In Sickness and in Debt

Ombudsman

An investigation by the Ombudsman into the administration by the Health Service Executive of schemes that fund necessary medical treatment in the EU/EEA or UK

Ombudsman

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(Under Section 4 of the Ombudsman Act 1980, as amended)

April 2023

Contents

Foreword

People should be able to access necessary health care, in a timely manner and as close to home as possible. This is the vision for the future of our healthcare system in Sláintecare. However, this is not the reality for many today. This investigation is about those who cannot access that necessary healthcare at home, who have had to travel abroad for their healthcare, and then found themselves caught in an administrative impasse when seeking reimbursement from the HSE under three schemes: the Treatment Abroad Scheme, the EU Cross Border Directive scheme and the Northern Ireland Planned Healthcare Scheme.

Ultimately, these patients replaced their fight to get treatment with a fight to be reimbursed by the HSE. Those that had borrowed money for their treatment also faced a fight against falling into debt. Unfortunately, many of the complaints that I received as Ombudsman were from patients that now face such debt.

I am pleased that both the HSE and the Department of Health have accepted the recommendations made in this report and I look forward to our engagement as those recommendations are implemented. I am hopeful that their implementation will bring positive change to the administration of all three schemes and ensure that patients are at the centre of all future decisions.

Healthcare is of such importance that it is considered a human right under Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights, which recognises the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health". On the other hand, when we are unwell we have to deal with not just the pain and related symptoms of an ongoing illness but also the immense worry and anxiety that can accompany it. This can affect our ability to engage in day-to-day living, to hold down a job, to interact with our family and loved ones, and to enjoy hobbies and activities. During this time, when we can be at our most vulnerable, we turn to the State to provide us with access to the care and treatment that we need.

I would want to access this care as close to home as possible where I can count on the support of friends, family and being in familiar surroundings to recuperate. I would surmise that this is also the case for many other people, including those who had to travel to receive necessary medical treatment. I would also want my treatment to happen as soon as possible. Given current waiting lists, this is not a possibility for everyone. In these circumstances, some people have no option but to travel abroad for their care. To do so they engage with the following schemes administered by the HSE - the Treatment Abroad Scheme (TAS), the Cross Border Directive (CBD) scheme and the Northern Ireland Planned Healthcare Scheme (NIPHS).

With this in mind, my purpose in commencing this investigation was to bring improvement to the administration by the HSE of schemes designed to allow patients in Ireland to travel to other jurisdictions in the EU/EEA and UK for treatment. In particular, I sought to identify if any barriers exist for patients seeking access to the schemes, to propose possible improvements in the administration of the schemes and identify ways to bring additional clarity for patients.

I believe a major contribution to our success in achieving this was the unwavering commitment of the Investigation Team which carried out the work on behalf of this office. I want to thank them for their dedication, persistence and professionalism in completing this very important investigation.

The TAS and the CBD are both schemes set up nationally to provide for people wishing to exercise their rights to access treatment abroad within the context of the EU Directive and related legislation. At EU level, in acknowledgement of the complexity of the governing legislation and the imperative to support people to access their rights to treatment abroad, it was deemed necessary to designate a National Contact Point (NCP) in each member state[1]. The HSE is the NCP for Ireland and I am therefore conscious throughout this report of its statutory role and specifically its duty to provide information to patients on their rights under the EU Directive and related legislation.

In the main part, this investigation will focus on the CBD scheme. However, following Brexit, in 2021 the NIPHS was put in place for those who are required to travel to Northern Ireland for treatment and this scheme has now become the predominant scheme for patients seeking treatment abroad. Although currently only an administrative scheme and not governed by legislation, NIPHS is being run by the HSE as directed by the Department of Health and is administered using analogous criteria and processes to the CBD scheme. Therefore, I am of the view that all recommendations identified in this report for the CBD scheme should be applicable to the NIPHS.

This is not the first time my Office has looked at issues related to accessing treatment abroad. In 2018, my predecessor, Peter Tyndall, published an investigation into the Treatment Abroad Scheme. All the recommendations in that report were accepted by the HSE at the time. However, given the additional challenges faced by the HSE and the country, during the recent pandemic, there has not been the level of monitoring of these recommendations that would usually take place. Therefore, this investigation was an opportunity for me to follow up this work and my findings on this matter are set out in Chapter 4.

While having to travel abroad for care is no doubt stressful, it is important to note that the people who contacted my Office were relieved to have finally had their treatment despite having had to travel abroad. This was a lifeline for many that changed their lives for the better. For this reason, I want to make it very clear that I welcome the fact that such schemes are in place and that in the main they work well. However, this investigation report identifies when the schemes do not work well.

I want to consider, pay tribute to and thank the people who have contacted my Office to make a complaint and who, in bringing their complaint to us, played a part in prompting this investigation. Often they were elderly and their everyday quality of life was severely impacted by their condition. Many of the complaints we received were from patients who needed access to common treatments such as hip replacements or cataracts. These were treatments that if received in a timely manner would have a life changing impact on their day-to-day living. However, they were unable to access their treatment at home in a timely fashion. As we constantly see in the media, the demand for healthcare services in this country consistently outstrips supply. In December 2022 there were 690,223[2] people on active hospital waiting lists for acute scheduled care with many waiting over 12 months.

Some of the complaints my Office received were from patients who were on a fixed income such as the statutory old age pension. In addition, one of the reasons they sought out these schemes was because they could not pay privately for treatment, as many others who have private health insurance may be able to do in similar circumstances. Therefore, in many of the cases I saw, people had borrowed

1 Transposed into Irish legislation by S.I. No. 203 of 2014, as amended by S.I. No 65 of 2015
2 Department of Health 2023 Waiting List Action Plan

significant amounts of money from family, friends or financial institutions to pay for their treatment with the expectation that they would be able to pay them back when reimbursed by the State.

When a refund was subsequently refused these patients effectively exchanged the anxiety and worry associated with their illness for a new stress of dealing with a debt incurred while accessing a treatment which they were entitled to receive, but could not access, within the State. They expressed absolute dismay that a scheme they had understood was designed to allow them to access their necessary healthcare abroad could prove to be absolutely unforgiving and lacking in empathy when it came to administrative or pathway errors. Many felt a sense of being misled or that the information provided did not warn them clearly about eligibility or administrative issues they may encounter when seeking reimbursement of the money they spent on their treatment. These patients entered the process in good faith but found themselves without recourse when the HSE declined their applications for reimbursement.

I am also conscious of the important and challenging time that our frontline healthcare workers have faced over the last few years as they spearheaded the fight against Covid 19. I am conscious that throughout this time frontline staff have retained a strong focus on patients and engaging with patients in a manner that meets the HSE core values of Care, Compassion, Trust and Learning. These values should also be apparent in how administrative staff in the HSE deal with applicants to all three treatment abroad schemes. The fact that patients, through no fault of their own, have been forced to access treatment abroad, does not negate the need for the HSE to treat those individuals in a manner that is both patient focused and caring.

Under the Waiting List Action Plan for 2023 the Government is putting considerable effort and planning into tackling the significant waiting lists patients face to access care nationally. However, as that work is ongoing, it is unfair that patients who find themselves with no option but to travel abroad for necessary treatment should have to bear the brunt of organising their own treatment abroad while often facing the prospect of living in poverty or debt if they cannot successfully navigate their way through the appropriate reimbursement scheme.

The recommendations in this report are designed to bring positive changes to the lives of those who need to access treatment abroad through improving the administration of the treatment abroad schemes and encouraging decisions that are patient focused, empathetic and caring. Therefore, I welcome the fact that both the HSE and Department of Health have accepted the recommendations and I look forward to working with them to ensure the timely and considered implementation of these recommendations.

Ger Deering
Ombudsman
April 2023

Executive Summary

Findings and Recommendations

At the outset of this report, I would like to make it very clear that I am keenly aware that the Treatment Abroad Scheme, the EU Cross Border Directive scheme and the Northern Ireland Planned Healthcare Scheme provide a vital route for patients in Ireland to access necessary medical treatment abroad. Within this context, the EU Directive and associated regulations have provided options for patients facing long waiting times at home or suffering from rare conditions.

I do not underestimate the life-changing impact of accessing treatment under these schemes for these patients and I want to acknowledge the work of the HSE to date in implementing these schemes. Notwithstanding this, my Office has received complaints from those who have not benefited from being able to access the schemes. Although the number of complaints to my Office has been low in the context of the overall schemes, as I mentioned earlier in my Foreword, I was struck by the impact on the physical, mental and financial well-being that the process had on those complainants. This also rings true for those that have not complained to my Office but may have been similarly refused and impacted.

Therefore, the recommendations I make in this report are focused on improving the administration of the Cross Border Directive (CBD) scheme, the Northern Ireland Planned Healthcare Scheme (NIPHS), and the Treatment Abroad Scheme (TAS), both moving forward and in the investigation of complaints that are currently with my Office.

All recommendations are made in circumstances where I consider that the actions of the HSE amount to maladministration under section 4(2)(b) of the Ombudsman Act 1980 (as amended).

Cross Border Directive scheme (CBD)

Recommendations in relation to Qualifying Conditions

Finding 1: Provision of information for those in receipt of EU/EEA state pensions

Some people who complained to my Office were refused reimbursement for the cost of their treatment abroad as they were in receipt of a State benefit from another EU/EEA country. It is clear that the legislation surrounding patients in receipt of State benefits from another EU/EEA country is complex. Both my Office and the HSE have examined the legislation on the issue and have both felt the need to seek further guidance from the European Commission to ensure we properly understood it.

Faced with that level of complex legislation it is both unrealistic and contrary to fair and sound administration to expect that patients would be able to navigate this issue by themselves. The HSE is the National Contact Point for Ireland and under the EU legislation has a responsibility to provide information to patients. It is my belief that the HSE is not fulfilling its duty in relation to this issue.

✚ Recommendation 1 – Provision of information for those in receipt of EU/EEA state pensions

The HSE should examine its communications on this issue and, by the end of Quarter 3 of 2023, should amend both its website and the Cross Border Directive scheme application form to highlight the complexity of the legislation, the possible effect being in receipt of EU/EEA state benefits may have on a patient, and who in the HSE they may contact to discuss the matter.

Finding 2: Application of a first charge

In the context of the CBD scheme, a first charge relates to an amount of money that has been reimbursed to an applicant which the HSE later sought to recoup. When, following engagement with my Office the HSE agreed not to recoup that money, the HSE instead decided to apply that amount as a charge which would be applied if the patient sought to apply for a further reimbursement in the future.

The information available to patients regarding EU/EEA pensions and the effect it may have on an application is in my opinion insufficient. These patients applied for reimbursement in good faith. The application was approved and paid, and the patients moved on with their lives post-treatment. I am not satisfied that the decision to implement a first charge, or the process followed by the HSE (which was in the complete absence of a corporate policy around those decisions), was fair and reasonable. I do not believe that the HSE should be applying a first charge against patients with UK pensions who applied for and received a reimbursement under the Cross Border Directive scheme.

✚ Recommendation 2 – Application of a first charge

The HSE should reverse its decision to apply a first charge against patients with UK pensions who applied for and received a reimbursement under the Cross Border Directive scheme. By the end of Quarter 3 of 2023 the HSE should write to each patient affected and explain clearly that the decision has been reversed and the patient is free to engage with the Northern Ireland Planned Healthcare Scheme without penalisation as any other patient would.

Recommendations in relation to the Public Patient Pathway

Finding 3: Prior outpatient consultation

I accept that an outpatient consultation is an important part of both the domestic and Cross Border Directive pathways. However, I do not believe there is any basis on which the HSE can insist that a patient making an application for reimbursement under CBD must have had their outpatient consultation on a DATE prior to their admission/treatment as opposed to, for example, a consultation on the same day but prior to their admission/treatment.

✚ Recommendation 3 – Prior outpatient consultation

An outpatient appointment that takes place at any time PRIOR to admission/treatment should be acceptable for the purposes of receiving a reimbursement under the Cross Border Directive scheme. The HSE should review cases where reimbursement was refused only on the basis that the outpatient appointment was on the same day as admission/treatment with a view to reimbursing those patients.

Finding 4: Telemedicine consultations

I believe it is unfair that patients are not being reimbursed for telemedicine consultations (that is, consultation by phone or video). I appreciate that the Cross Border Directive Office is dependent on the Health Pricing Office to produce a telemedicine specific rate but these are two arms of the HSE which need to show some joined-up thinking and resolve the situation. Patients should not suffer for this.

✚ Recommendation 4 – Telemedicine consultations

The HSE should identify a specific telemedicine reimbursement rate by the end of Quarter 3 of 2023. In the absence of this, the HSE should apply the same reimbursement rate that applies to in-person outpatient consultations for telemedicine consultations.

Recommendations in relation to the Applications Process

Finding 5: Application form

Many patients engaging with the Cross Border Directive scheme may be older, more vulnerable and not have access to, or be comfortable accessing information online. For this reason, they often access the application forms in hard copy only. The CBD scheme application form does not sufficiently explain the purpose or impact of some of the questions asked, particularly around the pensions issue and this can lead to patients not fully understanding that they need to consider their entitlement, or possibly lack of entitlement, under the CBD.

✚ Recommendation 5 – Application form

By the end of Quarter 3 of 2023, the HSE should re-design the Cross Border Directive scheme application form to ensure that questions with significant impacts, such as the pensions issue, have those impacts highlighted next to the questions, rather than only being explained deep in the terms and conditions, or on the HSE website, where some patients may not become aware of them.

