veterans Affairs (DVA)

The Agreement between the Repatriation Commission, Military Rehabilitation and Compensation Commission, the Australian Government and the Northern Territory Government provides eligible Veterans and war widows' (entitled persons) access to the full range of outpatient services at public hospitals.

Entitled Persons will ***not*** be covered under this Arrangement if they:

(a) ***elect to be public patients*** under the National Health Reform Agreement 2011 (NHRA); or

(b) are ***compensable*** Patients.

5.8. Motor Accident Compensation (MAC)

The non-admitted fees are not paid for individually under the MAC Scheme.

5.9. National Disability Insurance Scheme (NDIS)

A person entitled to access the NDIS will be charged for services based on the Price Guide available from https://www.ndis.gov.au/providers/price-guides-and-pricing

6. Rehabilitation fees

6.1. Rehabilitation services

Go to *5.2 Compensable, 5.3 Medicare ineligible* or *5.6 Australian Defence Force personnel* for more information.

Rehabilitation services provided to non-admitted patients are charged at the gazetted rate for services provided by an Allied Health professional or a Clinical Nurse.

Classes and education sessions may be provided to an individual or a group. The fee is applied per patient regardless of the number of people in the class or education session.

Table 3.1 Ineligible, Compensable and ADF non-admitted services	Fee	Date effective	Last gazetted change	Review date
Rehabilitation classes (including hydrotherapy)/ Rehabilitation Education Sessions	$60	1 July 2024	S62 2024	1 July 2025

6.2. Hydrotherapy Facility

The hydrotherapy facility is in Palmerston Regional Hospital (PRH).

Public Access (without an external therapy provider)

The public are able to use the hydrotherapy pool at set times each day. NT Health staff will supervise the public, similar to a life guard, but will not provide any therapeutic input. The public will need to meet the following eligibility criteria to be able to use the pool;

a) Are 18yrs and over;
b) Have an exercise program provided by a health professional;
c) Are able to independently access the pool and complete their own exercise program (or have their own carer to assist);
d) Do not have an existing medical condition that may exclude them from safe water based exercise OR has been provided with a medical clearance to participate in water based exercise;
e) Agree to comply with the PRH Hydrotherapy rules and regulations; and
f) Have completed the casual user's hydrotherapy waiver.

NT Health staff are able to refuse entry to the facility or ask the patron to leave the facility, if the client is considered unsuitable for water based exercises.

External Therapy Providers

As a condition of external therapist's hiring the facility, therapists must hold a current Hydrotherapy Rescue Training Certificate (or equivalent), CPR training, reviewed the External Provider Induction Package and have completed an orientation to the PRH hydrotherapy facility.

External therapist are required to ensure their clients meet the eligibility criteria for facility access.

Table 3.2 Type of User	Fee	Date effective	Last gazetted change	Review date
Public Access				
Concessional	$5 per entry or $45 for a 10 entry pass	2 March 2024	S62 2024	1 July 2024
Non-Concessional	$10 per entry or $90 for a 10 entry pass	1 March 2024	S62 2024	1 July 2024
External Therapy Provider Hire				
With one clients	$31 per hour^	1 March 2024	S62 2024	1 July 2024
With up to 3 clients	$51 per hour^	1 March 2024	S62 2024	1 July 2024
Private pool use	$102 per hour^ $513 per day on weekend only	1 March 2024	S62 2024	1 July 2024
Facility use for all is on a shared basis, unless otherwise indicated				

^ sessions with bookings for part of a hour (e.g. 1.5hrs) will have the booking rounded **up** to the next full hour and charged accordingly.

Bookings

For queries and to book the facility, clients can either phone the Hydrotherapy's unit mobile 0460 009 346 or email PRH.HydrotherapyPool@nt.gov.au

External providers are required to review the External Provider Induction booklet. Booking forms are required to be completed by external providers. Booking forms can cover a single booking or reoccurring bookings. Cancellations within 24 hours of the booking will be charged the full fee.

7. Dialysis fees

7.1. Dialysis

The following charges apply to overseas visitors and compensable patients requiring renal dialysis in Northern Territory Health Service facilities.

Table 4.1 Ineligible and compensable patients	Fee	Date effective	Last gazetted change	Review date
Dialysis	$860	1 July 2024	S62 2024	1 July 2025

Acute dialysis required as part of the treatment of an urgent medical condition is part of medically necessary treatment under the RHCA.

Maintenance renal dialysis may be made available without charge to patients from countries which include maintenance dialysis in their RHCA with Australia.

Access to maintenance dialysis will depend on the availability of resources in the treating health facility and meeting the conditions below:

- arrangements directly between the overseas health authority and the Health Services must be made in advance of arriving in the NT and agreed to by the service provider's appropriate delegate; and
- no more than 10 treatments in NT health facilities are required during one visit to Australia.

Where arrangements are not made in advance or the number of treatments exceeds 10 services, treatment should be charged at the ineligible dialysis rate above.

For up to date RHCA information, go to:
www.services.gov.au/individuals/services/medicare/reciprocal-health-care-agreements

8. Surgically implanted prostheses fees

8.1. Prostheses

Schedule 1 of the *National Health Amendment (Prostheses) Act 2005*, sets benefits for prostheses which registered health benefits organisations (health funds) must fund when provided as part of an episode of hospital treatment. The relevant benefit amounts are determined by the Australian Government Minister for Health. These are contained on a Prostheses List that is updated in March, July and November each year.

The Prostheses List ('the List') is the schedule to the *Private Health Insurance (Prostheses) Rules*.

The Prostheses List is available from:
https://www.health.gov.au/health-topics/private-health-insurance/the-prostheses-list

The rates contained in the Prostheses List are used for all chargeable patients.

Current prostheses list	1 July 2024

Financial categories will be charged at the benefit rate for prostheses as per Table 5.1A below:

Table 5.1A Chargeable patient	**Listed Prostheses**	**Not listed Prostheses**
Private	Benefit	Prior agreement required
DVA		
Ineligible	Benefit	Full cost recovery
Compensable		
ADF personnel		
Immigration detainees		

Under Australian Government legislation, health funds are only required to pay benefits for items on the Prostheses List. This means if any hospital (public or private) uses prostheses on a private patient and it is not on the Prostheses List, then the health fund is not compelled to pay **any** benefit.

To reflect further arrangements negotiated between the States, Territories and Health Funds, a discount will be applicable for any Cardiothoracic or Ophthalmic item. This removes the need to provide supplier invoices to the health fund to obtain a benefit.

Table 5.1B Private patients	Health insurer rebate	Discount	Details
All items on the Prostheses List (excluding Cardiothoracic and Ophthalmic items)	Benefit	Not Applicable	No Invoice required
Cardiothoracic items		7.5%	
Ophthalmic items		20%	

Benefit amounts are to be calculated using the current benefit on the Prostheses List for the item and then taking off the relevant percentage discount listed above.

If the cost of purchasing a cardiothoracic or ophthalmic item is above the calculated benefit a health fund will pay, hospitals may provide supplier invoices to the health fund for these items. In this instance health funds will reimburse the cost of the prostheses up to, but not exceeding, the minimum benefit level.

Where possible, and clinically appropriate, hospitals should source prostheses which are on the prostheses list or able to be fully funded by health funds so that patients have no out-of-pocket expenses.

9. Prosthetic, orthotic fees and Seating Equipment and Technical Service (SEAT)

9.1. Prosthetic and Orthotic fees

Prosthetics are assistive devices that replace a missing body part for either functional or cosmetic reasons.

Orthotics are assistive devices externally applied to the body, used to modify the structural and functional characteristics of the neuromuscular and skeletal system.

Public Prosthetics and Orthotics services are provided in accordance with the *Northern Territory Artificial Limb Service* (NTALS) and the *Northern Territory Orthotic Service (NTOS)* guidelines.

Intake criteria for prosthetics and orthotics services
Service users can be referred to the Royal Darwin Hospital (RDH) or Alice Springs Hospital (ASH) prosthetics and orthotics Departments by anyone, and can even refer themselves. Medical referrals are preferred where possible. Suitability and priority of referrals for service provision will be determined by the RDH or ASH prosthetist/ orthotist, in accordance with the NTALS and NTOS guidelines.

Eligibility for "no charge" prosthetics and orthotics services
Medicare-eligible residents of the **NT** are entitled to prosthetic and orthotic services **without charge**.

Ineligible service users
Medicare ineligible patients and Medicare eligible interstate visitors will be charged for prosthetics and orthotics services.
The fee is calculated using the formula below:

Manufacturing hours + materials cost + componentry/consumables costs
(@ $200 per hour) ($115)

Compensable prosthetics and orthotics service users
Prosthetic and orthotic service users are considered 'compensable' if they:

- are members of the Australian Defence Force
- holders of a gold or white Department of Veteran's Affairs card
- have an accepted motor vehicle accident compensation claim, either in the NT or interstate
- have an accepted worker's compensation claim, or are
- persons incarcerated at correctional facilities

Compensable service users **will be charged** for prosthetic and orthotic services. This includes clinical hours, devices, and requisitions (repairs, adjustments and supplies of consumables). The fee is calculated using the formula below:

Clinical hours + administrative hours* + manufacturing hours* + materials cost ($115) + (componentry/consumables costs + 50%)*

*Hourly rate is $200

Warranty
A 3-month warranty applies to prosthetics and orthotics **materials and labour**. Any repairs performed during this warranty period will not be charged. Any repairs outside this period will be charged, post approval. **Components** which fail within the manufacturer's warranty period will be replaced in accordance with the manufacturer's warranty conditions.

