

Recommendations for Pharmaceutical Benefits Scheme (PBS) Business Practices in Public Hospitals

Prepared by the Victorian Therapeutics Advisory Group (VicTAG) January 2004

During 2003 VicTAG surveyed member institutions regarding business practices implemented in association with the introduction of the PBS. The results of the surveys have been used to develop recommendations that aim to assist members and facilitate uniformity of business practices. However individual hospitals have the right to determine their own policies provided they are in accordance with the Commonwealth State agreement on pharmaceutical reforms.

1.Charges for medications supplied from the Emergency Department after hours

1.1 Is a charge levied?

The decision to charge for medications supplied from the Emergency Department after hours will depend on the practical logistics of fee collection. When the cost of billing exceeds the fee levied the only rationale for charging for medication is to ensure consistency with charging at other times and so act as a disincentive to those patients who may present after hours in order to obtain free medication. Alternatively a policy of sending patients out to local pharmacies with prescriptions is appropriate in many instances.

1.2 If yes, what is the charge?

The fee levied should be consistent with PBS charging.

1.3 How is the fee collected?

Issuing invoices is the most practical method of collecting of fees from patients presenting to the Emergency Department after hours. However the cost of billing may exceed the fee levied.

2. Brand Price Premiums (BPP) and Therapeutic Group Price (TGP)

2.1 Are these charges levied?

Hospitals have largely chosen not to charge premiums. As hospital formulary and purchasing decisions restrict product choice Brand Price Premium and Therapeutic Group Premium charging may not be appropriate. However consistency with external community pharmacy pricing is a consideration.

3. Level of charges levied

3.1 Non-PBS items

Pricing for non-PBS items should reflect PBS pricing with a minimum price of \$3.80 to a maximum of \$23.70. Individually priced items should include a dispensing fee or mark-up depending on local policy. Please note that for non-PBS items the Commonwealth State agreement allows for the patient to be charged the cost price of the medication.

3.2 OTC Items

Pricing for OTC items should reflect PBS pricing with a minimum price of \$3.80 to a maximum of \$23.70. Hospitals may choose to utilise community pharmacy price guidelines such as Sigma prices and/or encourage patients to purchase OTC items from their community pharmacy.

3.3 Small quantities of medications

There may be no charge or a minimum fee of \$3.80 made for small quantities of medications.

3.4 Patients covered by TAC or Workers' Compensation

For patients covered by TAC or Work Cover fees should be consistent with charging for other patients. TAC and Work Cover may be invoiced directly if claim details are available.

4.Co-payments

4.1 What quantities are supplied when co-payment is NOT received?

When a co-payment is not received at the time of supply the full supply should be issued with an invoice. A system should be in place to approve supply without co-payment in cases of genuine financial hardship. Liaison with the Social Work Department may be appropriate.

For bad debtors (with the capacity to pay) liaison with the hospital finance department regarding debt collection procedures may be appropriate. Supplying limited quantities to bad debtors may be an appropriate disincentive.

4.2 Are discounts given for upfront payment of co-payments?

PBS co-payments should not be discounted for upfront payment.

5. What is your hospital's policy/practice regarding inclusion of repeats on PBS prescriptions?

5.1 For discharge prescriptions

Hospitals may choose to discourage the ordering of repeats on discharge prescriptions as this may delay follow up with the patient's general practitioner. However the therapeutic need of patients should be the overriding consideration. Authority prescriptions, written by a hospital prescriber, with repeats authorised should be honoured as another authority prescription may not be approved until the repeats have expired.

5.2 Outpatient prescriptions

The therapeutic needs of the patient and the date of follow-up appointments will influence the requirement for repeat prescriptions for outpatients. If a patient is to be reviewed by the general practitioner inclusion of repeat prescriptions may delay follow-up. Authority prescriptions, written by a hospital prescriber with repeats authorised, should be honoured as another authority prescription may not be approved until the repeats have expired.

To avoid confusion consistency in the application of PBS rules across the hospital and community settings is encouraged.

5.3 Authority prescriptions

Authority prescriptions, written by a hospital prescriber, with repeats authorised, should be honoured as another authority prescription may not be approved until the repeats have expired. Hospitals may choose to discourage prescribers from requesting repeats, however patients therapeutic needs should be considered.

6. What is your hospital's policy/practice regarding deferred items?

The therapeutic needs of the patient and the date of follow-up appointments will influence the requirement to issue repeat authorisations for deferred items.

7. What is your hospital's policy/practice regarding referring patients to community pharmacy?

7.1 For emergency department patients after hours

Patients should be referred to community pharmacy after hours when essential medication is not available through the usual hospital supply channels. Patient access to community pharmacy must be considered, especially late at night.

7.2 For day surgery patients after hours

Patients should be referred to community pharmacy after hours when essential medication is not available through the usual hospital supply channels. Patient access to community pharmacy must be considered, especially late at night.

7.3 For discharged patients after hours

This should not be encouraged where possible unless the pharmacist can verify the appropriateness and accuracy of the script first. Patients should be referred to community pharmacy after hours when essential medication is not available through the usual hospital supply channels. Patient access to community pharmacy must be considered, especially late at night.

7.4 For items not stocked by the hospital pharmacy

Referral of patients to community pharmacy for items not stocked by the hospital pharmacy will depend on the status of the patient (inpatient, outpatient or discharge), the therapeutic needs of the patient, the availability of a similar product on the hospital formulary and the availability of the product. In general this referral should only be for outpatient or discharge prescriptions with inpatients being dealt with through the existing hospital policies.

7.5. Additional comments

It is essential to liaise with a patient's usual community pharmacy regarding supply of medication at discharge if a patient uses a dose administration container or unit dosing system such as a Dosett®, Nomad® or Webster® pack. Hospitals may opt for the discharge supply to be completed by the local pharmacy when these dose administration systems are required.

8. Do you have any policies/practices for genuine financial hardship cases (patients who are genuinely unable to pay)?

In cases of genuine financial hardship a system should be in place to approve supply without co-payment on a case-by-case basis. Liaison with the Social Work Department may be appropriate.

9. Other issues

9.1 "Non" supplied prescriptions in closed claims

Difficulties arise when the PBS claim is closed, and then for a variety of reasons some prescription items are supplied to the patient in the ward but the patient's discharge is cancelled. Ideally, items supplied but later returned to the pharmacy should be cancelled before the claim is closed, however, it is recognised this is not always practical in the hospital setting. If the hospital is concerned that some items have been claimed that should not have been they can contact the HIC and inform them of the items in question.

9.2 Refunds for Non-PBS items

Hospitals should develop their own policies on the period of time that they will accept concession or entitlement details and provide refunds for non-PBS items.

9.3 Medicare Refunds after closing the claim

Hospitals should develop their own policies regarding refunding patients who receive incomplete refunds from Medicare. Eg items below the patient co-payment for concession cardholders or Section 100 drugs are not refunded.

9.4 Overseas Patients

Hospitals should develop their own policies on what to charge overseas patients (i.e. those not covered by reciprocal health agreements) for their medication. Most hospitals charge cost price.

9.5 Private Patient Non-PBS Medication

Hospitals reported that they generally charge the same amount for public and private patients.

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