Finding 6: Errors in referral letters

When errors with referral letters, which are beyond the patient's control, arise with Cross Border Directive scheme applications, the patient has no mechanism to rectify the error and their application is refused. This contrasts with the situation where errors arise in the process for receiving similar treatment in Ireland, where issues with referral letters are resolved between the hospital and the GP without any adverse effect on the patient.

The HSE is penalising patients for errors which are entirely beyond patients' control and is not affording them an opportunity to explain or remedy those errors.

✚ Recommendation 6 – Errors in referral letters

The HSE should put in place a mechanism whereby the Source of Referral can explain a mistake in a referral letter, specifically date and signature, at the time the application is being processed. The HSE may wish to consider a mechanism whereby the GP certifies the explanation of the error or omission. If the HSE is concerned about the content or accuracy of any GP explanations, it has the option to bring these concerns to the attention of the Medical Council. However, the HSE cannot continue to punish patients for errors which are entirely outside of the patient's control.

Finding 7: Addressing referral letters

The HSE has raised issues with reimbursement applications on the basis that a referral letter from a GP has been addressed to a speciality, for example Orthopaedic, as opposed to a named individual. The Irish College of General Practitioners/Health Information and Quality Authority guidelines clearly envisage a place for letters addressed to a speciality. I believe such letters are appropriate for the purposes of the Cross Border Directive scheme.

✚ Recommendation 7 – Addressing referral letters

The HSE should not refuse applications because referral letters are addressed to a speciality rather than to an individual consultant.

Finding 8: Proof of payment

It is my opinion that the HSE is seeking excessive documentation from patients in order to satisfy its proof of payment requirement. This practice is proving an unnecessary obstacle for patients who are seeking reimbursement under the Cross Border Directive scheme.

✚ Recommendation 8 – Proof of payment

A patient who provides any of the five examples of proof of payment that are listed on the HSE website should be deemed to have satisfied the proof of payment criteria that the HSE requires for reimbursement.

Finding 9: Proof of travel

In addition to evidence that the treatment took place, the HSE often seeks further proof of travel such as plane tickets, toll receipts or petrol receipts when processing CBD applications. The HSE's position is that by requesting these documents it is simply asking for evidence that a patient actually travelled abroad for their treatment. The HSE policy of asking all patients for proof of travel is excessive in the circumstances and in my opinion creates an obstacle for patients seeking to apply for reimbursement under the Cross Border Directive scheme.

✚ Recommendation 9 – Proof of travel

The HSE should discontinue its practice of asking all patients seeking reimbursement under the Cross Border Directive scheme to provide documents such as "flight/ferry tickets, accommodation receipts in patients/applicants name, toll/parking charges or a till receipt from a shop in the locality" in order to prove they travelled for treatment. The HSE should also amend its website and application form to reflect this change.

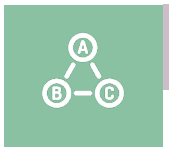
Recommendations in relation to the CBD Appeals Process

Finding 10: Time to appeal

The current 10-day time frame to appeal a decision of the Cross Border Directive Office is inappropriately short and may deter patients from appealing decisions.

✚ Recommendation 10 – Time to appeal

The time to appeal a decision of the CBD Office should be extended to at least 21 days and patients should be informed in the decision letter of how they can request an extension of time to appeal if appropriate. This change should take place as soon as possible and by the end of Quarter 2 of 2023 at the latest.



Finding 11: Diagnosis Related Grouping Code appeals

In Ireland the amount of reimbursement a patient may be entitled to is either the price paid for the treatment abroad or the cost of providing that treatment in Ireland, whichever is the lesser. The cost of providing the treatment in Ireland is identified using what are known as Diagnosis Related Grouping (DRG) Codes. The appropriate DRG code is identified by the Health Pricing Office (HPO) of the HSE when an application for reimbursement is received. Appeals related to DRG codes do not provide for the HPO to recode or check the original assigned code. In my opinion such appeals are not meaningful if the treatment is not sent to have the coding checked and confirmed by the Health Pricing Office.

✚ Recommendation 11 – Diagnosis Related Grouping code appeals

All Diagnosis Related Grouping appeals should be sent to the Health Pricing Office to be checked and confirmed. This change should take place as soon as possible and by the end of Quarter 3 of 2023 at the latest.

Finding 12: Independent CBD appeals process

The CBD Appeals Officer has direct line management responsibility for the CBD Office. Therefore, I do not believe the appeals process as currently constructed is truly independent of the Cross Border Directive Office.

✚ Recommendation 12 – Independent CBD appeals process

The appeals process should be entirely separate from the CBD Office and not within the remit of the management of the CBD Office. The HSE should move the entire appeals process to its National Appeals Service by the end of 2023.

Finding 13: Signposting to the Ombudsman

The decision letters from the Appeals Officer contain limited information regarding a complainant's right to bring a complaint to my Office and how they may do so.

+ Recommendation 13 – Signposting to the Ombudsman

The HSE should amend its appeal decision letters to include the following paragraph.

"If you remain unhappy with our response then you can refer your complaint to the Office of the Ombudsman.

The Ombudsman is fair, independent, and free to use. The Ombudsman will ask you for details of your complaint and a copy of this letter/email (our final response to your complaint). The best way to contact the Ombudsman is by:

- Clicking on the 'Make A Complaint' link at www.ombudsman.ie
- Writing to: Office of the Ombudsman, 6 Earlsfort Terrace, Dublin 2, D02 W773
- Calling the Ombudsman on 01 639 5600 if you have any queries."

This change should take place as soon as possible and by the end of Quarter 3 of 2023 at the latest.

Recommendations in relation to Communications

Finding 14: National Contact Point engagement with patients

National Contact Points have a responsibility to assist patients resident in the State who are seeking to understand their rights and entitlements to receive healthcare in another Member State. I do not believe the HSE's position that it only provides information for "eligible" patients is in keeping with the role of a National Contact Point in particular, or the role of a public body in general, when it interacts with members of the public.

+ Recommendation 14 – National Contact Point engagement with patients

The HSE should expand the level of provision of information to patients about their rights and entitlements under CBD. The HSE must change its approach of limiting itself to providing information exclusively to "eligible people" and should assist all patients who are seeking assistance establishing their entitlements.

Finding 15: HSE Website

The HSE's website contains several instances of inaccurate, outdated and vague information. It is also lacking in information in relation to crucial issues, such as patients who are in receipt of income from other EU/EEA countries. There are similar issues with the CBD application form albeit to a lesser extent.

✚ Recommendation 15 – HSE Website

By the end of Quarter 3 of 2023 the HSE should review the content of its website and application form to remove all inaccurate information related to the scheme. It should seek to ensure the website and application form provide all the information patients need to make an informed decision about engaging with CBD. All information related to CBD should be centralised and not spread out over several different webpages which provide inconsistent versions of the same information.

Finding 16: National Contact Point engagement with healthcare providers

The HSE, as National Contact Point in Ireland, is not fulfilling its role in relation to the provision of information to healthcare providers. The HSE appears to engage with healthcare providers in a reactive rather than a proactive manner.

✚ Recommendation 16 – National Contact Point engagement with healthcare providers

The HSE needs to put in place a plan to proactively engage with clinicians and their representative bodies, specifically GPs given their importance to the CBD pathway, in order to ensure they are fully aware of patients' rights under CBD and the issues that may affect those rights.

Northern Ireland Planned Healthcare Scheme (NIPHS)

Recommendations in relation to the NIPHS

Finding 17: Terms and Conditions of the NIPHS

The "Guidance on the NI Planned Healthcare Scheme for HSE" lacks detail and is not a complete set of terms and conditions. Decisions in relation to the Scheme appear to be based on incomplete information.

✚ Recommendation 17 – Terms and Conditions of the NIPHS

The Northern Ireland Planned Healthcare Scheme should be put on a legislative footing as soon as possible. In the meantime, there should be clear terms and conditions of the scheme that are publicly accessible. All recommendations made in this report in relation to the administration of the Cross Border Directive scheme should also be applied to the Northern Ireland Planned Healthcare Scheme.

Finding 18: Prior authorisation in the NIPHS

Under the Cross Border Directive, Prior Authorisation and Prior Notification are separate and distinct processes which provide separate and distinct approvals. Previously the CBD Office used the term Prior Authorisation to describe both. In mid-2022 the CBD Office amended its terminology to reflect the difference between the two. However the Northern Ireland Planned Healthcare Scheme only uses the term Prior Authorisation. The Prior Authorisation aspect of the Northern Ireland Planned Healthcare Scheme is poorly explained and the failure to change the terminology in the Northern Ireland Planned Healthcare Scheme when the terminology was changed in Cross Border Directive scheme will inevitably cause confusion for patients.

✚ Recommendation 18 – Prior authorisation in the NIPHS

In order to ensure a consistency for patients, the Department of Health should consider bringing the Prior Authorisation procedure in the Northern Ireland Planned Healthcare Scheme in line with the Prior Notification and Prior Authorisation procedure in the Cross Border Directive scheme when the Northern Ireland Planned Healthcare Scheme legislation is being drafted.

Finding 19: NIPHS residency requirement

The eligibility requirement for the Northern Ireland Planned Healthcare Scheme that a person simply be ordinarily resident in the State is clear and removes a layer of difficulty that patients seeking reimbursement under the Cross Border Directive scheme are faced with.

✚ Recommendation 19 – NIPHS residency requirement

The impact of patients being in receipt of EU/EEA pensions on the CBD and the benefit of its exclusion from NIPHS should be noted by the Department of Health and borne in mind when the Northern Ireland Planned Healthcare Scheme legislation is being drafted.

Finding 20: Independent NIPHS appeal

The NIPHS Appeals Officer has direct line management responsibility for the NIPHS Office. Therefore, I do not believe the appeals process as currently constructed is truly independent of the Northern Ireland Planned Healthcare Scheme Office.

✚ Recommendation 20 – Independent NIPHS appeal

The appeals process should be entirely separate from the NIPHS Office and not within the remit of the management of the Northern Ireland Planned Healthcare Scheme Office. The HSE should move the entire appeals process to its National Appeals Service. This change should take place as soon as possible and by the end of 2023 at the latest.

Treatment Abroad Scheme (TAS)

Recommendations in relation to the TAS

Finding 21: Independent TAS appeal

The TAS Appeals Officer has direct line management responsibility for the TAS Office. Therefore, I do not believe the appeals process as currently constructed is truly independent of the Treatment Abroad Scheme Office.

✚ Recommendation 21 – Independent TAS appeal

The appeals process for TAS should be entirely separate from the TAS Office and not within the remit of the management of the TAS Office. The HSE should move the entire appeals process to its National Appeals Service. This change should take place as soon as possible and by the end of 2023 at the latest.

Chapter 1

Legislation and the role of the HSE in administering the schemes

The HSE administers three schemes for accessing treatment abroad:

1. Cross Border Directive scheme

The Cross Border Directive (CBD) scheme entitles patients to access healthcare, that is available in Ireland, by undergoing treatment in another Member State. The patient must pay for the treatment up front and then apply for reimbursement from the HSE. Patients are only reimbursed the lesser of either the cost of the healthcare abroad or what the healthcare would have cost in the public system in Ireland.

2. Treatment Abroad Scheme

The Treatment Abroad Scheme (TAS) provides access to treatment not available in Ireland. It involves the referral of a patient from the public system in Ireland to the public system in another Member State. The patient does not pay any money up front and the application must be fully approved by the HSE before treatment takes place.

3. Northern Ireland Planned Healthcare Scheme

On 31 January 2020 the UK withdrew from the EU. Following this it was confirmed that the TAS scheme will remain unchanged. However the CBD Scheme ceased to apply between the UK and EU/EEA Member States, including Ireland. To mitigate the effects of this the Department of Health put in place an administrative scheme called the Northern Ireland Planned Healthcare Scheme (NIPHS). NIPHS operates analogously to the CBD and the patient must pay for the treatment up front and then apply for reimbursement from the HSE. As with CBD, patients are only reimbursed the lesser of either the cost of the healthcare abroad or what the healthcare would have cost in the public system in Ireland. NIPHS only covers Northern Ireland and does not cover the rest of the United Kingdom.

The Directive and Regulations

The free movement of workers was one of the founding principles of the European Economic Community (the EEC) in 1956. In order to give effect to this freedom, the Member States knew that it would be necessary to have some level of coordination of national social security systems. Workers would be reluctant to move to a different Member State if they were in some way disadvantaged in accessing the social welfare system of either their host Member State or their Member State of Origin.

One of the first regulations enacted by the EEC was Regulation 3 [1958] on the coordination of social security systems. The current Regulation 883/2004 is the successor of Regulation 3. Between Regulations 3 and 883/2004, there were a number of intermediary regulations and judgments of the European Court of Justice (CJEU) that informed the content of Regulation 883/2004.