A person entitled to access the NDIS will be charged for services based on the Price Guide available from https://www.ndis.gov.au/providers/price-guides-and-pricing

9.2. SEAT Technical fees

The Territory Equipment Program provides prescribed equipment and aids to people with a functional impairment to assist in maintaining and improving their capacity to live and participate in everyday activities.

An allied health professional or specialist nurse registered with the Disability Equipment Program (DEP) is able to prescribe equipment to a client according to their professional qualifications, experience and type of aid/equipment.

Often equipment and aids will need to be modified to meet the client's range of movement and their physical characteristics.

The Seating Equipment and Technical Service (SEAT) customises and fabricates prescribed pressure care, mobility, and seating equipment to clients with a functional impairment, with intermediate to complex seating, wheeled mobility, pressure care and assistive technology needs. The SEAT Service also repairs and maintains this equipment.

Medicare Ineligible and Compensable clients not eligible to access NDIS will be charge a fee for the SEAT Technical Service calculated using the formula below:

$115 per hour + componentry costs

10. Medical transport

10.1. Medical Transport

No charge is raised when a public or private patient is retrieved from a rural or remote area, or transferred between hospitals either within the Northern Territory or interstate for medical reasons. These patients are covered by the Patient Assistance Travel Scheme (PATS).

Note, where a public or private patient is required to be transferred to an interstate hospital, the Health Service will generally transport the patient to Adelaide. If the patient nominates a facility/institution in another state or territory, the Health Service will fund the equivalent of the commercial Adelaide return fare. Any difference in transport costs are the patient's responsibility.

Further information for patients about PATS is available from:
https://nt.gov.au/wellbeing/health-subsidies-support-and-home-visits/patient-assistance-travel-scheme/introduction

All other patient financial categories are to be charged for transport in accordance with Tables 6.1A (dedicated aeromedical service), 6.1B (commercial transport) and 6.1C (ground based ambulatory services provided by public Health Services).

Table 6.1A Aeromedical transport (dedicated aeromedical service)	Fee	Date effective	Last gazetted change	Review date
Full aero-medical retrieval and inter-hospital transfers – Careflight	$52 per aero nautical mile* per flight	1 July 2024	S62 2024	1 July 2025
Shared medical retrieval and inter-hospital transfers (separate payer's) – Careflight	$33 per aero nautical mile* per patient	1 July 2024	S62 2024	1 July 2025
Full inter-hospital transfers – Royal Flying Doctor Service	$6.10 per aero nautical mile* per flight	1 July 2024	S62 2024	1 July 2025
Shared inter-hospital transfers (separate payer's) – Royal Flying Doctor Service	$5.10 per aero nautical mile* per patient	1 July 2024	S62 2024	1 July 2025

* *Fees are calculated from the place of dispatch and return to the dispatch location.*

Table 6.1B Commercial transport	Fee	Date effective	Last gazetted change	**Review date**
Aeroplane, bus, etc.	Full cost recovery**	1 July 2024	S62 2024	1 July 2025

** *Full cost recovery – as per third party service provider's invoice.*

Ground based ambulatory retrieval and transfer services provided by either Top End or Central Australia Health Services are charged at the rates detailed in Table 6.1C below:

Table 6.1C Ground based ambulatory retrieval/transport services provided Health Services		**Fee**	**Date effective**	**Last gazetted change**
Retrieval (site of accident to clinic)	0-24 km	$455	1 July 2024	S62 2024
	25-49 km	$515	1 July 2024	S62 2024
	50-99 km	$680	1 July 2024	S62 2024
	100-149 km	$805	1 July 2024	S62 2024
	150-199 km	$905	1 July 2024	S62 2024
	200+ km	$1,030	1 July 2024	S62 2024
Transport (clinic to aerodrome)		$290	1 July 2024	S62 2024

10.2. Cost sharing

Where more than one patient is transported via a dedicated aeromedical transport service in a single trip, cost sharing is able to be applied in certain circumstances.

In the case of a medical retrieval where there are **multiple patients** being transported (either from a single location or multiple locations within a single retrieval), cost sharing will only apply where there is a **single payer** responsible. For example, if there are two patients being transported as a result of a single motor vehicle accident, where TIO is the insurer, this will result in a single transport charge at the full aeromedical retrieval rate to TIO, provided there is an accepted claim. If there are two patients being transported as a result of two separate motor vehicle accidents where TIO is the insurer, then this will again result in a single transport charge to TIO provided they both have their claims accepted.

Where there are **multiple patients** with **separate multiple payer's** responsible for individual patients who have been transported on a single flight, then the cost of the flight will be applied singularly at the shared medical retrieval rate to each payer (as per Table 6.1A for aeromedical transport only).

11. Medi-Hotel Accommodation

11.1. Lorraine Brennan Centre (LBC)

The Lorraine Brennan Centre (LBC) is a facility for the purpose of easing the bed pressure of the Royal Darwin Hospital (RDH) by providing accommodation to Hospital In The Home (HITH) patients, remote patients who require ongoing non-acute medical care, escorts for patients who are in the Intensive Care Unit (ICU) or Special Care Nursery (SCN) and for transitional care patients who are awaiting accommodation at other facilities acting as a step down to a more community setting.

There LBC has capacity for 100 guests over the 50 rooms. Each room is air-conditioned with attached bathroom and shower amenities. Rooms are configured to either two person occupancy rooms with a curtain divider separating the room or family rooms. Some rooms contain fridges for the specific purpose of medication and meal supplement drinks storage.

Three meals per day are provided to those guests at the LBC. These are a continental breakfast, lunch and a hot meal for dinner. However sandwiches and snacks are available all day for patients at their convenience. The LBC also offers a “do it yourself” laundry service at no charge and transports patients between LBC and RDH for their appointments.

Table 7.1 Description of Client	Charge per night	Date effective	Last gazetted change
NT PATS Public Patient	No charge	1 July 2025	S62 2024
NT PATS Approved Escort	No charge	1 July 2025	S62 2024
Transitional Care Program clients	$70	1 July 2025	S62 2024
TIO Motor Vehicle accident clients	$140	1 July 2025	S62 2024
Ineligible and other compensable patients	$140	1 July 2025	S62 2024
WA PATS Patient	$70	1 July 2025	S62 2024
WA PATS Escorts	$70	1 July 2025	S62 2024
Unapproved Patients / Escorts (Social Admissions)	$45	1 July 2025	S62 2024

12. Medical reports, copies of medical records and imaging

12.1. When charges should be raised

*Circumstances under which charges **should** be raised are for:*

- a search for a medical record (unless it cannot be found).
- copies of a patient's medical record is requested by and provided directly to the patient.
- copies of medical images to CD are requested by and provided directly to the patient.
- replacements of medical certificates and Centrelink forms when required to be rewritten.
- requests for medical reports or copies of medical records by solicitors, compensable insurers and other third parties, for legal or employment purposes, subject to written consent being given by the patient (this excludes requests from Gallagher Bassett in relation to workers compensation claims by a NT Health staff-member).
- copies of medical images to CD are requested by an insurer, solicitor or other third party, subject to written consent being given by the patient.
- requests for information from interstate health authorities or other employers in respect to the eligibility of candidates for appointment.
- requests for information by solicitors acting on behalf of a victim of crime.
- requests to provide evidence or an assessment for circumstances not outlined below in ***12.2 – When charges should not be raised***.

12.2. When charges should not be raised

*Circumstances under which charges should **not** be raised are:*

- when a copy of the discharge summary is requested by and provided directly to the patient.
- when requests are made for copies of a patient's discharge summary, operation findings and other relevant letters between health professionals, by a health professional concerned only with the patient's continued treatment or care, e.g. the patient's General Practitioner.
- when completing medical certificates and Centrelink forms at the time of consultation.
- requests from Gallagher Bassett in relation to workers compensation claims by a NT Health staff-member.
- requests by a body responsible for regulating the activities of health professionals, e.g. a professional registration board investigating the conduct of a professional or a Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing.
- requests from Territory Families, the Police or the Department of Justice relating to Victims of Crime, required in the conduct of investigations.
- requests from Community Corrections for reports in relation to matters of sentencing, parole and supervision of court orders.
- request from private health insurers to assess their members ability to access benefits under their policy, e.g. assessing if applicable, any waiting period for members' pre-existing conditions.
- when a medical report is required to support the early release of superannuation funds under compassionate grounds or due to a terminal medical condition.

- when a single request is made for a medical report and photocopied from a medical record, no Search Fee is applied. This is included in the Medical Report Charge.

Table 8.2A Patient request	Calculated	Fee (GST exempt)	Last gazetted change	Review date
Search Fee	Per search	$44.15	S62 2024	1 July 2025
Copy of Medical Records	Per page	$0.45	S62 2024	1 July 2025
Copy of Discharge Summary	No charge		S62 2024	1 July 2025
Replacement Medical Certificate	Per certificate	$44.15	S62 2024	1 July 2025
Medical/allied health report (max 2 pages)	Per report	$375	S62 2024	1 July 2025
Medical report (additional pages)	Per page	$195	S62 2024	1 July 2025
Medical images		$15.30	S62 2024	1 July 2025

Table 8.2B Third party request	Calculated	Fee (GST inclusive)	Last gazetted change	Review date
Search fee	per search	$47.20	S62 2024	1 July 2025
Copies of medical records	per page	$1.15	S62 2024	1 July 2025
Medical/ allied health report (max 2 pages)	per report	$415	S62 2024	1 July 2025
Medical report (additional pages)	per page	$210	S62 2024	1 July 2025
Medical images to CD		$26.50	S62 2024	1 July 2025

Specialist medical assessments are calculated at the specialist hourly rate. This includes salary on-costs (superannuation and category allowance). Travel time is charged (at the specialist hourly rate) where travel is required by the specialist to provide or perform an assessment.

