

Best practice guidelines for hospitals

**Managing hospital admissions where the pre-existing ailment rule
might apply**

Table of Contents

Summary – overarching principles to best practice application of the PEA rule..... 3

Introduction 5

Key points – Pre-existing ailments..... 6

Planned Admission – initial steps 7

No PEA assessment required 9

PEA assessment IS required..... 10

Outcome of Assessment – All or some health fund benefits are payable 12

Outcome of Assessment – PEA rule applies – NO benefits payable 13

Emergency admission 14

Patients transferring from public hospitals..... 15

Best practice relationship management – Pre-existing ailments 16

Attachment A. Steering committee membership 16

Summary – overarching principles to best practice application of the PEA rule

These best practice guidelines have been written for all hospitals that offer private patient hospital treatment. They provide hospitals with a clear explanation of the pre-existing ailment rule and a best practice approach to managing the admission of a patient who may be affected by it.

The success of the pre-existing ailment rule relies on the adoption by hospitals of the following over-arching principles:

1. Commitment to adopt admission procedures consistent with these best practice guidelines.
2. Act in good faith and work co-operatively with health funds, medical practitioners and fund members/patients to provide patients with certainty over their benefit entitlements prior to admission in all circumstances possible.
3. Commitment, where it is not already the case, to put in place an electronic web-based or other telecommunications system to provide an interface between the hospital and health funds 24 hours per day, 7 days per week so that hospitals can confirm the following basic membership details prior to admission:

Member name	Date joined current hospital table
Patient name	Excess payable
Patient date of birth	Co-payments payable
Financial status of membership	Excluded treatments
Current hospital table	Restricted benefits treatments

4. Commitment, where relevant, to negotiate with health funds to include in agreements, an acceptable cost sharing arrangement to cover emergency admissions where it is not possible for the hospital to confirm the above basic membership details with the fund prior to the admission.
5. In most cases, pre-existing ailment assessments and confirmation of benefit entitlements will be clear-cut. These guidelines will be most useful in ensuring fairness where cases are less clear. Remember, usually all parties will be acting in good faith.

Warning

Hospitals should reinforce in the mind of the patient/contributor that the only person able to determine a pre-existing ailment is a medical practitioner appointed by the fund. Neither the hospital or their treating practitioner can make this assessment.

Introduction

The need for best practice guidelines

The need for best practice guidelines on the pre-existing ailment rule (PEA) was identified in an independent review that found there was inconsistency in the way health funds applied the PEA rule creating uncertainty and potential unfairness for consumers.

Guidelines for hospitals

These best practice PEA guidelines have been written for both public and private hospitals to assist them to:

- understand the pre-existing ailment rule; and
- manage the admission of a patient where the pre-existing ailment rule may apply.

Similar best practice guidelines have been developed for medical practitioners and health funds.

There is also a brochure explaining the rule for consumers.

Who developed these best practice guidelines?

Representatives from private hospitals, health funds, medical practitioners, the Office of the Private Health Insurance Ombudsman, consumer representative organisations and the Department of Health and Aged Care developed these guidelines. A full list of the committee members is at *Attachment A*.

Why do we have a pre-existing ailment waiting period?

People choose to take out private hospital insurance for many different reasons. If there was not a pre-existing ailment waiting period people could take out hospital cover or upgrade to comprehensive cover only when they know or suspect that they might need hospital treatment and immediately make an expensive hospital claim. If these new members then left the fund or downgraded to a low premium table, their hospital costs would have to be paid for by the long-term members who remain on these hospital tables. This would not be fair.

Remember, new members who do have pre-existing ailments can still seek treatment for these conditions in a public hospital under Medicare.