Over the years there have been a number of judgments of the CJEU which have confirmed that patients have, in certain cases, the right to access healthcare products and services in Member States other than their own, with the cost being borne by their own health system. In 2011, the EU published Directive 2011/24/EU (referred to in the rest of this report as the Directive) on patients' rights in cross-border healthcare to clarify patients' legal rights in this area. The Directive is the legal basis for the cross border healthcare scheme. It states that the default position is for patients to be treated in their home Member State but if that is not possible it has the following aims:

- establish rules for facilitating access to safe and high-quality cross-border healthcare in the Union
- ensure patient mobility in accordance with the principles established by the Court of Justice
- promote cooperation on healthcare between Member States

The Directive sets out the conditions on which a patient may travel to another Member State to receive medical care and have the costs of that care reimbursed. There is a significant overlap between the provisions of the CBD and the 2004 EU Regulations. The CBD seeks to clarify certain rules and build on rights contained in the 2004 EU Regulations. The CBD can be complicated to navigate, in particular the areas where there is an overlap with the provisions of the Regulation. As such Articles 5 and 6 of the CBD put an obligation on the Member State to provide information to patients on their rights and entitlements, in particular in relation to the right to reimbursement. Each Member State must designate one or more bodies to be a National Contact Point (NCP), tasked with providing this information.

Statutory Responsibilities of the HSE

The CBD is implemented in Irish law by by Statutory Instrument (SI) No. 203/2014 - European Union (Application of Patients' Rights in Cross-Border Healthcare) Regulations 2014 (the 2014 Regulations). This legislation conferred on the HSE the statutory obligations to act as the National Contact Point for cross-border healthcare in Ireland and to administer the relevant schemes for access or reimbursement.

Under the 2014 Regulations, the HSE as the National Contact Point in Ireland has the following obligations:

1. To ensure the accessibility of information on the scheme, including information for healthcare providers and information on patients' rights and complaints procedures.
2. To cooperate with National Contact Points in other Member States.
3. To reimburse patients entitled to such reimbursement under the Directive and Regulations.
4. To identify specific treatments that will require prior authorisation.

The right to receive this information described above is both a right in itself but also more broadly a fundamental prerequisite to enable people to exercise their right to receive healthcare.

Chapter 2

The Cross Border Directive scheme

In this chapter I will look at the entire process a patient will face when seeking reimbursement through the CBD. I will begin by looking at the qualifying conditions for the scheme, what they are based on and how the HSE interprets them. I will then look at the application process and how the HSE actually administers the qualifying conditions and what it requires from a patient. Following the application process a patient may not be successful, or may only be partially successful, with their request for reimbursement and will then have an option to appeal. I will also examine that appeals process, its structure and how appeals are administered. Finally I will examine how the HSE communicates throughout each step of the process. This will include communications with both patients and medical professionals.

I. Qualifying Conditions

In this section, I am looking at the conditions a patient must fulfil in order to qualify for a reimbursement under the CBD. I will look at the source of those conditions, how the HSE interprets and applies them and how that approach can effect individual patients.

When looking at the conditions imposed by the HSE I am also cognisant of Article 7(7) of the Directive which states that a Member State may impose, on a patient seeking reimbursement of costs of cross-border healthcare, the same conditions, eligibility criteria and regulatory and administrative formalities as it would impose if this healthcare was provided in its territory.

However most importantly, the Directive also provides that no conditions, criteria or formalities can be discriminatory or constitute an obstacle to the free movement of patients, unless they are justified by planning requirements. Furthermore, Article 9(1) requires Member States to ensure that administrative procedures for the use of cross-border healthcare are based on objective, non-discriminatory criteria that are necessary and proportionate to the objective to be achieved.

Pensioners Beware

The very first step in applying for reimbursement under the CBD is establishing which Member State is the appropriate Member State to process the application. For the majority of patients in this country that is a very straightforward process as they are patients who are ordinarily resident in Ireland with no other extenuating circumstances. However this simple determiner becomes complicated when a patient is resident in Ireland but receives a state pension or benefit in another EU/EEA Member State.

In those circumstances, the legislation that identifies the Member State that a patient should apply to is extremely complicated. To determine the appropriate Member State requires an understanding of a number of pieces of EU legislation; Regulations (EC) No. 883/2004 and No. 987/2009 which co-ordinate social security systems in the EU and the Directive which deals with patients' rights in cross-border healthcare as well as any Annexes to these.

My Office first received a complaint on this issue in September 2020 and a further 11 complaints followed in the next 9 months. When I took up my Office in February 2022 this was one of the first issues brought to my attention.

This pensions issue has arisen most frequently with patients who are resident in Ireland but have state pensions from the UK. Irish migration to the United Kingdom has occurred from the earliest recorded history and continues to the present. Due to their proximity, the movement between the two jurisdictions has been continuous. In 2018 the Annual Population Survey carried out by the UK's Office of National Statistics (ONS) put the Irish-born population for the UK at 380,000[1]. Some of these Irish people will have moved to the UK on a permanent basis and some will have moved temporarily before returning to Ireland after a period of time. Many of those returning to Ireland would bring an entitlement to a UK state pension with them.

The migration is not simply one way. The 2016 census found that there were 103,113[2] UK citizens living in Ireland. 37,430 of those UK citizens living in Ireland were over the age of 65 and many will have an entitlement to a UK pension.

Between Irish citizens working in the UK returning to Ireland and UK citizens moving to Ireland, there are a large number of individuals resident in Ireland who are in receipt of UK pensions.

In 2019 the HSE identified that some patients who were resident in Ireland and in receipt of a UK state pension were seeking reimbursements from the HSE through the CBD. The HSE was of the opinion that due to the fact that these patients were in receipt of a UK pension, they should in fact have been applying to the UK for reimbursement and/or information on their entitlements. The HSE told my investigations team that, up until that time, the HSE had been assuming that patients were aware of their own pension and benefits entitlements. The HSE assumed therefore that patients fully understood the impact that those entitlements would have on their ability to seek reimbursement under the CBD and where they should apply for that reimbursement. On that basis, up until 2019, the HSE had not asked any patients about their pension status and processed applications on the assumption that applicants were correctly applying in Ireland.

I do not understand the position the HSE states it took on this issue. If the HSE was always aware of the impact an EU/EEA pension had on where an applicant could apply, I cannot understand why it would not check that as part of the application process. The HSE has a responsibility to check and process applications for reimbursement. Checking if an applicant is eligible to apply to the HSE at all is surely a fundamental check that needs to happen. The HSE did not make any other assumptions when processing applications. It would never simply assume that an applicant had a valid referral letter or that an applicant had an outpatient consultation in line with the terms of the scheme. It makes no sense that the HSE was aware that many applicants would not be eligible for reimbursement but made a conscious decision not to check the eligibility requirement that may rule them out.

1 https://www.cso.ie/en/releasesandpublications/ep/p-cpnin/cpnin/uk/ - accessed 17 January 2023
2 https://www.irishtimes.com/life-and-style/abroad/britain-s-shrinking-ageing-irish-population-1.3817868 - accessed 17 January 2023

It appears to me from the HSE's handling of the matter and the content of its interactions with The European Commission's Directorate General for Health and Food Safety (DG Santé) that the HSE was simply not aware of this issue or its potential impact until 2019. In a letter to my Office from 15 February 2022, the HSE was clear that when the issue arose in 2019 it did not understand the impact and had to seek advice from DG Santé on the matter at that time.

My Office has examined the eligibility of pensioners to qualify for the CBD scheme in detail and has found it to be intensely complex. The basic right under the CBD is simple and set out in Article 7(1) of the Directive – individuals have a right to receive treatment abroad and have the costs of that treatment reimbursed by their home Member State. The operation of Article 7(2)(a) as a derogation to this is also straightforward. If the Member State of treatment is listed in Annex IV [3]of Regulation 883/2004 EU then nationals of that Member State are to be treated as residents for the purpose of healthcare when returning from abroad. Thus, a Polish pensioner living in Ireland is outside the CBD system when they return to Poland. Instead, they have the same rights as a Polish resident to healthcare. They are treated as if they had not left Poland.

However, it is the operation of the exemption in Article 7(2)(b) that is exceedingly complex to understand. This is because it refers back to the Regulation. It operates if the healthcare is not provided in accordance with Chapter 1 of Title III of the Regulation. Thus it is necessary to consider all the possible scenarios under that part of the Regulation. There are a significant number of variables that need to be understood in order to determine if treatment is or is not covered by the Regulation, such as:

1. The nationality of the pensioner.
2. The place of residence of the pensioner.
3. The Member State of treatment.
4. The number of pensions that the pensioner is in receipt of.
5. The type and amount of pensions that the pensioner is in receipt of.
6. The type of healthcare (be it planned or emergency).
7. Whether the Member State of residence has opted for reimbursement on the basis of fixed amounts.

Post 2019 the HSE has been treating applications from patients who are resident in Ireland but in receipt of a pension from another EU/EEA membership on a case by case basis. When the HSE receives an application in these cases it examines the individual's circumstances i.e. value and type of EU/EEA state pension entitlement, which country that entitlement is from, the value of any Irish state pension entitlement, the country the treatment was received in etc. It then determines if the patient should be applying for reimbursement in Ireland or in another Member State. The HSE said that it is unable to provide a simple definitive answer to the question of where individuals should apply as "as the scope of individual cases must be considered".

However, the HSE in its 15 February 2022 letter indicated that the pensions issue was more basic than that by saying simply that "patients in receipt of a pension from another EU/EEA country which at the time included the UK should apply to the country from which they receive the pension for

3 Belgium, Bulgaria, Czech Republic, Germany, Greece, Spain, France, Cyprus, Luxembourg, Hungary, The Netherlands, Austria, Poland, Slovenia, Sweden.

reimbursement under the Directive and the healthcare cannot be accessed in the country of residence or the competent State (UK)".

Given the difficulty that the investigations team had in establishing the position of individual pensioners, it is not acceptable for the HSE to put the onus on understanding the system on individual applicants. Indeed, the Directive recognises that it would be very difficult for patients to exercise their rights under the Directive without adequate information. It thus contains a number of important provisions in relation to providing information to patients. Article 5 (c) puts an obligation on the Member State of Affiliation (such as Ireland) to provide information to patients on their rights and entitlements to cross-border healthcare, in particular in relation to the terms and conditions for reimbursement and for any appeal or redress procedure. In addition, Article 6 obliges each Member State in the EU to set up a National Contact Point to comply with the obligations under Article 5.

The HSE has repeatedly suggested that my Office seek directions on this from the Department of Health as legislation and policy fall within its remit. The Department on the other hand responded that the decisions in pension cases are being made on a case by case and there is simply no role for the Department in the assessment of individual applications. It advised that there is an EU framework available to provide support to National Contact Points, including clarifications of the relationship between the Directive and the Social Security Coordination Regulations. The HSE has advised the Department that it interacts with the European Commission for advice on individual cases and the Department of Social Protection in relation to individual pensioner's arrangements as appropriate.

Case Study

Refusal of reimbursement due to UK pension

When Maurice complained to my Office he said it was a "matter of desperation". Maurice was in his seventies, and both himself and his wife were in ill health which was making their daily life very difficult. Maurice was in significant pain due to his medical conditions and the waiting list for his treatment was very long. His GP suggested that he access his treatment in Northern Ireland though the Cross Border Directive scheme. Because Maurice and his wife had limited income, they needed to raise the cost of his treatment in advance. Maurice's treatment cost him approximately £1,300.

When Maurice completed his treatment, he submitted his application for the reimbursement of his medical costs to the HSE. The HSE declined his application because he was receiving a UK Social Security pension. He was told that this linked him to the UK as his Member State and as the UK was his Member State he was not eligible to claim reimbursement towards the cost of his treatment from the HSE.

Maurice appealed the decision of the HSE, stating that because of the cost of the treatment and his limited income, both himself and his wife reviewed all of the information in relation to the scheme before he accessed his treatment. He said that at no stage was it clear to him that if he was in receipt of a UK pension he would not be eligible for reimbursement. He also said that if he had known this he would never have committed to the financial cost of the treatment.

The appeal decision letter from the HSE to Maurice outlined that a patient in receipt of a UK pension should apply to the UK for guidance prior to availing of treatment under the Cross Border Directive scheme to avoid finding themselves in a situation where they are not eligible for reimbursement from either the UK or Ireland. At this stage, Maurice contacted the National Contact Point in the UK and was advised that this was a matter for the HSE as he is in receipt of a medical card in Ireland.

When my Office began investigating Maurice's complaint it was clear that Maurice had been asked "Are you in receipt of a pension or benefit from another EU/EEA country? If so from which country do you receive the pension or benefit?" and that he had answered "UK". However, it was also clear that nowhere in the seven-page application form was there any indication of what the implications of this question and answer might mean to a patient. Furthermore, there was also no information on the HSE website at the time to warn patients that they may not qualify for the Cross Border Directive scheme if they were in receipt of a pension or benefit from another EU/EEA country.

The issue of applicants who were refused reimbursement based on their pension entitlements, during the period in which the HSE had not provided important information on the potential impact of EU/EEA pensions, is very complicated. Due to the fact that these applications are examined and decided upon on a case-by-case basis by the HSE, I do not think there is scope to make a general recommendation in this report in relation to them. However my Office will continue to pursue the cases on this issue that have already been brought to my attention as well as any further cases from this period that may yet arise. While all these cases will be dealt with separately and individually, I am of the view that generally applicants who were declined reimbursements due to their pension entitlements during this period should be reimbursed by the HSE either through the CBD or an alternative mechanism if required.

It should also be noted that although this issue first came to my attention in relation to people resident in Ireland and in receipt of UK pensions, it is not an issue solely related to the UK and residents in receipt of a pension in any EU/EEA country will be affected by this. I have already seen cases of patients with pensions from Germany and pensions from Poland also being affected by this issue. In the 2016 census, eight of the top ten foreign nationalities in Ireland were from current EU/EEA countries[4]. Those eight countries alone accounted for over a quarter of a million individuals with foreign nationality living in Ireland. The 2016 census showed 4,353 individuals from other EU/EEA countries resident in Ireland who were already over 65. The number for EU/EEA nationals living in Ireland aged between 50 and 65 in 2016 was 24,118 so this is not an issue that has gone away with Brexit and its impact on CBD applicants will likely increase in the future.