Procedures for safeguarding the privacy of Medical Records are set out in the *Hospital Network: Patient Information Privacy Policy* available from: https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/726/3/New%20Privacy%20Policy.pdf

13. Other patient categories

13.1. Prisoners

Australian prisoners and those in police custody are ineligible to assess Medicare benefits, under *Section 19 (2) of the Health Insurance Act 1973*. While in custody, any health services provided to a prisoner are considered the responsibility of the state/territory. Prisoners are still required to complete the ***Patient Election Form.***

Prisoners from correctional facilities outside the Northern Territory will be charged at a rate equivalent to that of a Medicare ineligible patient.

These patients also have the right to election for private treatment. In the event the patient elects to be private they will not be entitled to the Medicare Rebate and the patient is responsible for the payment of all the resultant fees.

13.2. Reciprocal Health Care Agreements (RHCAs)

The Commonwealth of Australia has Reciprocal Health Care Agreements (RHCAs) with citizens from the following countries: the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. RHCAs provide ***medically necessary*** medical treatment as public patients at no charge to people who are temporarily in Australia. Medically necessary, in the context of the RHCA's, refers to treatment of ill health or injury which occurs while you are in Australia and which requires treatment before you return home. They do not cover any treatments as a private patient. Overseas visitors requesting to be admitted under a RHCA need to select the appropriate box on the ***Patient Election Form.***

Detailed information for staff is available to NT Health staff in the **Reciprocal Patient Billing Guideline** available in the Policy and Guideline Centre on the NT Health intranet site. An overview of entitlements is below:

Country	Length of entitlement to RHCA
Belgium	Duration of stay
Finland	Duration of stay (excluding students on student visas)
Italy	covered for Medicare for 6 months from the date of arrival in Australia
Malta	covered for Medicare for 6 months from the date of arrival in Australia (excluding students on student visas)
Netherlands	Duration of stay
New Zealand	Duration of stay
Norway	Duration of stay (excluding students on student visas)
Republic of Ireland	Duration of stay (a(excluding students on student visas)
Slovenia	Duration of stay
Sweden	Duration of stay
United Kingdom	Duration of stay

Patients covered

RHCAs are *not* designed to replace private travel health insurance and charges may apply for some services. Where charges apply, they are at the Medicare ineligible rate.

Under the RHCAs with Belgium, Finland, Italy, Malta, the Netherlands, Norway, Slovenia, Sweden and the United Kingdom, Australian public hospitals provide care at no charge to citizens from these countries as public patients, as well as subsidised out-of-hospital medical treatment under Medicare and some subsidised medicines under the Pharmaceutical Benefits Scheme.

The RHCAs with New Zealand and the Republic of Ireland provide care at no charge in public hospitals and some subsidised medicines under the Pharmaceutical Benefits Scheme, but **do not cover** out-of-hospital medical treatment.

Visitors from Italy and Malta are covered for a period of six months from the date of their arrival into Australia only. After this time they will be charged for services at the Medicare ineligible rate.

Visitors from Belgium, the Netherlands and Slovenia require their European Health Insurance card to enrol in Medicare. They are eligible for treatment in public hospitals until the expiry date indicated on the card, or up to the length of their authorised stay in Australia if earlier.

Eligibility can be confirmed by the patient presenting a Reciprocal Medicare Card or their passport of the country with which there is a RHCA. Hospital staff should check that the visa is valid.

Patients eligible for Reciprocal status are encouraged to enrol with Medicare either prior to receiving treatment or as soon as possible afterwards.

For more information on Reciprocal Agreements go to the Australian Government at: https://www.servicesaustralia.gov.au/individuals/services/medicare/reciprocal-health-care-agreements/when-you-visit-australia

Services covered

RHCAs only cover medically necessary treatment as a public patient and coverage will depend upon country specific terms and conditions.

In Northern Territory public hospitals 'medically necessary' refers to the initial assessment, diagnosis and treatment of an injury, sickness or other health condition that is clinically required during the RHCA patient's stay in Australia before they can return home. Exclusions apply. NT Health staff can seek further information via the *Reciprocal Patient Billing Policy and Guideline* on the Policy and Guideline Centre.

Patients may be eligible for air transfer services between public hospitals provided they meet the eligibility criteria.

Services Not Covered

Other services not covered under the RHCAs are:

- Ambulance Cover
- Medical evacuations intra or interstate
- Other transport
- Dental care
- Optometry Services
- Medical Evacuation to the visitor's home country
- Funerals
- Elective treatment
- Treatment as a private patient in a public hospital
- Treatment that has been pre-arranged before arrival in Australia
- Treatment deemed by a medical professional to be not immediately necessary
- Prostheses
- Care from an allied health practitioner
- Some outpatient services

13.3. Overseas students

Patients on student visas from the United Kingdom, Sweden, the Netherlands, Belgium, Slovenia, Italy or New Zealand, are covered by Medicare. Students from Norway, Finland, Malta and the Republic of Ireland are not covered by the RHCAs with those countries.

Go to *1.4 Medicare ineligible* for more information.

With the exception of students from Belgium, New Zealand, Norway and Sweden, it is a condition of their student visa that they take out Overseas Student Health Cover (OSHC). Overseas students are charged the same rates as other Medicare ineligible patients and are required to complete the ***Overseas Patient election form***.

14. Primary health care fees

14.1. Primary health care fees

Primary Health Care services provide prevention and early intervention treatment. These services are mainly delivered through a network of clinics throughout the NT.

Fees apply to services delivered within small rural towns and remote communities*.

The level of health practitioner staffing in these clinics vary based on the population size and clinical need in each location. It may comprise of medical, nursing and Aboriginal health practitioners. Health practitioner staff provide services on both an appointment and emergency basis. In circumstances where the patient is compensable or Medicare ineligible, the fees in Table 9.1A and Table 9.1B can be applied. The 'Health assessment for employment' fee applies where a person is seeking a health assessment or pre-employment medical check for employment purposes. Note, these fees are **not for public health** screening.

Table 9.1A Primary health care fees		**Fee**	**Last gazetted change**
General Practitioner type consultations			
Medical Officer consult**		250% of MBS rate	S62 2024
Full health assessment for employment***^		$465	S62 2024
Medical assessment for employment***		$160	S62 2024
Hearing screening for employment***		$110	S62 2024
Respiratory screening for employment***		$110	S62 2024
Drug screening for employment***		$110	S62 2024
Nurse / Aboriginal Health Practitioner consultation/service	Time based > 1-15 mins	$37.50	S62 2024
	Time based > 15 - 30 mins	$75	S62 2024
	Time based > 30 - 45 mins	$112.50	S62 2024
	Time based > 45 - 60 mins	$150	S62 2024
	Time based > 60 - 75 mins	$187.50	S62 2024
	Time based > 75 mins	$225	S62 2024

*Based on the Modified Monash Model, classifications MM5 – MM7
**Includes telephone consultations
***Service includes GST
^ includes medical assessment, hearing, respiratory and drug screening

Table 9.1B Primary health care fees		**Fee**	**Last gazetted change**
Emergency service presentations			
Medical Officer attendance	Emergency attendance	$805 per hour	S62 2024
Nurse attendance	Emergency attendance	$485 per hour	S62 2024

Where **both** a nurse and medical officer attend an emergency service presentation, only the fee for the medical officer will be applied. Chargeable patients will not be charged for more than one health professional per presentation.

15. Dental Fees

15.1. Eligibility for public dental services

Dental and oral health services are provided Territory wide on either a permanent or visiting basis depending on where the services are delivered.

Eligibility for dental and oral health services without charge (public) is limited to patients and circumstances described in Table 10.1.

If a patient's eligibility status changes during a short course of care, such as routine fillings, their entitlement to treatment will not change.

Where there is a change in a patient's eligibility during a long course of care, such as during orthodontics, root canal treatment, prosthetics or periodontics, the patient will be referred to the private health sector after immediate treatment is completed.

Table 10.1
NT Eligibility for 'no fee' Public Dental and Oral Health Services

Eligibility Criteria*	Emergency Service	Routine Services
Concessional Persons holding or listed as a dependent on any of the following Australian Government Cards: 1) Health Care Card (issued by the Australian Department of Human Services); 2) Pensioner Concession Card (issued by the Australian Department of Human Services) 3) Commonwealth Seniors Health Card (issued by Australian Department of Human Services) 4) Gold or White Repatriation Health Cards (issued by the Department of Veterans' Affairs (DVA))	✓	✓
Children Children enrolled in school up to the age of 18 years old	✓	✓
Cleft Lip and Palate Cleft Lip and Palate Scheme recipients up to the age of 22 years old	✓	✓
Cancer Persons undergoing cancer therapies and requiring oral health support	✓	✓**
Disability Persons with a disability whereby their conditions is affecting their oral health significantly	✓	✓**
Department of the Attorney-General and Justice Persons in custody and detainees in an NT Government correctional facility or in youth detention	✓	✓

Table 10.1 NT Eligibility for 'no fee' Public Dental and Oral Health Services		
Eligibility Criteria*	**Emergency Service**	**Routine Services**
Homeless Homeless people, refugees and asylum seekers	✓	✓**
Inpatients Hospital inpatients where a dental or oral health condition is impacting on the condition for which the patient has been admitted	✓	✓**
Mental Health Persons with mental health conditions residing in residential care, hospital or community facilities	✓	✓**
Residential Care Persons living in full-time residential facilities, such as nursing homes or homebound patients	✓	✓**
Remote Patients Persons who reside in remote communities with a distance greater than 100 kilometres from the nearest available private dental service	✓	✗
Renal and Cardiac Persons requiring renal and cardiac transplant surgery	✓	✓**
Rheumatic Heart Disease Persons listed on the NT Rheumatic Heart Disease Register	✓	✓
Substance Misuse Persons actively enrolled in programs for substance misuse treatment	✓	✓**
Palliative Care Persons in palliative care	✓	✓
Victims of Crime Persons who have experienced or are at risk of experiencing domestic, family and sexual violence	✓	✓**

*All patients are required to be Medicare Eligible, with the exception of refugees and asylum seekers
**Requires referral from the patient's medical practitioner

15.2. Private dental services

Patients who do not meet the eligibility criteria in table 10.1 will be charged a fee for the dental services they receive. A schedule of dental fees can be found in Appendix 1.