Key points – Pre-existing ailments

1. The legislated definition of pre-existing ailments only applies to hospital tables. Some funds do apply similar rules to their ancillary cover;
2. It is the medical practitioner appointed by the health fund who decides if an ailment, illness or condition is pre-existing. They must also consider any information regarding signs and symptoms provided by the treating medical practitioner(s);
3. Whether or not a member has a pre-existing ailment must always be assessed from that person's individual circumstance. It is not allowable to say that certain conditions are always pre-existing;
4. The medical practitioner appointed by the health fund must be satisfied that there is a direct link between the ailment, illness or condition that requires hospital treatment and the signs and symptoms that existed in the 6 month period prior to the member joining or upgrading hospital cover;
5. It is not necessary for the ailment, illness or condition, to have been diagnosed in the 6 month period – only that signs or symptoms were, or would have been, evident;
6. These signs and symptoms should have been reasonably apparent to either the member, or a reasonable general practitioner had the member been examined, in this 6 month period;
7. The waiting period for pre-existing ailments cannot exceed 12 months from date of joining or upgrading hospital tables.

Planned Admission – initial steps

Notification of admission

Hospitals receive notification of a planned admission from:

- medical practitioners with admitting rights; or
- the patient.

Clarify membership details with the patient and/or treating medical practitioner

As soon as a planned admission is advised, the hospital is to obtain the following membership details from the patient and/or the treating medical practitioner(s):

- Member name
- Fund membership number (if known)
- Patient name (if different to member)
- Patient date of birth
- Anticipated procedure/s and/or reason for admission (procedure MBS numbers and/or ICD10 codes)
- Date of admission
- Anticipated length of stay

Immediately contact health fund

Hospital should provide the health fund with a documented (written or electronic) record of the membership details above.

Hospital should request fund to provide same day documented record of the following membership details:

- Member name;
- Member number;
- Patient name (if different to member);
- Patient date of birth;
- Financial status of membership;
- Date joined current hospital table;
- Other waiting periods that apply (if relevant);
- Level of benefit payable for specified treatment including details of:
 - restricted benefits
 - exclusions
 - copayments payable
 - excess payable
 - membership on previous hospital tables (if relevant)
- Other restrictions that apply such as exceptional drugs (if relevant);
- If PEA assessment is required.

Patient to contact the health fund

The hospital should advise the patient to contact their health fund, if they have not already done so, to confirm their eligibility for benefits.

Planned Admission – initial steps, continued

Advise the patient to confirm estimates of medical gap fees

Advise the patient to ask their health fund and treating doctor for written estimates of any likely medical gap fees associated with the planned treatment, *prior* to admission.

No PEA assessment required

Confirm admission

If the health fund confirms in writing that the patient membership is current and she/he has 12 months membership on their current hospital table the pre-existing ailment waiting period does **not** apply.

Provide full informed financial consent

Hospital provides the patient with full informed financial consent including written confirmation of:

- Planned date of admission.
- Anticipated procedure/reason for admission.
- Confirmation of health fund benefit entitlements.
- Estimate of out of pocket hospital costs associated with the planned hospital admission including costs due to:
 - restricted benefits
 - exclusions
 - copayments
 - excess
- Any other restrictions that apply, such as exceptional drugs (where relevant).
- Costs associated with sundry items not covered by health insurance such as telephone calls, newspapers and magazines.

Advise the patient to request from their health fund and treating medical practitioners written confirmation of any medical gap fees. These costs will be in addition to any out of pocket hospital charges.

Cost estimate only

The written estimate of out of pocket costs associated with the hospital admission should note that the estimate is based on information provided by the treating medical practitioner(s) and the health fund. In the event of unforeseen complications or variations from the proposed treatment, the cost estimate may vary.

Re-confirming eligibility

If there is a lengthy lapse between the initial booking and the admission (for example, in obstetrics cases) the hospital should contact the health fund again about 7 days prior to the anticipated date of admission to re-confirm the patient's eligibility for benefits.

PEA assessment IS required

Advise the patient PEA assessment is required

Immediately contact the patient and advise via telephone and in writing that:

- They have less than 12 months membership on their current hospital table and a pre-existing ailment assessment is required.
- Do not offer any opinion about whether or not the condition may or may not be pre-existing.
- The person who decides if a condition is pre-existing is the medical practitioner appointed by the health fund.
- The patient should immediately contact the health fund to request a pre-existing ailment assessment.
- The health fund will need up to 5 working days to complete the assessment.
- If the patient proceeds without confirmation of benefit entitlements and the condition is subsequently determined by the fund to be pre-existing, the patient will be required to pay all outstanding hospital and medical charges.