At present, the HSE website states that "You may need to apply for the CBD scheme in another country if you:

- get your income from another EU or EEA country
- are a dependent of someone who gets their income from another EU or EEA country".[5]

4 https://data.cso.ie/table/E7020 - accessed 17 January 2023
5 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/how-to-get/ - accessed 17 January 2023

Income in this case includes a pension. The use of "may" is crucial here. This information is correct, if you receive your income in another EU/EEA country or are a dependent of someone who does then you may need to apply in another country. However that does not exclude the possibility that you may need to apply in Ireland. At this point, the HSE website directs patients to "Contact the National Contact Point for the other country to check if they are responsible for your claim. They can also tell you if you are entitled to a reimbursement". In doing so, the HSE is asking the National Contact Point in another country to provide information to patients who need assistance in determining their eligibility. It is still a possibility that Ireland may be where the patient must apply. However, we have the very peculiar situation where the HSE, as the National Contact Point in Ireland, is not prepared to provide the assistance itself that it would ask another National Contact Point to provide.

The HSE is not providing any guidance to patients on how they may establish what an income from another EU or EEA country means for their application. It does not give even a brief background on the reason for this warning, it simply points patients in the direction of a different National Contact Point.

> *"As a pensioner with limited income I cannot be out of pocket for the sum of €2,600 due to an error that was not of my own making. My husband had to use his credit card to settle the bill and is now paying this off over the months from pension income. This is creating financial hardship for us"*

The current version of the Application Form for reimbursement, also known as the CBD Pro Forma Invoice, contains a similar notice to the website. "If you are in receipt of an income e.g. pension, salary, etc., from another EU/EEA country but live in Ireland you may not be entitled to reimbursement from Ireland. This provision extends to dependents of persons who are in receipt of an income from another EU/EEA country. You should contact the National Contact Point of the country from which you receive the income to confirm your eligibility for reimbursement". Again, this is a situation where Ireland or another EU/EEA country may be the appropriate place for a patient to seek reimbursement but the HSE is abdicating any responsibility for assisting the patient to understand their eligibility and is simply directing them to a National Contact Point in another country.

Finding 1: Provision of information for those in receipt of EU/EEA state pensions

It is clear that the legislation surrounding patients in receipt of State benefits from another EU/EEA country is complex. Both my Office and the HSE have examined the legislation on the issue and have both felt the need to seek further guidance from the European Commission to ensure we properly understood it. Faced with that level of complex legislation it is both unrealistic and contrary to fair and sound administration to expect that patients would be able to navigate this issue by themselves. The HSE is the National Contact Point for Ireland and under the EU Legislation has a responsibility to provide information to patients. It is my belief that the HSE is not fulfilling its duty in relation to this issue. For this reason I consider that the actions of the HSE amount to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended) as they are based on an undesirable administrative practice.

✚ Recommendation 1: Provision of information for those in receipt of EU/EEA state pensions

The HSE should examine its communications on this issue and, by the end of Quarter 3 of 2023, should amend both its website and the Cross Border Directive scheme application form to highlight the complexity of the legislation, the possible effect being in receipt of EU/EEA state benefits may have on a patient, and who in the HSE they may contact to discuss the matter.

First Charge

In 2019, when the HSE identified that some patients who were resident in Ireland and in receipt of a UK state pension were seeking reimbursements from the HSE through the CBD, it also identified 11 patients that had received reimbursement from the HSE who the HSE later believed were not in fact entitled to reimbursement due to them being in receipt of a UK pension. On discovery of this the HSE wrote to the 11 patients explaining the situation and requesting that the patients repay the money. In some cases the patients had received their reimbursements more than a year prior. These letters were understandably both unexpected and worrying for the patients.

The matter was brought to the attention of my Office and there was extended engagement with the HSE. At a meeting between representatives of my Office and the HSE in December 2021 the HSE agreed not to continue to seek to recoup the reimbursements made to the 11 patients. My Office wrote to the HSE in January 2022 stating that the then Ombudsman was very encouraged by the outcome of the meeting. Likewise, I believe that the HSE closing the matter at that stage and not seeking to recoup the reimbursements would have brought the matter to a satisfactory conclusion.

However, in February 2022 the HSE wrote to my Office and stated that the 11 patients "are receiving another letter advising that the HSE will not actively pursue the repayment of the monies but the monies will become a first charge on any other reimbursement applied for under any other scheme e.g. the Northern Ireland Planned Healthcare Scheme, should the applicant so apply in the future". The letter to the complainant stated that the first charge applied only to the Northern Ireland Planned Healthcare Scheme.[6]

Essentially this means that should any of the 11 patients qualify for reimbursement under the NIPHS in the future the amount that the HSE had previously sought to recoup will be deducted from that reimbursement. The effect of this on a patient is profound. The amounts in dispute in some of these cases is over €10,000. Patients seeking reimbursements under these schemes are in need of medical treatment which they are entitled to publicly in this country but which they are unfortunately unable to obtain in the State due to lack of availability or excessive waiting lists. If any of the 11 patients identified by the HSE find themselves in this situation and turns to the schemes specifically designed to assist them in these difficult circumstances, they are faced with a large financial obstacle, which I do not believe they had any part in creating.

As I have explained above, I believe the problems that led to the 11 patients being reimbursed were in no way the fault of those patients. I have already highlighted what I believe to be the lack of information currently provided by the HSE to assist patients on this topic. In 2019 the situation was even worse.

6 "Please note that should you seek reimbursement for any healthcare received under provision of the NIPHS, this charge will become a first charge against any reimbursement you will be due" – Excerpt from letter from HSE to patient on 2 February 2022

Neither the HSE's website or CBD application form highlighted the effect an EU/EEA pension may have on an application. In fact, it was not until mid-2019 that the HSE even asked if a patient was in receipt of a pension or income from another EU/EEA state. I have said earlier I believe the warnings presently on the HSE website and the Application Form are inadequate and there was even less information than that available in 2019.

Up until 2019 it appears that the CBD Office, the body specifically charged with administering the scheme in the State and providing information to applicants, did not fully understand the implications of an EU/EEA pension itself. It certainly was not providing information to patients about the issue or even suggesting anywhere that the issue might exist. I do not believe it is realistic that patients faced with a lack of information and clarity from the public body charged with providing it, could be expected to understand the extremely complex web of EU legislation that governs the CBD Scheme. The patients applied to, and were reimbursed by, the HSE. The patients acted entirely in good faith and I do not believe they should suffer for that.

It was not my understanding then, nor is it my understanding now, that the issue of a first charge was ever raised in the December 2021 meeting my Office had with the HSE. It is my position that when my Office received the letter in February 2022 it was the first time the issue of a first charge had been brought to my attention or the attention of anyone in my Office.

The HSE confirmed to my Office that the decision to implement the first charge was based on custom and practice within the HSE. There is no actual policy on first charges within the HSE.

As such, it would appear that the National Director in consultation with the acting Assistant National Director of the Commercial Unit[7] approved the decision based on the aforementioned custom and practice. It is troubling to me that a decision as impactful as the application of a first charge on patients was made without broader input from other relevant HSE divisions and without reference to any documented policy whatsoever.

I am also concerned that the Department of Health was not formally consulted on this matter. The NIPHS is not on legislative footing as of yet. It is an administrative scheme setup and overseen by the Department which is simply administered by the HSE. The issue in these cases arose in the CBD, an entirely separate scheme altogether. The fact that the HSE is seeking to impose barriers to a patient's ability to access the NIPHS due to an issue that arose in a different scheme and without consulting the owners of the scheme would seem unusual to me. I would have expected the HSE to consult with the Department of Health before making this decision to impose such a punitive measure.

I understand that since the decision to implement the first charge was made the HSE has consulted with both its own Internal Audit Unit and the Office of the Comptroller and Auditor General and a policy has been drafted and is currently being considered by the HSE Management Team. While that is a welcome development and will hopefully provide future decision makers with a more solid foundation than simply "custom and practice", it does not alleviate the concerns I have about the appropriateness of the first charge and how it was applied in these cases.

7 it is my understanding that the position of Acting Assistant National Director of the Commercial Unit is currently occupied by the General Manager of the Commercial Unit. See HSE Organisational Chart at Appendix 4.

Finding 2: Application of a first charge

The information available to patients regarding EU/EEA pensions and the effect it may have on an application is in my opinion insufficient. These patients applied for reimbursement in good faith. The application was approved and paid, and the patients moved on with their lives post treatment. I am not satisfied that the decision to implement a first charge, or the process followed (which was in the complete absence of a corporate policy around those decisions), were fair and reasonable. I do not believe that the HSE should be applying a first charge against patients with UK pensions who applied for and received a reimbursement under the Cross Border Directive scheme. I consider that the HSE's decision to apply a first charge in these cases amounts to maladministration under section 4(2)(b)(viii) of the Ombudsman Act 1980 (as amended) as it is contrary to fair or sound administration.

+ Recommendation 2: Application of a first charge

The HSE should reverse its decision to apply a first charge against patients with UK pensions who applied for and received a reimbursement under the Cross Border Directive scheme. By the end of Quarter 3 of 2023 the HSE should write to each patient affected and explain clearly that the decision has been reversed and the patient is free to engage with the Northern Ireland Planned Healthcare Scheme without penalisation as any other patient would.

Case Study

Application of a first charge

Margaret came to my Office a year after she had received reimbursement of €11,500 from the HSE for treatment she accessed abroad under the Cross Border Directive scheme. The HSE had contacted her to say that it had reviewed her application and had noted that she was in receipt of a UK pension. For this reason it had now come to the view that she was not eligible for reimbursement towards the cost of her treatment. The HSE apologised for the error but requested repayment of the €11,500.

Margaret appealed this decision stating that she had completed the Prior Notification* process prior to accessing her treatment. She said she had filled this form out to the best of her knowledge and that all of the information supplied in her application was true and correct. She pointed out that there was no question on the form, which related to having a pension from another EU/EEA country. Margaret also told the HSE that the demand to repay the money had caused her great distress. The HSE reply to Margaret outlined the legislation underpinning its decision. It advised her that when she drew down the reimbursement in 2019 she did not make the HSE aware that she was in receipt of a pension from the UK. The HSE advised her that she was liable to repay the reimbursement, which it stated she had incorrectly drawn down.

When my Office examined Margaret's complaint, we found that it was clear that Margaret's initial application form had no question relating to her source of income that required or allowed Margaret to declare that she was in receipt of a UK pension at that time.

The HSE only became aware that Margaret was in receipt of a UK pension when she had a further treatment a year later. This time the application form included a question that related to the source of pension or income.

Following ongoing engagement with my Office, the HSE agreed not to take further measures to recoup the debt. However, Margaret was also told by the HSE that should she seek reimbursement for any healthcare received under the Northern Ireland Planned Healthcare Scheme (NIPHS), this charge would become a 'first charge' against any reimbursement she would be due.

*At the time generally and in its correspondence with Margaret specifically, the HSE was incorrectly using the term Prior Authorisation for applications, which were in fact applications for Prior Notification, see note in Part IV of this Chapter.

Public Patient Pathway

The Legislation

In May 2014 SI No. 203/2014[8] became law. Its purpose was to give effect to Directive 2011/24/EU of the European Parliament. Regulation 10(1) of those 2014 Regulations states that a patient resident in the State can apply for reimbursement of expenditure which qualified in accordance with subparagraph (2). The qualifying criteria from subparagraph 2 are:

a) the patient was entitled under the Health Acts 1970 to 2013 (as amended) to the healthcare in question,

b) the healthcare was necessary to treat or diagnose a medical condition of the patient,

c) the healthcare was the same as, or equivalent to, healthcare that would have been made available to the patient in the State, in the particular circumstances of the patient,

d) the healthcare has not been excluded under Regulation 11, and

e) where required, the Health Service executive granted prior authorisation in accordance with Regulation 12.

In addition, Regulation 6 says that the HSE can impose the same conditions, criteria for eligibility and regulatory and administrative formalities that it would impose on the patient if the healthcare sought was provided in the State.

Under Regulation 11 the HSE can exclude certain cross border health from reimbursement based on overriding reasons of general interest, such as:

a) planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high quality treatment in the State, or

b) the wish to control costs, or to avoid, as far as possible, any waste of financial, technical and human resources.

8 S.I. No. 203/2014 - European Union (Application of Patients' Rights in Cross-Border Healthcare) Regulations 2014.

The same regulation is clear however that any decision to exclude certain cross border health must be limited to what is necessary and proportionate and not be a means of arbitrary discrimination or an unjustified obstacle to the free movement of goods, persons or services.

As with all directives, Directive 2011/24/EC leaves the method of implementation in the hands of the individual member states. Each Member State benefits from the principle of national procedural autonomy. This means that each Member State can decide the procedures that can be adopted to give effect to the rights in the relevant directive and it is not for the EU to interfere in any domestic rules adopted.

However, any national procedural rules must comply with the twin principles of equivalence and effectiveness. Equivalence means that EU rights that are similar to the domestic rights in question must have the same type of procedural rules. Effectiveness means that national procedural rules must not undermine the effective exercise of the rights by individuals in that Member State.