16. Waiving of fees

16.1. Waiving fees

Waivers (remitting the payment) extinguish the NT Health's right to collect the debt at a future date. However prior to fees being waived, there should be every attempt to establish a payment plan. Please contact Patient Accounts with regards to payment plan options.

In particular cases, where it is established that that a person does not have the financial capacity to pay as it would involve personal financial hardship or where it is not in the public interest, charges can be waived. Examples include:

- Ineligible patients who are hospitalised for communicable diseases
- Financially disadvantaged pensioners
- Patients without any independent source of income, such as children of pensioners

The Chief Executive may waive fees and charges up to $20,000 or postpone fees and charges up to $100,000, under the *Medical Services Act*. Waivers over $20,000 are to be referred to the Minister for Health for Approval. Medical Services Act available from: https://legislation.nt.gov.au/Legislation/MEDICAL-SERVICES-ACT-1982

As soon as it is established that a person does not have the financial capacity to pay, a briefing showing the amounts owing and the reason why the charges should be waived shall be submitted to the Chief Executive, through the Chief Finance Officer.

16.2. Credit memos

Credit memos and adjustments of invoices should only be used where there has been an error in billing, i.e. services incorrectly charged in price or quantity. An example of this is the charging of a second Emergency Department consultation within a 24 hour period. A credit memo/adjustment is to be used when the invoice has been finalised and issued.

17. Explanatory notes

17.1. Maintenance Care

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment.

The types of Maintenance care are:

- Convalescent
- Respite
- Nursing Home Type
- Other Maintenance

A separate maintenance care rate is only available to public, private and DVA patients. Compensable or Medicare ineligible patients will be charged at the standard same day or overnight rate, regardless of the type care provided.

Convalescent care is where a patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. The patient would otherwise be discharged home due to home factors and lack of community support, e.g. awaiting home modifications or equipment.

Respite care is where the primary reason for admission is the short-term unavailability of the patient's usual care. Examples may include:

- Admission due to carer illness or fatigue
- Planned respite due carer unavailability
- Short term closure of care facility
- Short term unavailability of community services

Unless exceptional circumstances apply, respite care cannot directly follow an acute or subacute admission where there has been no discharge home of the patient.

In the Northern Territory, Gove District Hospital is a multipurpose service facility and has two dedicated beds for respite care.

Patients are reclassified as **Nursing Home Type Patients** (NHTP) if, after 35 days of continuous hospitalisation the patient no longer requires acute or sub-acute (rehabilitation or restorative) care and requires accommodation and maintenance care only. Charges are raised against all public, private and DVA Nursing Home Type patients (except ex Prisoner of War or Victoria Cross recipients). Acute Care Certificates are valid for a period up to 30 days, after which a new certificate will need to be issued.

The 35 day qualifying period may be accrued in a single or multiple hospitals (public or private). Transferring between hospitals does not effect on the qualifying period. The qualifying period is only broken if the patient is discharged from hospital and is not re-admitted within 7 days. In such cases a new 35 day period will commence from day one of the next admission, excluding statistical discharges. Periods of less than 7 days out of hospital do not break the qualifying period, though this period outside hospital care is not

included in the count e.g. a patient who has accrued 20 days then takes three days of weekend leave will start day 21 when returning to the hospital.

Patient Contribution rates (only applicable to public and private patients) are adjusted by the Australian Government in March and September every year.

Private Nursing Home Type patients are to be charged both the Patient Contribution and the Default Benefits (met by the patient's health insurance fund) rate for each overnight stay.

Other Maintenance Care applies to any other reason the patient may require a maintenance care episode other than those already stated.

17.2. Newborn babies

All newborn babies are admitted patients and are either unqualified or acute (qualified).

Classification criteria

A newborn patient day is acute (qualified) if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care (Alice Springs Hospital and Royal Darwin Hospital only); and/or
- is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

If a newly born baby is classified as acute (qualified), the parent or parents must elect whether the baby is to be treated as a public patient or a private patient; admission documentation must be completed as for any other patient. Should only the mother continue to require admitted patient care on the 10th day, the baby is classified as a boarder.

17.3. Primary care referred

A patient is classified as Primary Care Referred where they are:

- Medicare eligible;
- referred to a specialist medical practitioner;
- by an eligible practitioner following provision of a primary care level service in the community for a consultation or a procedure, including radiology and pathology services.

Under ordinary circumstances (i.e. in the context in which the MBS rules have been designed) specialist consultants would receive GP type primary care level referrals in their private rooms and would Medicare bill for these services. In the Northern Territory there is insufficient critical mass of population for most specialist consultants to establish private rooms, therefore Specialist Medical Consultants see private patients on hospital premises.

The important thing is that the services, which are Medicare billed, are provided within the following conditions:

- They are primary level services (i.e. community patients) and not related to a current hospital admission;
- They are referred by an eligible practitioner to a Specialist Medical Consultant;
- The Specialist Medical Consultant has the right of private practice; and
- The classification of Primary Care Referred is for non-admitted patients only.

Go to *1.5 Right of Private Practice* for more information.

A primary care referred patient will be Medicare bulk-billed 85% of the MBS schedule fee (no patient contribution) for non-admitted consultations, radiology and pathology services.

The Health Insurance Regulations determine practitioners who are eligible to make a referral (Section 96) and the period of validity for referrals (Section 105). The Health Insurance Regulations are available at:
https://www.legislation.gov.au/Details/F2020C00656

17.4. Right of Private Practice

Under the Medical Officers Enterprise Agreement, Staff Specialist Clinicians may be eligible to treat patients who elect to be private within a public hospital.

Under such arrangements, eligible clinicians will elect to receive either the Category A, Category B or Category C Private Practice Allowance in exchange for the undertaking to exercise their right to private practice to the fullest extent possible and paying over to the Health Services an agreed amount of the fees arising from such Private Practice work.

17.5. Section 19(2) Exemptions initiative of the Health Insurance Act (1973)

To improve access to primary care in rural remote areas, the Australian Government will allow Medicare benefits to be claimed in respect of bulk-billed, non-admitted, non-referred professional services provided in Emergency Departments and outpatient clinics at some small rural hospitals. This includes nursing and allied health services.

This situation existed prior to the National Health Reform. The Australian Government supports six exempt sites in the Northern Territory: Gove District and Tennant Creek Hospitals, Adelaide River, Batchelor, Jabiru and Yulara health centres.

It is important to note that these are public patient services that are claimed against the MBS under a Section 19(2) exemption. So whilst the public hospital employed doctor providing the service requires a valid provider number for claiming MBS benefits, they do not require rights of private practice.

17.6. Multiple visits on the same day/ attendances during the same episode/ attendances for admittance as inpatient subsequent to Inter-Hospital Transfer

The possibility exists that a person may attend, or be admitted to, and discharged from a hospital more than once in the same day.

Hospitals may charge for **every outpatient attendance** for chargeable patients. This means hospitals can charge for the following:

- Multiple same-day outpatient hospital attendance;
- Outpatient attendances when the patient is subsequently admitted.

Hospitals may also charge for an Emergency Department (ED) and an Outpatient attendance on the same day.

When a chargeable patient attends ED multiple times in one day (within 24 hours) for the same injury/ illness, only one emergency account is raised, being the first ED episode of that 24 hour period from the time of the prior discharge.

When a chargeable day stay patient is admitted and discharged, and then subsequently readmitted and discharged within the period of one day (midnight to midnight) at the same hospital, only one day stay account is to be raised, being the first same-day inpatient episode of the day.

When a chargeable day stay patient is subsequently retained by the hospital (or if discharged and readmitted on the same day) beyond midnight on the day of admission, the patient is reclassified as an overnight stay and only charged the overnight fee.

When a chargeable patient is admitted in one hospital through the ED and is subsequently transferred to another hospital within the NT for medical reasons, admitted through ED, the second triage is not raised.

When a chargeable patient is admitted (either on a ward or as Hospital in the Home) and attends ED or an outpatient appointment within that admission period, the ED or outpatient appointment is not charged.

Explanatory notes

17.7. Change of election

Patients should make an informed decision to be public or private at the time of admission, or as soon as possible after admission. The patient should be advised that this choice will remain for the total hospital stay unless there are unforeseen circumstances.