Advise the treating medical practitioner that PEA assessment is required

Hospital should contact the treating medical practitioner and advise that the patient has less than 12 months membership on their current hospital table and a pre-existing ailment assessment is required.

Advise the treating medical practitioner(s) that the health funds will send the PEA medical forms to the patient to be signed with instructions to then forward the forms to the treating medical practitioner(s) for completion and return to the health fund.

PEA assessment IS required, continued

Further advice to patient if late notification of admission and PEA assessment is required

If the hospital is notified less than 5 days prior to the planned admission date, hospitals must advise the patient that:

- The health fund may not have enough time before admission to confirm if the condition is pre-existing.
 - The patient should contact the health fund immediately and advise that an urgent pre-existing ailment assessment is required.
 - The patient will be responsible for an up-front payment for some or all costs for the hospital treatment and medical fees if they proceed with a hospital admission before the health fund has confirmed their benefit entitlements.
 - Some or all of these costs will be reimbursed by the fund if the health fund confirms that benefits *are* payable after the treatment is received.
 - The patient must confirm in writing that they wish to proceed with the admission in the knowledge that they may be responsible for paying some or all of the costs of hospitalisation and medical fees.
 - Advise the patient to consult with their treating medical practitioner about other treatment options, if they do not wish to proceed with the admission.
-

Outcome of Assessment – All or some health fund benefits are payable

Condition is NOT pre-existing – Benefits on current hospital table payable If the health fund confirms the condition is NOT pre-existing and the patient’s membership is financial, the patient will be eligible for benefits payable under their current hospital table.

Condition IS pre-existing - Benefits on previous table payable If the pre-existing ailment rule applies, but the patient has accrued 12 months membership taking into consideration previous hospital cover, the patient will be still be eligible for benefits but at the level specified under their previous table.

Informed financial consent If fund benefits are payable, the hospital should immediately provide the patient with full and open disclosure of all hospital costs the patient is required to pay.

Hospital provides patient with written confirmation of:

- planned date of admission;
- anticipated procedure/reason for admission;
- confirmation of health fund benefit entitlements;
- estimate of out of pocket hospital costs associated with the planned hospital admission including costs due to:
 - restricted benefits
 - exclusions
 - copayments;
 - excess
- Any other restrictions that apply, where relevant, such as exceptional drugs.
- Costs associated with sundry items not covered by health insurance such as telephone calls, newspapers and magazines.
- Advise the patient to ask their health fund and treating medical practitioners for written confirmation of any medical gap fees. These costs will be in addition to any out of pocket hospital charges.

Hospital to assist the patient with this process where ever possible.

Cost estimate only The written estimate of out of pocket costs associated with the hospital admission should note that the estimate is based on information provided by the medical practitioner and the health fund. In the event of unforeseen complications or variations from the proposed treatment, the cost estimate may vary.

Outcome of Assessment – PEA rule applies – NO benefits payable

**PEA applies -
No benefits payable**

If the condition is considered by the health fund to be pre-existing and the patient has had no previous hospital insurance and no benefits are payable for the planned treatment, hospitals should:

- Immediately advise the patient that the pre-existing ailment rule applies and the cost of their treatment will not be covered by the health fund.

**Provide full estimate
of hospital costs**

Hospitals should provide the patient with a written estimate of the full cost of the anticipated hospital treatment.

Advise the patient to ask their treating medical practitioner(s) for a written estimate of all medical gap fees associated with the anticipated hospital treatment. These costs will be in addition to the estimated hospital charges.

**If the patient elects to
proceed with
admission & pay all
costs**

Hospital should write to the patient and confirm:

- Date of admission.
- Anticipated procedure/reason for admission.
- All known and anticipated costs of hospital treatment.
- Any items not covered by the cost of hospitalisation or treatment, such as telephone calls, newspapers and magazines.
- Obtain patient's confirmation in writing that they intend to proceed with the admission in the knowledge that they will bear the full cost of hospitalisation and out of pocket medical gap fees.
- The written confirmation should note that the estimation of costs is based on information provided by the medical practitioner and the health fund, but in the event of unforeseen complications or variations from the proposed treatment, the costing estimate may vary.
- On admission, the patient sign a second copy of this letter, and this copy should be held on the patient's file.