HSE Pathway Requirements

On its website HSE sets out that the pathway to be followed for CBD patients is;

1. Qualify for public healthcare.
2. Have a letter of referral from a public health professional in Ireland.
3. Arrange a consultation with a healthcare provider abroad - this is called an outpatient appointment.
4. Travel abroad for healthcare.

In the Irish public system, a patient is referred by their GP to a consultant. It is only once a consultation has actually taken place that a patient can be approved for treatment and added to a waiting list.

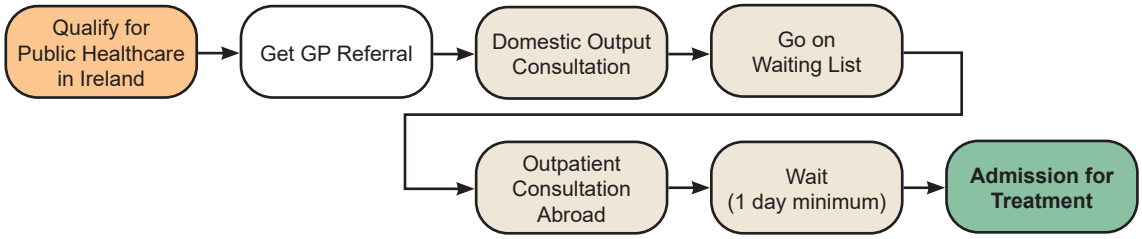
Article 7(7) of Directive 2011/24/EU entitles the State to impose on patients seeking cross-border healthcare "the same conditions, criteria of eligibility and regulatory and administrative formalities... as it would impose if this healthcare were provided in its territory". When adopting national procedural rules for the administration of the CBD, the HSE must comply with the principle of equivalence described above.

Therefore, the pathway CBD patients must follow is a mirror of the domestic pathway. In order to qualify for reimbursement under the CBD, a patient must follow the CBD pathway, which, like the domestic pathway, requires that a patient be referred by a GP (in this scenario directly to the named clinic abroad) for an outpatient consultation before they are approved for the treatment.

Patients may also follow the CBD pathway in a less direct manner than the most common pathway described above. This less common pathway is almost a hybrid of the Irish and common CBD pathways.

> *"I did not ask for private surgery, I just wanted the surgery so that I could lead a normal life and continue to work and earn a living"*

In this situation a patient is referred into the Irish public system by their GP, has an outpatient consultation and then goes on the HSE waiting list. However, for whatever reason, e.g. waiting lists, the patient may then choose to have the treatment abroad and seek reimbursement through the CBD. In this scenario the patient does not need a new referral directly to the clinic abroad, the fact that they are on a public waiting list in Ireland means that they can go straight to the outpatient consultation abroad phase.



Analysis of Pathway Requirements

1. Qualify for public healthcare.

There are two distinct aspects to this requirement. Firstly, the treatment an applicant is seeking reimbursement for must be publicly available in Ireland. Secondly, the applicant must qualify for that publicly available healthcare in Ireland.

In terms of publicly available healthcare, the Directive is clear that reimbursements under CBD should be limited to healthcare that a person is entitled to within the public system in Ireland.[9] It does not matter if the healthcare is available publicly in other EU/EEA countries, according to the Directive the HSE should only reimburse for treatments that are available publicly within Ireland.[10]

Recital 13 of 2011/24/EU "It is clear that the obligation to reimburse costs of crossborder healthcare should be limited to healthcare to which the insured person is entitled according to the legislation of the Member State of affiliation"

Recital 33 of 2011/24/EU "This Directive does not aim to create an entitlement to reimbursement of the costs of healthcare provided in another Member State, if such healthcare is not among the benefits provided for by the legislation of the Member State of affiliation of the insured person.

9 Recital 13 of 2011/24/EU "It is clear that the obligation to reimburse costs of crossborder healthcare should be limited to healthcare to which the insured person is entitled according to the legislation of the Member State of affiliation"
10 Recital 33 of 2011/24/EU "This Directive does not aim to create an entitlement to reimbursement of the costs of healthcare provided in another Member State, if such healthcare is not among the benefits provided for by the legislation of the Member State of affiliation of the insured person. Equally, this Directive should not prevent the Member States from extending their benefits-in-kind scheme to healthcare provided in another Member State. This Directive should recognise that Member States are free to organise their healthcare and social security systems in such a way as to determine entitlement for treatment at a regional or local level."

Equally, this Directive should not prevent the Member States from extending their benefits-in-kind scheme to healthcare provided in another Member State. This Directive should recognise that Member States are free to organise their healthcare and social security systems in such a way as to determine entitlement for treatment at a regional or local level."

In terms of an individual qualifying for that publicly available healthcare, if you live in Ireland and you are ordinarily resident (i.e. have been living in Ireland for at least a year or intend to live here for at least a year) you can access inpatient and outpatient services in public hospitals. Under Sections 45 and 46 of the Health Act 1970 (as amended), any person, regardless of nationality, who is accepted by the HSE as being ordinarily resident in Ireland is eligible for public healthcare in Ireland. This includes HSE hospitals and voluntary hospitals.

Certain visitors to Ireland are also entitled to public health services, for example, people covered under EU Regulations. However, while this category of individual is entitled to public health services while in Ireland, an application for CBD would be made through the National Contact Point in their country of origin.

My Office has had no complaints about this requirement and I do not have any difficulty with how it is being implemented by the HSE. The Directive is very clear that patients must qualify for healthcare in their Member State of Affiliation. In cases where Ireland is the patient's Member State of Affiliation, the Health Act 1970 (as amended) says that they qualify for healthcare by being ordinarily resident in the state.

2. Have a letter of referral from a public health professional in Ireland.

In the Irish domestic pathway described above, a patient is referred, primarily by their GP, to a consultant. Additionally, in the case of orthodontic treatment, patients may be referred into the Irish domestic pathway by a dentist. A full list of who can refer into the Irish domestic system is contained in the National Treatment Purchasing Fund (NTPF) National Outpatient Waiting List Management Protocol[11].

As with the domestic pathway, referrals into CBD can come from any of the clinicians listed in the NTPF protocol. In practice, of all the clinicians on the list, it is GPs and dentists who are in fact the primary Source of Referral (SOR) for the scheme. However, the CBD pathway also allows for referrals by public optometrists[12]. This is a significant variance to the domestic pathway as a large number of CBD applicants have been patients who have travelled to Northern Ireland for cataracts surgery following optometrist referrals. It is the practice of the CBD Office to accept referrals from public optometrists when they are drafted in line with in line with Irish College of General Practitioners (ICGP)/Health Information and Quality Authority (HIQA) guidelines.

The requirement to have a referral letter is part of both the domestic and CBD pathways. In the EU, health is a national competency and Member States are allowed to set their own rules for accessing public health care. The HSE requires a referral letter in the domestic system and with the principle of equivalence in mind, the CBD pathway mirrors this requirement. I have no issue with the HSE requiring the patients seeking reimbursement under the Cross Border Directive scheme have a referral letter from a public health professional in Ireland. That does not mean I am satisfied with how the HSE is actually administering this requirement and that will be discussed later in this chapter.

11 https://www.ntpf.ie/home/pdf/Outpatient%20(OP)Waiting%20List%20Management%20Protocol%202022.pdf at Page 14
12 Community optometrists cannot refer into the CBD as their contract with the HSE relates only to the provision of glasses

3. Arrange a consultation with a healthcare provider abroad - this is called an outpatient appointment.

As described in the CBD pathways above, the HSE requires that a patient has an outpatient appointment on a date prior to being admitted for inpatient treatment.

The previously mentioned Article 7(7) of the Directive entitles the HSE to apply the same conditions and criteria on CBD applicants as apply to domestic patients. However, it may not "be discriminatory or constitute an obstacle to the free movement of patients, services or goods, unless it is objectively justified by planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high quality treatment… or to wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources".

Further, Article 7(9) empowers the State to "limit the application of the rules on reimbursement for cross-border healthcare based on overriding reasons of general interest", such as those referred to in Article 7(7). In addition, Article 9(11) requires that the decision under Article 7(9) must be "restricted to what is necessary and proportionate".

Thus, the HSE is only entitled to require an outpatient consultation in the treating country takes place at least the day before the treatment and prior to admission if —

a) the same requirement would be imposed if the treatment was being provided domestically,

b) it is necessary for determining the patient's entitlement to healthcare,

c) it is not discriminatory and does not present an obstacle to the free movement of patients, unless it is objectively justified by planning requirements relating to ensuring sufficient and permanent access to a range of treatment or by the wish to control costs and avoid waste, or other overriding reasons of general interest, and it is necessary and proportionate.

Taking (a) first, public patients accessing healthcare in the State, who have been referred by a GP, are required to have an outpatient consultation with the consultant prior to the treatment. Therefore, the requirement that patients seeking re-imbursement under the CBD have an outpatient consultation with the consultant prior to the treatment is the same requirement imposed on domestic patients and it would seem that (a) is satisfied.

As regards (b), it seems reasonable that the process required to determine the "entitlement to healthcare" would include a prior consultation. Such an assessment would allow a consultant make a decision as to the patient's care needs and whether inpatient or day case treatment is warranted. For example, upon physically examining a patient the consultant may decide that the medical issue is not sufficient to warrant inpatient admission or surgery and a non-surgical approach is more appropriate at that point in time. This is in line with good clinical practice, patient safety and the protection of valuable healthcare resources and the consultant can discuss all of this with the patient prior to scheduling such treatment. It is clear that an outpatient consultation is required to determine an individual's entitlement to healthcare and therefore (b) is also satisfied

Outside of simply satisfying (b), the HSE website also details the benefits of a prior consultation[13] to a patient stating that "having a consultation before they have any healthcare gives them time to decide if they:

13 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/before-you-go-abroad/ - accessed 17 January 2023

- are comfortable with the consultant and the hospital abroad
- want to proceed with healthcare at a date in the future
- have any questions before the procedure"

Finally (c), specifically the "it is not discriminatory and does not present an obstacle to the free movement of patients". If the requirement that the consultation is on a day other than the day of admission or treatment is not imposed in the case of treatment in the State, then applying it to patients who undergo treatment abroad would clearly be a potential obstacle to obtaining treatment abroad.

The fact that the HSE requires an outpatient consultation abroad on a day other than the day of admission or treatment necessitates, at a minimum, an extra night of accommodation abroad for the patient and possibly even a requirement for a separate trip for the consultation itself, is highly relevant in this regard. While cross border treatment may have the attraction of being available quicker, if there are extra costs beyond the cost of travel which would not arise domestically then that could present an obstacle to the free movement of the patient.

At a domestic level, as referenced in the discussion of (a), there will always be an outpatient consultation with the consultant between GP referral and treatment. However, it is unclear why the HSE requires that the outpatient appointment takes place on a date before the admission/treatment rather than simply before the admission/treatment. Domestically it would be extremely rare for the consultation and admission/treatment to occur on the same day due to waiting lists but the HSE has not been able to point to an actual rule prohibiting it. In interactions with my Office, the HSE has said that a patient is an inpatient for the entire date on which they become an inpatient but I do not see how that can be the case. A patient who attends an outpatient appointment at 9 in the morning and is admitted as an inpatient at 3 in the afternoon cannot suddenly have their status changed for the entire day. To deem that patient to have been an inpatient at 9 in the morning is simply illogical, regardless of their status later in the day they were an outpatient at 9 in the morning and indeed, until such time as they were admitted as an inpatient.

If it is the case, as it appears, that there is no actual domestic rule requiring a consultation on a date before, then the rule against an outpatient consultation followed by same day admission/treatment must be objectively justified by health service "planning requirements" or other "reasons of general interest". It would seem that the reasons/benefits on the HSE website are focused on the patient rather than the system, and are of specific as opposed to general interest. I therefore do not believe they come within the derogation allowing for obstacles to free movement of patients.

An argument could be made that it is in the general interest that patients have a period of time to think things through, make sure they want to go ahead with the treatment and ask any further questions they may have. In Ireland there is a statutory requirement for informed consent. There are three components to informed consent:

1. Adequate information: The patient must have sufficient information to 'make a choice', as without adequate information to make a decision any consent given would not be valid.
2. Capacity: The patient must have the capacity to understand and make the decision in question.
3. Voluntary: The patient must be able to give their consent freely and without coercion.

The HSE has stated that pre-op assessment and consent on the day of the procedure, in a foreign

country is not, in its opinion, conducive to informed consent. However, it is simply too broad a statement to say that same day admission/treatment after a patient has had an outpatient consultation does not mean that patient has not had time to fully consider the proposed treatment and give informed consent. In CBD cases the treatment is not a surprise to a patient. They have engaged with their GP and received an initial referral and they have then engaged with the clinic abroad to arrange for the outpatient appointment. It is fair to say that before they attend the outpatient appointment patients already have a fair understanding of the proposed procedure. Obviously the consultant needs to fully brief the patient and ensure that they completely understand the proposed procedure and an outpatient appointment is the appropriate forum for this. However, I do not believe that an outpatient consultation that takes place on the same day as, but prior to, admission/treatment, could be seen as invalid or not fit for purpose.

It is also the case that where CBD applications for reimbursement are concerned, the treatment has already taken place before the issue is raised. The patient cannot remedy the issue or re-do the outpatient appointment. They cannot undergo the procedure again. In those circumstances the HSE's insistence that an outpatient appointment cannot take place on the same day as admission/treatment simply leads to a refusal of a patient's application for reimbursement for a treatment which has already been completed without having any effect whatsoever on that patient's safety.