Unforeseen circumstances include, but are not limited to:

- A change in medical circumstances, for example where the patient is admitted for a particular procedure, but found to have complications requiring additional procedures.
- The length of stay is extended beyond that originally and reasonably planned by an appropriate health care professional.
- A change in social or financial circumstances while in hospital (e.g. loss of job).

Inadequate private health insurance cover is not sufficient reason to change an election.

To make a change of election, the patient must complete a new election form. The change is effective for the remainder of the admission and is not retrospective.

17.8. Telehealth and telemedicine

Charges for patients receiving services through telehealth will only be charged for the services in **one location**, i.e. location of the treating doctor, not where the patient is located. This applies to both inpatient and outpatient services delivered through telehealth. Telehealth rates can be found in the tables for non-admitted services in the applicable patient categories.

17.9. Private health insurance and compensation

Private Health Insurance cannot be utilised for treatment arising from compensable events.

17.10. When charges are not applied

In the event that a patient becomes subject to financial charges, purely as a result of receiving treatment in a location which is not standard hospital procedure (due to managing hospital operational demands or other once off events), then those charges will not be apply. Standard accommodation rates will apply.

If a Medicare ineligible does not have insurance and requires health services in the specific circumstance below, then charges should not be raised:

- presents as a victim of crime in the Emergency Department* and the police are in attendance or have supplied an event number which confirms that the person is a victim of crime; or
- has an unexpectedly high risk pregnancy and is unlikely to access clinically necessary treatment based on the costs; or
- has been admitted involuntarily by a detention order because of mental illness or mental disturbance; or
- presents for certain public health issues; or

- has been determined a potential organ donor (only for ventilation required for organ and tissue retrieval and the process of organ and tissue retrieval regardless of success).

If a Medicare ineligible patient in any of the above circumstances has insurance which is able to cover the charges, then charges will be raised to the insurer to the extent that the insurance covers the charges, ie there will be no out of pocket expenses to the patient.

* where a victim of crime requires ongoing medical services related to the initial crime (i.e. an admission to hospital immediately following the emergency treatment or subsequent readmissions or outpatient appointments), the standard charges or request for waiver process will apply to all subsequent episodes.

Appendix 1

18. Dental Fees

Dental Fees as published in NT Government Gazette S62, 1 July 2024

Description of Service	Service Provider	
Diagnostic Services	**Specialist Fee**	**Dentist Fee**
Comprehensive oral examination	$83.21	$71.32
Periodic oral examination	$69.12	$59.25
Oral examination–limited	$43.41	$37.21
Consultation (less than 30 mins)	$100.34	$86.00
Consultation-extended (30 mins or more)	$164.17	$140.72
Consultation by referral (less than 30 mins)	$238.57	$139.16
Consultation by referral–extended (30 mins or more)	$325.10	$278.66
Comprehensive clinical report (not elsewhere included)	$74.40	$63.77
Letter of referral. This must be a detailed typed referral.	$17.57	$15.05
Radiological Examination, Analysis and Interpretation		
Intraoral periapical or bitewing radiograph–per exposure	$58.49	$50.14
Intraoral radiograph-occlusal, maxillary or mandibular–per exposure	$97.32	$83.41
Extra oral radiograph-maxillary, mandibular–per exposure	$110.88	$95.04
Lateral, antero-posterior, postero-anterior or submento-vertex radiograph of skull–per exposure	$208.11	$178.38
Radiograph of temporomandibular joint–per exposure	$159.88	$137.03
Cephalometric radiograph-lateral, antero-posterior, postero-anterior or submento-vertex–per exposure	$234.87	$201.32
Panoramic radiograph–per exposure	$148.94	$127.67
Hand-wrist radiograph–per exposure	$139.37	$119.46
Computed tomography of the skull or parts thereof	$235.03	$201.46

Description of Service	Service Provider	
Other Diagnostic Services	**Specialist Fee**	**Dentist Fee**
Bacteriological examination	$62.12	$53.24
Culture examination and identification	$62.12	$53.24
Antibiotic sensitivity test	$108.87	$93.31
Collection of specimen for pathological examination	$58.72	$50.33
Saliva screening test	$63.99	$54.85
Bacteriological screening test	$117.67	$100.85
Biopsy of tissue	$195.83	$166.81
Histopathological examination of tissue	$95.66	$81.99
Cytological investigation	$159.38	$136.60
Blood Sample	$80.72	$69.19
Haematological examination	$80.72	$69.19
Diagnostic model–per model	$95.50	$81.86
Photographic records–intraoral	$51.41	$44.06
Photographic records–extra oral	$51.41	$44.06
Diagnostic wax-up	$377.27	$215.59
Cephalometric analysis - excluding radiographs	$102.67	$88.00
Tooth-jaw size prediction analysis	$167.12	$143.24
Tomographic analysis	$62.12	$53.24
Electromyography analysis	$183.21	$157.05

Description of Service	Service Provider	
Dental Prophylaxis	**Specialist Fee**	**Dentist Fee**
Removal of plaque and/or stain	$85.02	$72.88
Recontouring and polish of pre-existing restoration(s)–per appointment	$32.19	$27.58
Removal of calculus–first appointment	$141.79	$121.53
Removal of calculus–subsequent appointment	$92.27	$79.08
Enamel micro-abrasion–per tooth	$55.19	$47.31
Bleaching, internal–per tooth	$303.33	$259.99
Bleaching, external–per tooth	$298.56	$255.91
Bleaching, home application–per arch	$73.52	$63.01
Remineralising Agents		
Topical application of remineralising and/or cariostatic agents–one treatment	$54.65	$46.84
Topical remineralisation and/or cariostatic agents, home application- per tooth	$42.74	$36.64
Concentrated remineralising and/or cariostatic agent, application–single tooth	$42.74	$36.64
Other Preventative Services		
Dietary analysis and advice	$57.51	$49.30
Oral hygiene instruction	$78.17	$67.00
Provision of a mouthguard–indirect	$237.59	$203.65
Bi-maxillary mouthguard - indirect	$230.35	$197.44
Fissure and /or tooth surface sealing–per tooth	$72.81	$62.41
Desensitising procedure–per appointment	$42.74	$36.64
Odontoplasty–per tooth	$80.28	$68.82

Description of Service	Service Provider	
Periodontics	**Specialist Fee**	**Dentist Fee**
Treatment of acute periodontal infection–per appointment	$110.21	$94.46
Clinical periodontal analysis and recording	$222.88	$71.72
Periodontal debridement–per tooth	$56.84	$35.34
Non-surgical treatment of peri-implant disease–per implant	$56.84	$35.34
Gingivectomy–per tooth or implant	$153.95	$99.22
Periodontal flap surgery–per tooth	$289.03	$186.26
Gingival graft–per tooth or implant	$82.99	$71.14
Guided tissue regeneration-membrane implant	$836.77	$717.23
Guided tissue regeneration-membrane removal	$430.49	$368.98
Periodontal flap surgery for crown lengthening–per tooth	$884.55	$512.29
Root resection–per root	$427.84	$293.46
Osseous surgery–per tooth or implant	$434.66	$280.12
Osseous graft–per tooth or implant	$462.62	$298.16
Osseous graft–block	$807.37	$520.31
Periodontal surgery involving one tooth	$250.63	$107.57
Maxillary sinus augmentation–Trans-alveolar technique–per sinus	$1,245.68	$1,067.72
Maxillary sinus augmentation–Lateral wall approach–per sinus	$1,245.68	$1,067.72
Active Non-surgical Periodontal Therapy–per quadrant	$466.37	$199.89
Supportive Periodontal Therapy–per appointment	$435.07	$214.82
Oral Surgery		
Removal of a tooth or part(s) thereof	$257.86	$177.93
Sectional removal of tooth or part(s) thereof	$353.00	$227.35
Surgical Extractions		
Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division	$447.89	$288.74
Surgical removal of a tooth or tooth fragment requiring removal of bone	$556.06	$329.76
Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division	$688.49	$443.60

Description of Service	Service Provider	
Surgery for Prostheses	**Specialist Fee**	**Dentist Fee**
Alveolectomy–per segment	$264.49	$180.00
Osteotomy–per jaw	$702.67	$602.28
Reduction of fibrous tuberosity	$392.64	$253.08
Reduction of flabby ridge–per segment	$238.94	$143.36
Removal of hyperplastic tissue	$573.70	$229.49
Repositioning of muscle attachment	$645.61	$553.38
Vestibuloplasty	$684.51	$586.72
Skin or mucosal graft	$629.17	$539.28
Treatment of Maxillo-Facial Injuries		
Repair of skin and subcutaneous tissue or mucous membrane	$336.41	$216.76
Fracture of maxilla or mandible–not requiring fixation	$294.42	$252.37
Fracture of maxilla or mandible–with wiring of teeth or intra-oral fixation	$928.05	$795.46
Fracture of maxilla or mandible–with external fixation	$928.05	$795.46
Fracture of zygoma	$1,233.86	$1,057.59
Fracture requiring open reduction	$997.02	$854.59
Dislocations		
Mandible–relocation following dislocation	$93.84	$80.44
Mandible–relocation requiring open operation	$271.43	$232.65
Osteotomies		
Osteotomy–maxilla	$2,207.50	$1,892.14
Osteotomy–mandible	$2,207.50	$1,892.14