Emergency admission

Hospital is to contact the health fund as soon as possible to check the patient's eligibility for benefits. If the health fund advises that the patient is eligible for benefits, follow the procedures for "Patient eligible for health fund benefits."

If the admission occurs outside of business hours and the health fund cannot be contacted to confirm eligibility, or advises that a pre-existing ailment assessment is required:

Advice to the patient	<p>Advise the patient that:</p> <ul style="list-style-type: none">• the health fund cannot confirm eligibility for benefits at this stage.• the patient may be responsible for paying some or all costs for hospitalisation and treatment if the health fund subsequently advises that benefits are not payable.• The hospital may require the patient to make an up-front payment of some or all of the estimated hospitalisation costs on admission, and the patient may claim these costs from the health fund if they subsequently determine that benefits are payable.• do not offer any opinion about whether or not fund benefits might be paid.
Provide an estimate of costs to patient	<p>Where possible, provide the patient with an estimate of the cost of hospitalisation and treatment, taking into account any agreement between the hospital and the health fund in relation to cost-sharing for emergency admissions.</p>
Medical gap fees	<p>Advise the patient they may also incur medical gap fees from their treating medical practitioner(s). These costs will be in addition to any out of pocket hospital charges.</p>
Advise patient of options	<p>Arrange for the patient to be advised of their options:</p> <ul style="list-style-type: none">• Transfer to a public hospital on stabilisation of condition.• Payment of the costs of private hospital treatment.
Patient elects to remain in hospital	<p>Ask the patient (or agent) to sign a written confirmation that the patient has decided to remain in hospital in the knowledge that they may be responsible for the cost of the hospitalisation and treatment.</p>

Patients transferring from public hospitals

It is best practice for private hospitals to confirm the eligibility of patients for health insurance benefits prior to the transfer from the public hospital.

As patients who are transferred are generally no longer regarded as emergency patients (that is they have been stabilised) the best practice guidelines for planned admissions should be followed.

Best practice relationship management – Pre-existing ailments

It is best practice for private hospitals and public hospitals that offer private patient treatment to work with the medical practitioners with admitting rights and their receptionists, to ensure they clearly understand:

- the pre-existing ailment rule waiting period;
- that patients with less than 12 months membership on their current hospital table may be affected by it;
- that health funds need up to 5 working days to make a pre-existing ailment assessment and this should be done *prior* to admission in all circumstances possible;
- that, wherever possible, admissions should be scheduled to allow for patients to confirm their benefit entitlements prior to admission.

Steering Committee Membership

Dr Geoff Dreher	Australian Regional Health Group Limited
Mr Russell Schneider	Australian Health Insurance Association
Mr Michael Bassingthwaighte	Health Insurance Restricted Membership Association of Australia
Mr Norman Branson	Private Health Insurance Ombudsman
Ms Samantha Gavel	Office of the Private Health Insurance Ombudsman
Mr Roger Gimblett	Office of the Private Health Insurance Ombudsman
Ms Joan Lipscombe	Australian Consumers' Association
Mr Matthew Blackmore	Consumers' Health Forum
Dr Christopher Baggoley	Committee of Presidents of Medical Colleges
Dr John North	Royal Australian College of General Practitioners
Mr Michael Roff	Australian Private Hospital Association
Ms Rosemary Townsend	Australian Private Hospital Association
Mr Denis Hogg	Epworth Hospital, Victoria
Dr Bert Boffa	AXA Australia Health
Mr Dale Brooker	Medibank Private
Dr Gavin Frost	Medical Benefits Fund of Australia (MBF)
Mr Alan Kinkade	Hospital Contributions Fund of Australia (HCF)
Ms Chris Harrington	Commonwealth Department of Health and Aged Care
Ms Leonie Hull	Commonwealth Department of Health and Aged Care