It is also notable that Article 7(9) of the Directive gives, as an example of a reason of general interest, the "planning requirements" referred to in Article 7(7). That would suggest that personal patient issues are not the focus of the derogation.

In addition, it would appear to me that to require certain patients to attend an outpatient consultation at least a day before admission is simply disproportionate. For instance, for minor treatments in hospitals abroad which specialise in particular treatments (e.g. cataracts in Northern Ireland), was it proportionate to require that the patient arrived a day before admission/treatment to attend the outpatient consultation?

Finding 3: Prior outpatient consultation

I accept that an outpatient consultation is an important part of both the domestic and Cross Border Directive pathways. However, I do not believe there is any basis on which the HSE can insist that a patient making an application for reimbursement under CBD must have had their outpatient consultation on a DATE prior to their admission/treatment (as opposed to, for example, a consultation on the same day but prior to their admission/treatment). I consider such a requirement to be improperly discriminatory and as such amounts to maladministration under section 4(2)(b)(v) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 3 - Prior outpatient consultation

An outpatient appointment that takes place at any time PRIOR to admission/treatment should be acceptable for the purposes of receiving a reimbursement under the Cross Border Directive scheme. The HSE should review cases where reimbursement was refused only on the basis that the outpatient appointment was on the same day as admission/treatment with a view to reimbursing those patients.

Case Study

Outpatient consultation on the same day as treatment/admission

Agnes had suffered an injury and was receiving physiotherapy to treat it. The treatment was ongoing for a year and there was little progress. Her injury meant she could not work and she had to take daily pain medication. She was a single parent of one child and could not afford to be out of work. She was referred to a consultant who advised her to continue with the physiotherapy. She was very upset with this as she felt it was not working. She had another consultation and she was advised that surgery was required. The cost in Ireland would be approximately €9,000.

As she could not afford this amount, she decided to research options for this surgery in Lithuania. She sourced a clinic and following several phone conversations she forwarded a copy of her MRI along with her medical records. An appointment was arranged for her to have an outpatient consultation on 23 June in Lithuania, and a further appointment was reserved for the 27 June for surgery should the consultant decide she needed it and if she decided to go ahead with it.

When she travelled to Lithuania, she was contacted on the morning of the 23 June and advised that the consultant had postponed the initial consultation to the morning of the 27 June. As she had travelled over and wanted to meet the consultant, she accepted this appointment. She had her outpatient consultation at 9am on 27 June. Following this, it was agreed that she required surgery and she was admitted to the clinic that day for her treatment. The treatment cost her €1,239.

When she returned to Ireland, she applied for reimbursement under the Cross Border Directive scheme. The HSE declined her application, as she did not have her outpatient assessment on a date prior to the day case or inpatient treatment. Agnes appealed the decision and provided a letter from the clinic, which confirmed that due to a cancellation her consultation was postponed to the 27 June. The HSE advised that the decision to decline her application was correct and continued to reject her application.

4. Travel abroad for healthcare.

As the name of the scheme indicates, reimbursements under the CBD are only available if a patient undergoes treatment in a Member State other than their Member State of affiliation.[14]

Under CBD patients may travel to any other European Union (EU)[15] or European Economic Area (EEA)[16] member state to receive treatment.

Previously patients could travel to the United Kingdom (UK) to seek treatment but, following the UK's departure from the EU, the CBD stopped applying to the UK on 01 January 2021. The Northern Ireland

14 Recital 11 of 2011/24/EU "This Directive should apply to individual patients who decide to seek healthcare in a Member State other than the Member State of affiliation."
15 Austria, Belgium, Bulgaria, Croatia, Republic of Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden
16 Iceland, Liechtenstein, Norway

Planned Healthcare Scheme (NIPHS) is a partial replacement for the UK element of CBD and that is discussed further in Chapter 3.

The outpatient consultation discussed at point 3 above must also take place in the other Member State. The reason for this is that a patient seeking reimbursement under CBD must have been on the public pathway in Ireland. If you receive your initial consultation in Ireland from a consultant normally based in the clinic abroad, then you have left the public pathway. You have now been referred to a private consultant in Ireland and are no longer eligible for a reimbursement under CBD. There is a small exception to this in relation to telemedicine consultations in day cases which I will discuss in the next section.

It is important to highlight this requirement, as there have been a number of complaints to my Office from patients who have been unable to avail of reimbursements under the CBD as they have failed to understand the requirement that the outpatient consultation must also take place abroad.

Case Study

Initial consultation in Ireland

Alice's medical condition left her suffering from pain, limited mobility and depression. The waiting list to see a consultant for her required treatment was four years. Alice decided to access her treatment abroad under the Cross Border Directive Scheme and, having researched the scheme, she decided to travel to Belgium for her treatment.

Alice's Belgian consultant was providing outpatient consultation clinics in Dublin and Kerry, so Alice had her initial consultation in Dublin. Following this, she travelled to Belgium to have her treatment.

When Alice applied for her reimbursement, she was requested by the HSE to provide evidence that her outpatient appointment took place abroad rather than in Ireland. Alice told the HSE that she had attended her initial consultation in Dublin. Alice was of the view that the information, which she accessed on the HSE website was "open to misinterpretation".

She understood that she had followed all of the steps which included "arranging a consultation with a healthcare provider abroad – this is called an outpatient appointment". Alice was also of the view that she had fulfilled every item on the qualifying list which was set out on the website and did not include the requirement to have the initial consultation abroad. The HSE advised Alice that to qualify for reimbursement under the provisions of the CBD a patient must access the entire healthcare abroad. Alice's application for reimbursement was refused.

Telemedicine

Telemedicine is the practice of using technology to deliver care at a distance. For example, it may be a consultant in one location using a video call to deliver care to a patient in another location or country. The HSE's policy on telemedicine has meant its use has not been permitted in CBD. This was an overarching policy of the HSE rather than a CBD specific exclusion and in fact, the CBD has always envisaged that telemedicine might play a part in treatment. CBD requires that all treatment takes place abroad so section 10(10) of SI 203/2014 catered for that by specifying that in CBD cases "in the case of telemedicine, healthcare is considered to be provided in the Member State in which the healthcare provider is established". This means that if the HSE permitted telemedicine as part of the domestic pathway, it could then be used by CBD patients and they would still be deemed to have had the appointment abroad and remain eligible for reimbursement.

This issue has become very prevalent in recent years due to the COVID pandemic and the restrictions that were placed on people's movements at various times. In April 2020, the HSE published a document to deal with the use of video and audio consultations during the pandemic[17].

That document clearly envisaged the use of video consultations in the domestic pathway while emergency measures were in place. In line with this new policy, the CBD began allowing telemedicine outpatient consultations as part of the pathway for day cases only.

Case Study

Telemedicine in an inpatient case

Paulina suffered from very bad back pain. She had been receiving treatment for pain management but this was not working and her condition was deteriorating. Her GP referred her for an MRI scan. When she received the results of the scan, she was advised that an immediate neurological assessment was required. Paulina made enquiries about this and all she was offered was a place on a waiting list. She was concerned about this as she had already been on a waiting list for two years regarding other treatment she required.

Due to the urgency of her deteriorating health condition and for financial reasons, Paulina's GP referred her to a consultant in Poland. Paulina forwarded all of her medical records, including the results of the MRI scan, to the consultant abroad. Due to COVID restrictions, it was decided that Paulina would have her initial consultation over the telephone. Paulina then travelled abroad to have her treatment which involved a two-night stay at the clinic abroad.

When Paulina returned to Ireland, she submitted her application for reimbursement of medical costs under the Cross Border Directive scheme to the HSE. The HSE declined her application, as she did not have an outpatient consultation with the treating consultant in person on a date prior to her admission into the clinic.

17 HSE Clinical Governance Guidance on Secure Video and Audio Consultations during the Emergency Measures to address Covid 19 https://healthservice.hse.ie/filelibrary/staff/clinical-telehealth-governance-guidance.pdf

The HSE has stated that despite the fact that a telemedicine outpatient appointment is acceptable in day cases, there is no reimbursement available. The reason given for this is that the HPO has not identified a reimbursement rate for telemedicine consultations. There is a reimbursement for in-person consultations but not a specific rate for telemedicine consultations. While this matter remains unresolved due to HSE inaction, patients are continuing to be charged for telemedicine appointments and cannot be reimbursed.

Finding 4: Telemedicine consultations

I believe it is unfair that patients are not being reimbursed for telemedicine consultations (that is, consultation by phone or video). I appreciate that the Cross Border Directive Office is dependent on the Health Pricing Office to produce a telemedicine specific rate but these are two arms of the HSE which need to show some joined-up thinking and resolve the situation. Patients should not suffer for this. I consider the decision to exclude telemedicine consultations from reimbursement is improperly discriminatory and as such amounts to maladministration under section 4(2)(b)(v) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 4: Telemedicine consultations

The HSE should identify a specific telemedicine reimbursement rate by the end of Quarter 3 of 2023. In the absence of this, the HSE should apply the same reimbursement rate that applies to in-person outpatient consultations for telemedicine consultations.

II. Application Process

There are three different applications that a person may make under the CBD; Prior Authorisation, Prior Notification and an application for reimbursement (CBD Pro Forma Invoice). In Ireland, Prior Authorisation is required for just one procedure, Enzyme Replacement Therapy. A patient may apply for Prior Notification for any treatment abroad but it is completely optional. As the names suggest, both Prior Authorisation and Prior Notification take place before a patient travels for treatment.

When a patient has actually completed their treatment abroad and is seeking reimbursement from the HSE, they then complete the CBD Application Form. All patients seeking reimbursement under the CBD will have to complete an Application Form, including patients that have previously applied for Prior Authorisation and Prior Notification.

Applications Part 1 – Pre-treatment applications

Prior Authorisation

Articles 8 and 9 of the 2011 Directive allow a Member State to provide for a system of Prior Authorisation for the reimbursement of costs under the CBD.

The system of Prior Authorisation, and individual decisions under that system, must be restricted to what is necessary and proportionate to the objective of the scheme and may not constitute a means of arbitrary discrimination or unjustified obstacle to free movement of patients[18].

18 Article 8(1) of 2011/24/EU

Article 8(2) places certain restrictions on the types of healthcare that can be subject to prior authorisation. Prior authorisation healthcare is limited to:

a) Treatments subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balances range of high-quality treatments in the Member State;

b) Treatments presenting a particular risk to the patient; or

c) Treatments provided by a healthcare provider, that on a case by case basis could give rise to serious and specific concerns about the quality of safety of the care

In all circumstances, the Member State must notify the Commission of the categories of healthcare referred to in point (a). In Ireland, Prior Authorisation is only required for one type of treatment, Enzyme Replacement Therapy (ERT). The HSE has never received an application for Prior Authorisation for ERT. If an application for ERT were to be received it would need to include full details including the Diagnosis Related Grouping (DRG) codes, the consultant assessment, how the treatment would be provided, etc. A Prior Authorisation application can only take place after the patient has had a full multi-disciplinary team assessment and identified the consultant abroad.

Prior Notification

Article 9(5) of the Directive allows Member States to implement a voluntary system of Prior Notification.

"This Directive is without prejudice to Member States' right to offer patients a voluntary system of prior notification whereby, in return for such notification, the patient receives a written confirmation of the amount to be reimbursed on the basis of an estimate".

Thus, Member States can, but are not obliged to, implement a Prior Notification scheme.

Ireland has chosen to make a Prior Notification option available to CBD applicants. As per the 2011 Directive, Prior Notification is optional. The HSE notes that "Prior notification for all hospital care involving overnight accommodation is recommended but not a requirement".

Prior Notification takes place after a patient has had their outpatient consultation abroad but before they travel for treatment. Its purpose is to confirm if a patient has followed the correct pathway up until that point. When a patient submits a Prior Notification application to the HSE, they are essentially seeking confirmation, from the HSE, that the steps of the process already undertaken are in line with the HSE requirements and would be eligible for reimbursement under the CBD.

It stands to reason that the HSE cannot confirm any aspects of the pathway or treatment that have not yet occurred. To be eligible for reimbursement patients must continue to fulfil the conditions of the CBD scheme throughout the remaining process. For example, patients must still be able to provide evidence of their travel abroad and of the medical procedure actually undertaken.

Most significantly, however, the Prior Notification process does not allow the HSE to absolutely confirm the amount of reimbursement a patient may receive. When an applicant submits an application for Prior Notification, they identify the proposed treatment. At the time that is all that it is, a "proposed treatment". At the actual time of the treatment, the consultant may need to provide additional or varied treatment. Therefore, the actual treatment received may differ from the proposed treatment in the Prior Notification. It is the actual treatment, which will be eligible for reimbursement, or not as the case may

be. A patient's entitlement to reimbursement based on the treatment actually provided and not based on the treatment, which was indicated at Prior Notification.

When it approves an application for Prior Notification, the HSE is very clear in its letters to patients that it "cannot confirm the reimbursement rate at this point in time as it is only once the treatment has been provided [that] the treating consultant abroad will be in a position to indicate definitively the treatment he/she has provided".