Description	Service Provider	
General Surgical–Oral Pathology	**Specialist Fee**	**Dentist Fee**
Removal of tumour, cyst or scar-cutaneous, subcutaneous or in mucous membrane	$278.46	$278.46
Removal of tumour, cyst or scar involving muscle, bone or other deep tissue	$987.29	$987.29
Surgery to salivary duct	$1,014.12	$869.25
Surgery to salivary gland	$343.72	$294.61
Removal or repair of soft tissue (not elsewhere defined)	$426.48	$274.59
Surgical removal of foreign body	$240.98	$155.46
Marsupialisation of cyst	$621.64	$532.82
Other Surgical Procedures		
Surgical exposure of unerupted tooth–per tooth	$549.72	$471.19
Surgical exposure and attachment of device for orthodontic traction	$623.53	$534.45
Repositioning of displaced tooth/teeth–per tooth	$402.36	$258.63
Surgical repositioning of unerupted tooth–per tooth	$623.53	$534.45
Splinting of displaced tooth/teeth–per tooth	$419.39	$266.84
Replantation and splinting of a tooth–per tooth	$810.91	$522.50
Transplantation of tooth or tooth bud	$930.83	$797.86
Surgery to isolate and preserve neurovascular tissue	$297.28	$254.82
Frenectomy	$371.91	$239.64
Drainage of abscess	$195.08	$131.29
Surgery involving the maxillary antrum	$1,245.68	$1,067.72
Surgery for osteomyelitis	$813.32	697.13
Repair of nerve trunk	$1,632.90	$1,399.62
Control of reactionary or secondary post-operative haemorrhage	$70.84	$60.73
Pulp and Root Canal Treatments		
Direct pulp capping	$73.12	$47.30
Incomplete endodontic therapy (tooth not suitable for further treatment)	$301.72	$161.77
Pulpotomy	$139.37	$103.05
Complete chemo-mechanical prep of root canal–one canal	$626.84	$290.22
Complete chemo-mechanical preparation of root canal–each additional canal	$320.35	$138.27

Description	Service Provider	
Other Surgical Procedures	**Specialist Fee**	**Dentist Fee**
Root canal obturation–one canal	$626.84	$282.73
Root canal obturation–each additional canal	$320.35	$132.19
Extirpation of pulp or debridement of root canal(s)–emergency or palliative	$261.79	$186.91
Resorbable root canal filling–primary tooth	$301.72	$161.77
Periradicular Surgery		
Periapical curettage–per root	$645.61	$409.87
Apicectomy–per root	$645.61	$409.87
Exploratory periradicular surgery	$251.52	$172.37
Apical seal - per canal	$836.77	$491.74
Sealing of perforation	$597.67	$258.12
Surgical treatment and repair of an external root resorption–per tooth	$585.53	$358.51
Hemisection	$556.06	$329.76
Other Endodontic Services		
Exploration and/or negotiation of a calcified canal–per canal, per appointment	$222.88	$143.24
Removal of root filling–per canal	$222.88	$143.24
Removal of cemented root canal post or post crown	$208.87	$143.24
Removal or bypassing fractured endodontic instrument	$195.08	$119.46
Additional appointment for irrigation and/or dressing of the root canal system–per tooth	$222.88	$143.24
Obturation of resorption defect or perforation (non-surgical)	$222.88	$143.24
Interim therapeutic root filling–per tooth	$250.63	$191.05
Metallic Restorations–Direct		
Metallic restoration–one surface	$164.78	$141.23
Metallic restoration–two surfaces	$202.00	$173.15
Metallic restoration–three surfaces	$241.13	$206.69
Metallic restoration–four surfaces	$274.83	$235.56
Metallic restoration–five surfaces	$313.80	$268.98

Description of Service	Service Provider	
Adhesive Restoration–Anterior Teeth - Direct	**Specialist Fee**	**Dentist Fee**
Adhesive restoration–one surface–anterior tooth	$182.49	$156.42
Adhesive restoration–two surfaces–anterior tooth	$221.61	$189.96
Adhesive restoration–three surfaces–anterior tooth	$262.46	$224.96
Adhesive restoration–four surfaces–anterior tooth	$303.33	$259.99
Adhesive restoration–five surfaces–anterior tooth	$423.76	$305.54
Adhesive restoration–veneer–anterior tooth–direct	$423.76	$305.54
Adhesive Restorations–Posterior Teeth–Direct		
Adhesive restoration–one surface–posterior tooth	$195.01	$167.15
Adhesive restoration–two surfaces–posterior tooth	$244.75	$209.79
Adhesive restoration–three surfaces–posterior tooth	$294.20	$252.17
Adhesive restoration–four surfaces–posterior tooth	$331.51	$284.16
Adhesive restoration–five surfaces–posterior tooth	$496.28	$328.20
Adhesive restoration–veneer–posterior tooth–direct	$423.76	$305.54
Metallic Restorations–Indirect		
Metallic restoration–one surface	$860.51	$737.57
Metallic restoration–two surfaces	$1,099.69	$942.57
Metallic restoration–three surfaces	$1,434.43	$1,229.52
Metallic restoration–four surfaces	$1,601.84	$1,373.01
Metallic restoration–five surfaces	$2,366.55	$1,536.80
Tooth-Coloured Restorations–Indirect		
Tooth-coloured restoration–one surface	$1,434.43	$922.17
Tooth-coloured restoration–two surfaces	$1,625.67	$1,065.46
Tooth-coloured restoration–three surfaces	$2,055.84	$1,311.37
Tooth-coloured restoration–four surfaces	$2,223.09	$1,577.88
Tooth-coloured restoration–five surfaces	$2,366.55	$1,691.52
Tooth-coloured restoration–veneer–indirect	$1,434.43	$1,127.56

Description of Service	Service Provider	
Other Restorative Services	**Specialist Fee**	**Dentist Fee**
Provisional (intermediate/temporary) restoration–per tooth	$77.11	$66.09
Metal band	$64.98	$55.70
Pin retention–per pin	$44.40	$38.05
Cusp capping–per cusp	$47.87	$41.03
Restoration of an incisal corner–per corner	$47.87	$41.03
Bonding of tooth fragment	$195.08	$131.29
Crown–metallic–with tooth preparation–preformed	$549.72	$348.31
Crown–metallic–minimal tooth preparation–preformed	$241.13	$206.69
Crown–tooth-coloured–preformed	$549.72	$348.31
Removal of indirect restoration	$222.88	$131.29
Recementing of indirect restoration	$125.20	$107.31
Post–direct	$306.27	$203.00
Crowns		
Full crown–acrylic resin–indirect	$1,942.47	$1,251.74
Full crown–non-metallic–indirect	$2,824.91	$1,820.49
Full crown–veneered–indirect	$3,117.15	$1,712.59
Full crown–metallic–indirect	$2,493.56	$1,604.76
Core for crown including post–indirect	$671.00	$433.26
Preliminary restoration for crown–direct	$278.67	$179.03
Post and root cap–indirect	$682.54	$453.81
Provisional and Crown Bridge		
Provisional crown–per tooth	$240.98	$206.56
Provisional bridge–per pontic	$621.64	$409.87
Provisional implant crown abutment–per abutment	$295.25	$253.08
Bridges		
Bridge pontic–direct–per pontic	$2,055.84	$1,311.37
Bridge pontic–indirect–per pontic	$2,055.84	$1,398.14
Semi-fixed attachment	$669.20	$315.47
Precision or magnetic attachment	$602.34	$401.47
Retainer for bonded fixture–indirect– per tooth	$836.77	$532.82

Description of Service	Service Provider	
Crown and Bridge Repair and Other Services	**Specialist Fee**	**Dentist Fee**
Recementing crown or veneer	$185.59	$139.76
Recementing bridge or splint–per abutment	$211.89	$136.46
Rebonding of bridge or splint where retreatment of bridge surface is required	$197.87	$124.11
Removal of crown	$125.50	$83.54
Removal of bridge or splint	$292.46	$250.68
Repair of crown, bridge or splint–indirect	$294.42	$315.47
Repair of crown, bridge or splint–direct	$702.67	$401.47
Procedures for Implant Prostheses		
Full crown attached to osseointegrated implant–non-metallic–indirect	$2,824.91	$1,820.49
Full crown attached to osseointegrated implant–veneered–indirect	$3,117.15	$2,062.20
Full crown attached to osseointegrated implant–metallic–indirect	$2,493.56	$1,606.96
Prosthodontics		
Complete maxillary denture	$1,508.68	$1,293.15
Complete mandibular denture	$1,508.68	$1,293.15
Provisional complete maxillary denture	$1,131.49	$969.84
Provisional complete mandibular denture	$1,131.49	$969.84
Provisional complete maxillary and mandibular dentures	$2,006.46	$1,719.83
Metal palate or plate	$649.07	$418.30
Complete maxillary and mandibular dentures	$2,675.30	$2,293.10
Partial maxillary denture–resin base	$690.23	$591.62
Partial mandibular denture–resin base	$690.23	$591.62
Provisional partial maxillary denture	$517.69	$443.73
Provisional partial mandibular denture	$517.69	$443.73
Partial maxillary denture–cast metal framework	$2,021.01	$1,732.30
Partial mandibular denture–cast metal framework	$2,021.01	$1,732.30
Retainer–per tooth	$69.65	$59.70
Occlusal rest–per rest	$33.84	$29.01
Tooth/teeth (partial denture)	$57.14	$48.97