Case Study

Diagnosis Related Grouping (DRG) Codes

Brendan was referred by his GP to a hospital in Northern Ireland for nasal surgery. He completed a Prior Notification* application under the Cross Border Directive scheme for his treatment abroad and submitted it to the HSE. His consultant completed Part B of the application form and indicated that the treatment he was to receive was "Revision FESS (functional endoscopic sinus surgery) & nasal polypectomy". This would be inpatient treatment and the consultant assigned DRG code D06Z to the proposed treatment. In Ireland the amount of reimbursement a patient may be entitled to is either the price paid for the treatment abroad or the cost of providing that treatment in Ireland, whichever is the lesser. The cost of providing the treatment in Ireland is identified using what are known as Diagnosis Related Grouping (DRG) Codes. Brendan's application for Prior Notification was approved by the HSE.

Brendan paid approximately €5,600 for his treatment. When he checked the DRG Ready Reckoner on the HSE website, the reimbursement rate for the DRG code D06Z was €5,000. Under the terms and conditions of the scheme, Brendan therefore understood that he would receive reimbursement of €5,000 and would bear the difference of the cost.

Following the treatment Brendan submitted his application for reimbursement. The HSE said that his clinician had assigned an incorrect DRG code to the treatment that he had received. It said that the correct DRG code for the treatment he actually received was D66B, which had a reimbursement rate of €978. Brendan appealed the decision and explained that he had completed a Prior Notification application based on the code the consultant supplied.

The HSE told Brendan that when processing his reimbursement application, the CBD office used the information from his medical file to seek independent coding of the treatment. That independent coding confirmed that the correct DRG code for the treatment he received was D66B. That is the code for Other Ear, Nose, Mouth & Throat disorders of minor complexity and has a reimbursement rate of €978. Brendan was also told that his Prior Notification letter clearly highlights a warning for patients to satisfy themselves as to the appropriateness of the code identified by the provider abroad and that the HSE is not liable for errors of coding by consultants abroad. He was further advised that if the hospital abroad could provide him with a copy of the DRG coding they carried out it would be happy to compare that against the DRG coding carried out by the HSE. Finally, the HSE advised that where the provider abroad did not have access to or did not rely on ICD 10DRG coding system it must be assumed the DRG code identified by the provider was simply a best guess.

Following the examination of Brendan's complaint to this Office, it was noted that the letter of Prior Notification stated that it is a confirmation that a patient has followed the correct public pathway. The letter also advised Brendan that if the treatment abroad differs from that indicated at Prior Notification stage, the HSE cannot be held liable for same or any costs incurred by the patient. The letter cautions all patients to be careful and satisfied that their treating consultant has identified the correct DRG Code, both at time of Prior Notification, in so far as possible at that stage, but most importantly, at the time of the claim for reimbursement.

*At the time generally and in its correspondence with Brendan specifically, the HSE was incorrectly using the term Prior Authorisation for applications, which were in fact applications for Prior Notification, see note in Part IV of this Chapter.

When the HSE grants a patient's Prior Notification application, it makes a very clear statement that, having fully examined the facts of the case, the patient is on the correct public patient pathway. This statement is addressed directly to the patient in a letter. If the patient than acts on foot of this statement by travelling for treatment under the Cross Border Directive scheme, it is clear that this statement by the HSE has created a reasonable expectation which the patient is entitled to rely on and the HSE cannot later seek to draw back from.

In these situations, it is clear that the patient has an expectation that the HSE will treat the application for a refund on the basis that they were on the correct public patient pathway. The HSE cannot discount or ignore the statement made in the letter. The question of the patient's actual entitlement to a refund depends on the facts of the case, but the HSE cannot deny the patient a refund based on problems with the previously confirmed pathway.

Applications Part 2 – Applications for Reimbursement

In order to apply for reimbursement under the Cross Border Directive scheme the HSE says that you must submit the following:

- completed CBD Application Form
- referral letter from the GP or public consultant who referred you
- hospital's original invoice and receipt
- proof of travel such as a plane ticket receipt - this is to show you travelled abroad for your healthcare

When processing applications the HSE uses an internal checklist that is designed to ensure the applicant has provided all required documentation listed above. As per above, the checklist is broken into the same four sections which I will now examine further.

Completed CBD Application Form

The Application Form[19] states that its aim is "to ensure all the information required by the HSE to process your reimbursement claim in a timely and efficient manner is provided". It is clear that "The onus is on the patient to submit all the necessary original documentation to progress the claim for reimbursement".

19 See copy application form in Appendix 1.

Section A of the form is to be completed by the applicant. The majority of the questions are straightforward personal details e.g. name, address, date of birth etc. In terms of actually determining an applicant's eligibility for reimbursement, the two most significant issues in Section A relate to private health insurance and an applicant in receipt of a pension or other income from another country.

The private health insurance question is significant, as anyone whose treatment is being funded by their insurance company should not be applying for reimbursement under CBD. It is a clear condition of CBD that you may only be reimbursed for treatments that you pay for. A person that has private health insurance is under no obligation to use it to access treatment and is free to engage with the CBD process as if they had no insurance. It is only if the patient is being reimbursed by their insurance that the application will be effected as a patient cannot be reimbursed under CBD for a treatment they have not paid for or for which they have already been reimbursed. This issue is neither controversial nor confusing and has not been the subject of any complaints to my Office.

Patients with private health insurance should note that an outpatient consultation in a private capacity in Ireland will not be accepted by the HSE for the purpose of accessing healthcare abroad under the Cross Border Directive scheme. Public referral pathways as applicable in Ireland must be adhered to. Public consultant appointments can only be accepted. If a consultant works in both a private and a public capacity, a patient seeking access to CBD must attend the consultant's public clinic.

The second issue however, which related to applicants in receipt of a pension or other income from another country, has proved very confusing for applicants and has resulted in a several complaints to my Office. I have addressed this issue at the beginning of this chapter.

Section B of the form is to be completed by the treating clinician abroad. The earliest part of Section B deals with non-medical issues and, like Section A, the majority of the questions are straightforward e.g. name of clinician, address etc. or a repeat of questions seeking the patient's information e.g. name, address, date of birth etc.

The second part of Section B deals with medical information. It begins by seeking details of the outpatient appointment. I have already addressed this issue at Part I of this chapter. It then seeks details of the treatment provided, if it was a day case or inpatient treatment and the applicable DRG code. Again, I have already dealt with the DRG code issue earlier in this chapter. I have no issue with the HSE asking these questions on the application form as they all simply seek information which the HSE requires to make a decision on a patients' eligibility under the scheme.

The CBD only allows patients to apply for reimbursement of procedures that are available in the Irish public system. The medical questions in this section of the form are simply to ensure that the HSE has absolute clarity about the treatment that took place and is therefore in a position to determine if that treatment is appropriate for reimbursement under CBD.

There may of course be situations where the HSE receives an application form and is unsure if a treatment is medically necessary or a proven form of treatment. In those cases, the application will not be refused but the HSE will seek additional information. The HSE may consider any national standards that apply (e.g. bariatric surgery), seek clinical advice or ask the patient to submit further supporting information from their clinical records. If the HSE is unsure if a treatment is a proven form of treatment then it will seek clinical advice.

Finding 5: Application form

Many patients engaging with the Cross Border Directive scheme may be older, more vulnerable and not have access to, or be comfortable accessing information online. For this reason, they often access the application forms in hard copy only. The CBD scheme application form does not sufficiently explain the purpose or impact of some of the questions asked, particularly around the pensions issue and this can lead to patients not fully understanding that they need to consider their entitlement, or possibly lack of entitlement, under the CBD. I consider the lack of information being provided by the HSE constitutes an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 5: Application form

By the end of Quarter 3 of 2023, the HSE should re-design the Cross Border Directive scheme application form to ensure that questions with significant impacts, such as the pensions issue, have those impacts highlighted next to the questions, rather than only being explained deep in the terms and conditions, or on the HSE website, where some patients may not become aware of them.

Referral Letter

The HSE website says that a patient's referral letter must include:

- the name and address of a hospital consultant
- your name, address and date of birth
- your current health and any other relevant information
- the healthcare you need
- the GP or consultant's signature - it cannot be signed by their nurse or secretary
- the date of the referral letter - the letter must be issued before your first appointment abroad[20]

The website also says that "you do not have to use the consultant and hospital named in the referral letter. But your healthcare abroad must be the same medical specialty on your referral letter"[21].

In March 2011, HIQA issued a report and recommendations on GP referrals to outpatient consultations[22]. The report was undertaken as a number of high profile incidents had shown evidence of deficiencies within the domestic referral system. Recommendations 14 to 17 in the report dealt with referral letters, specifically the implementation of The National Standard for Patient Referral Information, guidance to ensure that referral letters are complete, reliable, relevant and up to date at the time of creation and how to manage referrals that are of unacceptable quality.

20 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/how-to-get/ - accessed 17 January 2023
21 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/how-to-get/ - accessed 17 January 2023
22 Report and Recommendations on Patient Referrals from General Practice to Outpatient and Radiology Services, including the National Standard for Patient Referral Information. https://www.hiqa.ie/reports-and-publications/health-information/report-and-recommendations-patient-referrals-general - accessed 17 January 2023

In 2014, the HSE published a guidance document entitled The Management of Outpatient Services[23]. This document had a number of associated operating procedures including one titled The HIQA Minimum Data Set for Outpatient Referrals[24].

In 2022, the NTPF published the National Outpatient Waiting List Management Protocol[25]. This was an update of the waiting list management component of The Management of Outpatient Services.

These two HSE documents have been the guiding documents for managing outpatient services since the introduction of the CBD and both have incorporated the referral letter structure from the 2011 HIQA report. It has been HSE policy throughout the lifetime of the CBD that referral letters into the domestic system align with what is set out in the HIQA report. As it is HSE policy, it is implemented by the CBD Office.

> *"The contention that I was not referred by a medical practitioner is at this point untenable, unjust and patently incorrect"*

It is appropriate that the HSE has consistent practices across its entire organisation and seeks to implement the HIQA protocols across both the public hospital system and the CBD application process. Implementation of the protocols across the board should in theory provide consistency to the source of referral (SOR), usually the GP in CBD cases. However, the nature of the public hospital system and the CBD application process means that the consistent approach to handling referrals breaks down when there is an error or omission in a referral letter.

Under section 5.3 of the 2022 protocol, when there is an error in a referral letter the SOR must be contacted to complete the required information. Where contact with the SOR is not possible within 48 hours, the referral must be brought to the attention of a clinician who will decide whether or not the referral is acceptable or should be returned to the SOR. This procedure is in line with recommendation 17 of the HIQA report, which stated that "The Health Service Executive, the ICGP, hospitals and GPs should develop processes to manage referrals that are of unacceptable quality while continuing to treat the patient accordingly and continuing to ensure that patients are not disadvantaged by poor quality referrals". This process for correcting an error in a referral letter makes perfect sense in the context of the public system. It allows any problems with referral letters to be rectified without the patient being adversely affected or even knowing there was ever an issue.

Unfortunately, the process does not work when it is applied to CBD applications. The nature of CBD applications is such that the HSE will only see the referral letter after the patient has already incurred some costs. In most cases, the patient will have already received and paid for the full treatment. In Prior Notification applications, the patient will already have incurred the cost of the outpatient consultation. The process that works in the hospital setting simply does not work in the CBD process. This is because there is no opportunity for the error to be identified in advance and rectified by the SOR.

23 https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/protocol-for-the-management-of-outpatient-services-and-guidance-documents/out-patients-protocol.pdf - accessed 17 January 2023
24 https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/protocol-for-the-management-of-outpatient-services-and-guidance-documents/guidance-003-the-hiqa-mds-for-outpatient-referral.pdf - accessed 17 January 2023
25 https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/protocol-for-the-management-of-outpatient-services-and-guidance-documents/national-outpatient-waiting-list-management-protocol-2022.pdf - accessed 17 January 2023

"I feel aggrieved that this process is unfair, in that it expects me to provide a specifically addressed letter which I cannot control myself. The claim process is dependent on circumstances outside of my control. Why should my claim be rejected and someone else's be accepted on the basis of the GP's addressing of a letter as "Dear Sirs" rather than "Mr. X""

The HSE's position on errors or omissions in CBD referral letters is that there are two particular issues that cannot be remedied at the CBD application stage.

Firstly, the HSE says that a referral letter that is undated or has an incorrect date is not sufficient for a CBD application. The reason being that the CBD pathway clearly requires a referral letter from prior to the outpatient appointment and treatment and a referral letter that is incorrectly dated or undated does not allow the HSE to verify when the referral actually took place.

Secondly, the HSE will not accept an unsigned or pp'd (i.e. signed on the GP's behalf) referral letter with a CBD application. As with the date issue, an unsigned or pp'd letter does not provide assurance to the HSE that the referral letter was in fact made by the SOR in question.

The HIQA report identifies both the signature and the date of referral as "required at the time of referral" and the reasons for this are understandable. However, in both these scenarios, the patient is being adversely affected by an act or omission that is completely outside of their control and there is simply no procedure or mechanism in place that will allow the error to be corrected or explained.

As mentioned above, recommendation 17 of the HIQA report clearly states that any process developed to manage unacceptable referrals should "ensure that patients are not disadvantaged by poor quality referrals". However this is not proving to be the case where CBD is concerned as in 2020 there were 78 applications declined on the basis of issues with referral letters. In 2021, even after patients' ability to travel for treatment had been curtailed by COVID and the NIPHS was in place for people travelling to Northern Ireland, there were still 63 patients refused reimbursement due to issues with referral letters and a further 66 to end of September 2022. There can be no doubt that these applicants were disadvantaged by poor quality referrals.