Description of Service	Service Provider	
Prosthodontics (continued)	**Specialist Fee**	**Dentist Fee**
Overlays – per tooth (can only be claimed with items 727 or 728 from the Australian Schedule of Dental Services and Glossary Australian Dental Association Twelfth Edition Published by the Australian Dental Association 12–14 Chandos St, St Leonards, NSW 2065 Australia © Australian Dental Association, 2017))	$69.65	$59.70
Precision or magnetic denture attachment	$418.27	$358.51
Immediate tooth replacement–per tooth	$14.40	$12.34
Resilient lining	$299.03	$256.31
Wrought bar	$278.67	$238.86
Metal backing – per backing (can only be claimed with 716, 727, or 728 from the Australian Schedule of Dental Services and Glossary Australian Dental Association Twelfth Edition)	$14.40	$12.34
Denture Maintenance and Adjustments		
Adjustment of a denture	$82.54	$70.75
Relining–complete denture–processed	$764.02	$451.30
Relining - partial denture–processed	$594.06	$384.75
Remodelling–complete denture	$1,065.64	$686.77
Remodelling–partial denture	$1,065.64	$686.77
Relining–complete denture - direct	$430.49	$245.91
Relining–partial denture - direct	$263.06	$204.81
Cleaning and polishing of pre-existing denture	$89.10	$57.38
Denture base modification	$267.07	$228.92
Denture Repairs		
Reattaching pre-existing tooth or clasp to denture	$167.87	$51.56
Replacing/adding clasp to denture–per clasp	$238.20	$204.15
Repairing broken base of a complete denture	$167.87	$143.88
Repairing broken base of a partial denture	$167.87	$143.88
Replacing/adding new tooth on denture–per tooth	$238.20	$204.15
Reattaching existing tooth on denture–per tooth	$64.45	$25.39
Adding tooth to partial denture to replace an extracted or decoronated tooth–per tooth	$241.13	$206.69
Repair or addition to metal casting	$616.74	$0.00

Description of Service	Service Provider	
Other Prosthodontic	**Specialist Fee**	**Dentist Fee**
Tissue conditioning preparatory to impressions–per application	$109.52	$93.87
Splint–resin–indirect	$717.07	$471.19
Splint–metal–indirect	$717.07	$471.19
Obturator	$924.64	$595.90
Characterisation of denture base	$35.66	$30.57
Impression–dental appliance repair/modification	$72.81	$62.41
Identification	$58.26	$49.95
Surgical guide for an immediate denture	$320.13	$274.39
Removable Appliances		
Passive removable appliance–per arch	$627.60	$404.47
Active removable appliance–per arch	$781.14	$503.42
Functional orthopaedic appliance–custom fabrication	$2,496.94	$1,609.20
Fixed Appliances		
Fixed palatal or lingual arch appliance	$750.97	$643.70
Partial banding for inter-maxillary elastics (cross elastics)	$625.73	$536.34
Maxillary expansion appliance	$1,189.07	$1,019.21
Passive fixed appliance	$525.64	$450.57
Minor tooth guidance–fixed	$882.38	$756.33
Extra Oral Appliances		
Extra oral appliance	$1,101.40	$944.06
Attachments		
Bonding of attachment for application of orthodontic force	$116.44	$99.81
Other Orthodontic Services		
Orthodontic adjustment	$134.18	$115.02
Repair of removable appliance, resin base	$100.11	$85.82
Repair of removable appliance–clasp, spring tooth	$100.11	$85.82
Addition to remove appliance–clasp, spring or tooth	$215.00	$184.28
Relining- removable appliance–processed	$303.86	$260.46

General Services		
Emergencies	**Specialist Fee**	**Dentist Fee**
Palliative care	$143.90	$92.65
After hours callout	$145.18	$124.44
Travel to provide services	$105.62	$90.52
Drug Therapy		
Individually made tray–medicaments	$250.64	$214.84
Provision of medication/ medicament	$43.42	$37.21
Anaesthesia, Sedation and Relaxation Therapy		
Sedition- inhalation–per 30 minutes or part thereof	$80.74	$69.20
Relaxation therapy (does not involve the use of drugs)	$80.74	$69.20
Treatment under general anaesthesia/sedation	$322.95	$276.84
Occlusal Therapy		
Minor occlusal adjustment–per appointment	$118.61	$69.20
Clinical occlusal analysis including muscle and joint palpation	$195.08	$119.48
Registration and mounting of casts for occlusal analysis	$143.60	$102.42
Occlusal splint	$1,410.46	$721.87
Adjustment of pre-existing occlusal splint–per appointment	$142.77	$102.42
Occlusal adjustment following occlusal analysis–per appointment	$215.21	$143.36
Adjunctive physical therapy for temporomandibular joint and associated structures–per appointment	$143.60	$102.42
Repair/addition–occlusal splint	$0.00	$389.34
Miscellaneous		
Splinting and stabilisation–direct–per tooth	$195.08	$131.29
Enamel stripping–per appointment	$150.53	$129.03
Single arch oral appliance for diagnosed snoring and obstructive snoring and sleep apnoea	$1,277.32	$823.19
Bi-maxillary oral appliance for diagnosed snoring and obstructive snoring and sleep apnoea	$1,277.32	$823.19
Repair/addition–snoring or sleep apnoea device	$454.22	$389.34
Post-operative care where not otherwise included	$139.38	$95.57

19. Glossary

Admission
The formal administrative process by which a patient commences a period of treatment, care and accommodation in a hospital.

Admitted Patient
A patient who has undergone the formal hospital admission process.

Allied health
This includes, but is not limited to, services provided by a physiotherapist, podiatrist, social worker, occupational therapist, orthoptist, dietician, audiologist or speech pathologist.

Australian Defence Force (ADF)
Personnel serving in the Royal Australian Air Force, the Australian Army and the Royal Australian Navy.

Australian Government
Commonwealth Government of Australia, responsible for the private health insurance industry, Medicare Benefits Schedule and the Prostheses List.

Boarder
A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. A boarder is thus defined as not admitted to the hospital. A hospital however may register a boarder. METeOR (Metadata Online Registry)

Compensable patient
A patient receiving hospital services who, is or may be, entitled to payment, or has received payment, by way of compensation in respect to the injury, illness or disease, for which the patient is receiving those services.

Coronary Care Unit (CCU)
A specialised ward dedicated to acute care services for patients with cardiac diseases.
METeOR (Metadata Online Registry)

Department of Veterans Affairs (DVA)
The Australian Government Department which arranges and/or pays for the health care of veterans and war widows, according to their entitlement for certain services and their clinical need for those services.

Discharge or separation
The formal administrative process by which an admitted patient ceases a period of treatment, care and accommodation in a hospital.

Eligible person
A person who is as an Australian resident or eligible overseas representative, as defined in Section 3 of the *Health Insurance Act 1973*,. A person covered by a Reciprocal Health Care Agreement is eligible for Medicare for medically necessary medical treatment, if they elect to be a public patient. The *Health Insurance Act 1973* gives the Minister discretionary powers to either include or exclude certain persons or categories of persons for eligibility for Medicare. Eligible persons must enrol in Medicare before benefits can be paid.

Emergency Department (ED)
A purposely designed and equipped area with designated assessment, treatment and resuscitation areas. It has the ability to provide resuscitation, stabilisation and initial management of all emergencies. It utilises skills of medical staff, designated Emergency Department nursing staff and nursing unit manager, 24 hours per day, 7 days per week. METeOR (Metadata Online Registry)

High Risk Pregnancy
A high-risk pregnancy is one that threatens the health or life of the mother or her fetus.

Hospital
A health care institution that has an organised medical and other professional staff, inpatient facilities and delivers medical, nursing and related services 24 hours per day, 7 days per week.
WHO (World Health Organisation)

Hospital-in-the-home (HITH)
Provision of care to hospital admitted patients in their place of residence or other accommodation facility as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
METeOR (Metadata Online Registry)

Inpatient
See "**Admitted patient**"

Intensive care unit (ICU)
A designated ward of a hospital, which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises skills of medical, nursing and other staff trained and experienced in the management of these problems.
METeOR (Metadata Online Registry)

Leave
Approved leave may be provided to admitted patients. This may be granted up to a maximum of 7 days leave without being separated from a hospital.

Non Approved Leave is where the patient leaves the hospital without being officially discharged or without giving notice or has left with medical advice been given and understood by the patient (informed decision).

Medicare Benefits Schedule (MBS)
The schedule of fees set by the Government for standard medical services, based on a fair price and how much Australia can afford to pay for the total health system. Whether you have private health insurance or you are a private patient paying for all your own costs, the Government provides a rebate on nearly all medical fees. This rebate is currently 75% of the MBS fee for in-hospital medical fees and 85% of the MBS fee for specialist medical fees incurred out of hospital. You can purchase health insurance to cover the difference between 100% of the MBS fee and the rebate, as well as gap cover for any potential additional fees.

Motor Accident Compensation (MAC) Act
The MAC Act is Northern Territory legislation which establishes a no fault compensation scheme in respect of death or injury as a result of motor vehicle accidents, prescribes the rates of benefits to be paid under the scheme and abolishes certain common law rights in relation to motor vehicle accidents.

Neonate
A live birth that is less than 28 days old. METeOR (Metadata Online Registry)

Newborn Qualification Status
Qualification status indicates whether a patient day within a newborn episode is either acute (qualified) or unqualified. METeOR (Metadata Online Registry)

Non-Admitted Patient
A patient who does not undergo a hospitals formal admission process. There are three categories of non-admitted patient:

- Emergency Department patient
- Outpatient
- Other non-admitted patient (treated by hospital employees off the hospital site – community/outreach services).

METeOR (Metadata Online Registry)

Nursing home type patient (NHTP)
A patient after 35 days of continuous hospitalisation that no longer requires acute or sub-acute (rehabilitation or restorative) care and requires accommodation and maintenance care only.

The patient may be waiting placement in a residential aged care facility.

Outpatient
See "**Non-admitted patien**t"

Overnight stay
Where a patient has been admitted into hospital and is accommodated in that hospital as at midnight (i.e. remains an admitted patient of the same hospital until a calendar day subsequent to that of their admission).

Patient
A person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patients, admitted and non-admitted. Boarders are not patients.

Primary care referred patient
A Medicare eligible person who is referred to a specialist medical practitioner from an eligible practitioner following a primary care level service in the community for a consultation or a procedure, including radiology and pathology services.

Patient Assistance Travel Scheme (PATS)
PATS promotes equity of access to specialist medical services. To be eligible for NT PATS the patient must: be a Medicare eligible resident of the NT, reside more than a 200km radius from the specialist (offshore locations are exempt from this such as Bathurst Island and Groote Eylandt) or more than 400km cumulatively in one week (to attend eligible renal and oncology services) and NOT entitled to compensation or other alternative funding for travel.

Private medical practitioner
A medical practitioner who is not a salaried medical practitioner. Medical Services Act (NT)

Private patient
A private patient is a person who is eligible for Medicare, who on admission elects to be treated as a private patient. The patient receives medical or diagnostic services from a specialist medical practitioner chosen by the patient.

Professional fees
Fees for services provided by a medical officer that qualifies for a Medicare benefit.

Medicare Ineligible/Workers Compensation patients, regardless of their Medicare status and ability to access Medicare benefits, will have their professional fees determined in line with the MBS fee framework.

Prostheses (surgically implanted)
Surgically implanted prostheses, includes such things as hip replacements, artificial lenses and heart valves.

Prostheses List
Under the *Private Health Insurance Act 2007*, private health insurers are required to pay mandatory benefits for a range of surgically implanted prostheses that are provided as part of an episode of hospital treatment (or hospital substitute treatment) where a Medicare benefit is payable for the associated professional service(surgery). There are more than 9,000 products on the Prostheses List. The List does not include; external legs, external breast prostheses, wigs and other such devices.

Public hospital
A hospital declared by the Commonwealth Minister for Health pursuant to section 121-5(6) of the *Private Health Insurance Act 2007*. 'Recognised' public hospitals have access to the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and private health insurance arrangements.

Public patient
A Medicare eligible patient who elects to be treated in a public hospital under Medicare, by a doctor appointed by the hospital.

Right of private practice
Under the Medical Officers Enterprise Agreement, Staff Specialist Clinicians may be eligible to treat patients who elect to be private within a public hospital.

Same-day patient
A patient who is admitted and separated on the same date, and who meets one of the following minimum criteria:

1. that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth),
2. that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient. METeOR (Metadata Online Registry)

Special care nursery (SCN)
A hospital ward staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.
METeOR (Metadata Online Registry)

Specialist fees
Fees for services provided by a medical officer who has successfully completed a recognised specialist training program and has been admitted as a Fellow of the College authorising program for which a Medicare benefit applies and is registered with Medicare and the Australian Health Practitioner Regulation Agency as a specialist in that field.

Telehealth
The use of telecommunication techniques for the purpose of providing telemedicine, medical education and health education over a distance. International Organisation for Standardisation

Telemedicine
The use of advanced telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers.
International Organisation for Standardisation

20. Quick Reference Guide

To be used in conjunction with the contents in this Fees and Charges Register.

Emergency patient fees - Hospital						
Patient Category	**ATS 1**	**ATS 2**	**ATS 3**	**ATS 4**	**ATS 5**	**Diagnostics**
Public/Reciprocal	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Private	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Compensable/Defence	$2,550	$1,465	$1,175	$680	$445	120% MBS
Medicare Ineligible	$2,550	$1,465	$1,175	$680	$445	120% MBS
Veterans Affairs	As per Agreement with the Department of Veterans Affairs					

ATS: Australasian Triage Scale

* only when there is no Admitted episode following directly on from the Emergency episode

Admitted patient fees - Hospital												
Patient Category	**Same Day**	**Band 1**	**Band 2**	**Band 3**	**Band 4**	**Overnight**	**ICU/SCN**	**HITH**	**Dialysis**	**Nursing Home Type**	**Respite**	**Diagnostics**
Public/Reciprocal*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	$75.55	$63.02	No Charge
Private	N/A	$316	$363	$418	$421	$436	$316	N/A	100% MBS	$222.74		100% MBS
Compensable/Defence	$3,505	N/A	N/A	N/A	N/A	$3,655	$8,480	$1,360	$860	N/A		120% MBS
Medicare Ineligible	$2,010	N/A	N/A	N/A	N/A	$2,705	$6,280	$1,360	$860	N/A		120% MBS
Veterans Affairs	As per Agreement with the Department of Veterans Affairs									$75.55	$63.02	Not Applicable

* Reciprocal classification is based on the Reciprocal Health Care Agreement criteria and if a patient does not meet Reciprocal criteria then they must be classified as Medicare Ineligible.

Prostheses

Patient Category	Listed Prostheses	Not listed Prostheses
Private	Benefit	Prior agreement required
Veterans Affairs		
Ineligible	Benefit	Full Cost Recovery
Compensable		
Defence		
Immigration detainees		

Medi-Hotel Accommodation

Description of Client	Loraine Brennan Centre (per night)
NT PATS	No Charge
NT PATS Approved Escort	No Charge
Transitional Care Program clients	$70
TIO Motor Vehicle accident clients	$140
Ineligible and other compensable patients	$140
WA PATS Patient	$70
WA PATS Escorts	$70
Unapproved Patients / Escorts (Social Admissions)	$45

Non-admitted patient fees - Hospital

Patient Category	Medical Practitioner	Telehealth – Medical Practitioner	Allied Health/ Nurse	Telehealth - Allied Health/ Nurse	Allied Health/Nurse Education Only	Hyperbaric	Minor Operations	Chemo therapy	Diagnostics	Rehab Classes
Public	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Reciprocal	Charges depend on the inclusions/exclusions under each country's Reciprocal Health Care Agreement. Where the services are excluded, the Medicare Ineligible rate is applied.									
Primary Care Referred	MBS rate	MBS rate	MBS rate	MBS rate	MBS rate	MBS rate	MBS rate	MBS rate	MBS rate	MBS rate
Compensable/Defence	$555	$560	$350	$240	N/A	$2,645	$1,000	$1,360	120%	$60
Medicare Ineligible	$555	$560	$350	$240	$80	$2,645	$1,000	$1,360	120%	$60
Veterans Affairs	As per Agreement with the Department of Veterans Affairs									

Medical reports, copies of medical records and imaging

Description of Client	Search Fee –per search	Copies of Medical Records – per page	Copy of Discharge Summary	Replacement Medical Certificate	Medical/ Allied health report		Images to CD
					2 Pages	Additional Pages	1 Study
Patient Request (GST Exempt)	$44.15	$0.45	No Charge	$44.15	$375	$195	$15.30
Third Party Request (GST Inclusive)	$47.20	$1.15	N/A	N/A	$415	$210	$26.50

Primary Health Care fees

Patient Category	Complete Health Assessment for Employment*	Medical Officer Consult	Nurse, AHP Consult> 1-15Mins	Nurse, AHP Consult> 15-30Mins	Nurse, AHP Consult> 30-45Mins	Nurse, AHP Consult> 15-60Mins	Nurse, AHP Consult 60-75Mins	Nurse, AHP Consult 75Mins +	Emergency Attendance – Medical Officer (per hour)	Emergency Attendance – Nurse (per hour)
Public	$465	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Reciprocal	$465	Charges depend on the inclusions/exclusions under each country's Reciprocal Health Care Agreement. Where services are excluded, the Medicare Ineligible rate is applied.								
Compensable/Defence	$465	250% of MBS	$37.50	$75	$112.50	$150	$187.50	$225	$805	$485
Medicare Ineligible	$465	250% of MBS	$37.50	$75	$112.50	$150	$187.50	$225	$805	$485

* Medical Assessment excluding hearing, respiratory and drug screening - $160
Hearing Screening for Employment - $110
Respiratory Screening for Employment - $110
Drug Screening for Employment - $110

Transport fees												
	Careflight Aero-medical retrieval – per aeronautical mile		Royal Flying Doctor Service Inter-hospital transfers - per aeronautical mile		Commercial transport	Ground based ambulatory retrieval/transport services provided Health Services						
Patient Category	Single payer	Multiple payer	Single payer	Multiple payer		0-24km	25-49km	50-99km	100-149km	150-199km	200+ km	Clinic to aerodrome
Public/Reciprocal	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Private	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Compensable/Defence	$52	$33	$6.10	$5.10	Full cost recovery	$455	$515	$680	$805	$905	$1,030	$290
Medicare Ineligible	$52	$33	$6.10	$5.10	Full cost recovery	$455	$515	$680	$805	$905	$1,030	$290
Motor Accidents TIO	$52	$33	$6.10	$5.10	Full cost recovery	$455	$515	$680	$805	$905	$1,030	$290
Veterans Affairs	$52	$33	$6.10	$5.10	Full cost recovery	$455	$515	$680	$805	$905	$1,030	$290

Hydrotherapy facility fees	
Public Access	
Concessional	$5 per entry or $45 for a 10 entry pass
Non-Concessional	$10 per entry or $90 for a 10 entry pass
External Therapy Provider Hire	
With one clients	$31 per hour^
With up to 3 clients	$51 per hour^
Private pool use	$102 per hour^ $513 per day on weekend only