Finding 6: Errors in referral letters

When errors with referral letters, which are beyond the patient's control, arise with Cross Border Directive scheme applications, the patient has no mechanism to rectify the error and their application is refused. This contrasts with the situation where errors arise in the process for receiving similar treatment in Ireland, where issues with referral letters are resolved between the hospital and the GP without any adverse effect on the patient.

The HSE is penalising patients for errors which are entirely beyond patients' control and is not affording them an opportunity to explain or remedy those errors. I consider the lack of a remedy for patients in the Cross Border Directive system as opposed to the domestic system to be improperly discriminatory and amounts to maladministration under section 4(2)(b)(v) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 6: Errors in referral letters

The HSE should put in place a mechanism whereby the Source of Referral can explain a mistake in a referral letter, specifically date and signature, at the time the application is being processed. The HSE may wish to consider a mechanism whereby the GP certifies the explanation of the error or omission. If the HSE is concerned about the content or accuracy of any GP explanations, it has the option to bring these concerns to the attention of the Medical Council. However, the HSE cannot continue to punish patients for errors which are entirely outside of the patient's control.

Case Study

Referral letter not signed

Angela was a nurse. She was the sole earner in her family. Her young son required an urgent procedure. He was unable to access the treatment in the main hospital of his home county due to COVID restrictions. His GP referred him to a hospital in Northern Ireland and Angela had to obtain credit to pay for the treatment. The GP referral letter was emailed to the consultant in Northern Ireland but the letter was not signed by the GP. The full treatment cost including the initial consultation was £2,670.

When Angela submitted her application for reimbursement of the medical costs under the Cross Border Directive scheme to the HSE, she was advised that her GP referral letter was not signed by the GP and therefore was not a valid referral letter. Angela reverted to her GP and another letter was provided for the purpose of the application. Her GP was on leave and another GP signed this referral letter. The HSE contacted the clinic in Northern Ireland for clarification of which referral letter was used to access the treatment. The Northern Ireland clinic only had one referral letter on file - the unsigned emailed version.

Angela's application for reimbursement was declined as the referral letter used to access the treatment abroad was not signed by her referring GP.

Angela appealed the decision to the HSE. Her GP wrote a letter of support to the HSE to verify that the referral was genuine, that she had examined the patient and emailed the referral directly to the hospital in Northern Ireland. There was no doubt that the referral had come from the GP surgery's email account.

The HSE said that the decision to decline the application was correct, and that the fact that the referral letter used to access the treatment abroad was not signed or stamped by the referring GP could not be remedied at the application stage of the process.

Angela thought this was very unfair as she considered the error was through no fault of hers and her GP had fully clarified the circumstances of the referral.

Finally, another issue that my Office has received complaints about is the HSE refusing reimbursement where a referral letter is not addressed to a named consultant. The reason the HSE has provided for the requirement that a consultant be named is that "a referral letter is the transfer of clinical responsibility from one clinician to another clinician". The HIQA report did identify that addressing to specific consultants could be useful for patients and GPs who wished to track referrals but it made no mention of formal hand over of responsibility as a reason that referral letters should be addressed to individuals. The report also identified that the tracking difficulty was actually largely caused by the lack of a central point of contact for referrals in individual hospitals rather than the lack of an identified consultant.

Page 12 of the HIQA report identified that effective communication and timely dissemination of information needs to be significantly improved and that "GPs can facilitate these improvements by directing referrals to services rather than to named consultants". Page 56 envisages that "Referrals will move from the current "referral to consultant" to referral to specialty or service, which will enable the more effective management of referrals". In the table (page 60) which lists the data contained in a referral letter the report lists the preferred consultant's details as "Optional. Used to identify the patient's and GP's preference for a named consultant to see their patient".

Again, the report makes no mention of formal hand over of responsibility as a reason referral letters should be addressed to individuals. Recommendation 4 of the HIQA report clearly states that "GPs should address referrals in the first instance to a central point within a hospital, then to the relevant specialty/service, followed by named consultant if relevant". That "if relevant" qualifier in the recommendation and other statements in the report clearly indicates a place for referral letters that are only addressed to the relevant specialty/service. The stated reason for addressing referral letters to individuals was for organisational purposes in Irish hospitals. This is not relevant with CBD applications and in my opinion, the CBD is an example of an area in which referral letters addressed to specialities rather than named individuals should be acceptable.

The refusal to accept a referral letter that is not addressed to a named individual is bizarre considering the CBD Office will accept a referral letter addressed to a different consultant and hospital than where the treatment eventually takes place. The fact that the CBD Office would accept this but refuse an application addressed to the correct speciality in the hospital where the treatment actually took place seems illogical.

In the course of this investigation, the HSE has assured me that while it still considers it best practice to identify the consultant to ensure transfer of clinical responsibility to a named doctor, a referral letter will be accepted if the name of the consultant is omitted in consideration of the entirety of the documentation submitted.

Finding 7: Addressing referral letters

The HSE has raised issues with reimbursement applications on the basis that a referral letter from a GP has been addressed to a speciality, for example Orthopaedic, as opposed to a named individual. The Irish College of General Practitioners/Health Information and Quality Authority guidelines clearly envisage a place for letters addressed to a speciality. I believe such letters are appropriate for the purposes of the Cross Border Directive scheme. I consider any decision to refuse an application for reimbursement as the referral letter is not addressed to a speciality as being taken on irrelevant grounds and as such amounts to maladministration under section 4(2)(b)(ii) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 7: Addressing referral letters

The HSE should not refuse applications because referral letters are addressed to a speciality rather than to an individual consultant.

Case Study

Referral letter not addressed to a named consultant

Joan's GP was concerned that she required urgent medical treatment. As there was a significant waiting list for this treatment under the care of the HSE, Joan's GP recommended that she access the treatment in a private hospital in Northern Ireland and seek reimbursement of her medical expenses under the CBD scheme. Joan's GP sent an open referral to the "ENT" (Ear, Nose & Throat) department of a named hospital in Northern Ireland, as he was not sure which consultant at the hospital would be available at the earliest possible date.

Joan had her treatment with a consultant at this named hospital and then submitted her application for reimbursement. The HSE told Joan that the GP referral letter used to access her treatment abroad was deemed invalid, as it was not directed to a named treating consultant abroad.

Joan reverted to her GP to get an updated referral letter that included the named consultant that she had attended. This was submitted to the HSE in support of her application. Her GP also wrote to the HSE indicating that he felt her application was being "obstructed unfairly". The HSE told Joan that her original referral letter was not addressed correctly and an amended referral letter cannot be accepted.

Joan appealed the decision. She was told by the HSE that her referral letter was required to be issued in line with guidelines drafted by the Irish College of General Practitioners in conjunction with HIQA. It further advised that these guidelines include the requirement for the GP referral letter to be signed by the referring GP and addressed to a named consultant. The HSE said that it regretted the referral letter used was not addressed to a named consultant abroad and this situation cannot be altered in arrears. The appeal decision confirmed that the original decision to decline her application for reimbursement was correct and therefore the HSE continued to decline the application.

In addressing Joan's complaint with the HSE, my Office highlighted that Recommendation 4 of the HIQA guidelines, which the HSE was relying on, stated that "GP should address referrals in the first instance to a central point within a hospital, then to the relevant specialty/service, followed by named consultant if relevant". We also highlighted to the HSE that in previous correspondence from the HSE to our Office we were advised that "In certain circumstances at appeal stage representation from the GP in respect of omissions e.g. name of consultant or the speciality, will be considered and usually accepted."

On this basis, my Office requested that the HSE review its decision and the HSE then approved the reimbursement on a "strictly once off basis". In closing Joan's complaint to the HSE, the feedback from my Office highlighted Recommendation 17 of the report: "The Health Service

Executive, the ICGP, hospitals and GPs should develop processes to manage referrals that are of unacceptable quality while continuing to treat the patient accordingly and continuing to ensure that patients are not disadvantaged by poor quality referrals." It was noted that this recommendation puts an onus on the HSE, whether the treatment is in the State or abroad, to ensure that patients are not unfairly disadvantaged by poor quality referrals.

The feedback also found that the decision of the HSE to approve the application on a "strictly once off basis and may not be considered as precedent for any other case" to be subjective and that every applicant should be afforded the same basis for approval.

Original Invoice and Receipt

In order for the HSE to establish the level of reimbursement a patient may be entitled to, it needs to compare the amount paid by the patient for the treatment to the cost of providing the treatment in Ireland. To do this the HSE needs to be able to accurately identify the amount paid by the patient for the treatment abroad and for that purpose it requires a copy of the original invoice from the clinic and a receipt or proof of the actual payment. In my opinion, this is a perfectly reasonable request and a necessary part of the application process.

Unfortunately, my Office has seen a number of complaints where applicants to the CBD scheme are hampered by poor documentation from their treating clinic abroad. It is sometimes the case that the invoice/receipt simply lists the total paid for all services (e.g. including accommodation, travel/transfer costs, additional treatments/therapies) and does not provide a breakdown of the costs. This does not allow the HSE to actually identify the true cost of the treatment alone. This is an issue with the treating clinics and outside of the control of the HSE and it should be noted that in the cases I have seen the HSE has made efforts to assist the patients to rectify this matter. I have seen examples of the HSE pursuing the clinics for copies of the correct documentation and cases where the HSE has sought the assistance of the National Contact Point in the other country in order to assist the patient with obtaining satisfactory copies of documents.

I have seen several cases where poor documentation from the clinic abroad has caused significant delays with reimbursements. It is an issue that patients should be aware of when going for treatment abroad as it can add a layer of difficulty to the reimbursement process if the documentation supplied to the patient does not contain the information required by the HSE.

Case Study

Poor Documentation and Proof of Payment from Clinics Abroad

Paul was an obese teenage boy whose life was being severely impacted by his condition. In an effort to manage his condition he had tried dieting and various slimming programmes but none were successful. Paul's condition was causing him crippling anxiety. He was self-harming and he dropped out of secondary school. Paul's mother was extremely concerned for him and felt she was "losing her child before her eyes".

Paul's GP advised that if Paul was to seek treatment publicly in Ireland the wait could be 5 years or more. The potential cost of seeking the treatment privately in Ireland was over €20,000. Paul's mother could not afford to pay for the private treatment and, given Paul's condition, felt they could not wait for the treatment publicly. They decided the best option was to travel abroad for the treatment and seek reimbursement under the Cross Border Directive scheme. Following engagement with the clinic abroad, Paul travelled to Poland with his mother, where he had his initial consultation and the following day he was admitted for his surgery. Paul's mother paid €5,490 to the clinic.

When Paul's mother applied for reimbursement from the HSE she was advised that the amount on the invoice she submitted included the cost of airport transfers and B&B accommodation. Paul's mother reverted to the clinic seeking an itemised bill, which highlighted the actual cost of the treatment. The clinic abroad sent her several versions of the invoice. Two were undated versions of final invoices and one had handwritten amendments. Although all were stated as being for the treatment, they were for the same total as the incorrect invoice that included transfers and B&B accommodations.

Paul's mother had paid cash for the treatment and there was no receipt or proof of payment on the clinic's file. As a result of the contradictory information provided and the lack of proof of payment, the HSE declined the application for reimbursement.

When Paul's mother complained to this Office, it was acknowledged that there were discrepancies with the invoices provided by the clinic, including 'gross' figures being provided which included accommodation and other costs not associated with treatment. With the permission of Paul and his mother, my Office contacted the clinic directly and the clinic provided sufficient clarification of the cost of the actual treatment for the HSE to allow the application to progress. Paul's mother had also provided evidence of a credit union loan in her application. The Ombudsman was satisfied that the proof of the loan, together with evidence that the treatment was completed and the existence of a final invoice marked "paid in full", was sufficient to show that the balance had been paid. The HSE was asked to review its decision. It agreed to do so and following the review, it approved the application. Paul's mother was reimbursed €5,150 which was the cost of the treatment alone and excluded the transfer and accommodation costs.

There have also been a number of complaints to my Office concerning issues with the payment for treatments accessed abroad. These issues have included the source of the funding used by patients to pay for the treatment, e.g. loans, or the fact that patients have paid for the treatment in cash.

"I have to add it is hard enough to travel abroad twice once for a consultation and again for an operation which you should be able to get at home, but to then come home and have to deal with the stress of fighting to get back payment has made things very difficult and recovery harder than what needed to be."

The HSE website provides examples of what it accepts as proof of payment[26]

- proof of direct payment to the hospital abroad such as a bank or credit card statement
- cash register receipt[27]
- credit or debit card receipt
- copy of the electronic fund transfer (EFT) from your account to the account of the hospital abroad
- copy of the bank draft paid to the hospital abroad

Where a patient supplies a copy of one of these documents then the HSE should have no issues regarding proof of payment. As far as I am concerned that should be the end of the matter.

However, I have seen patients encounter difficulties where the HSE has queried the source of the funds used for the payment and that has impacted the application for reimbursement. I am not aware of any provision in the legislation that provides for the HSE to seek additional information about where the money came from. It is not uncommon for a patient to receive a loan from a family member and then pay for the treatment, sometimes in cash, and I have seen cases where the HSE has openly queried the source of the funds used to pay for the treatment. I do not believe the HSE has any need for this information or any basis on which to request it. It does not matter if the patient transferred the money from their own bank account, received a loan from a family member or simply took the money from years of savings at home. It is my opinion that if an applicant has provided the HSE with any of the proofs of payment listed by the HSE then there should be no further difficulties in relation to that issue.

The HSE has raised concerns about fraud and money laundering and if the HSE genuinely suspects that is the case it should report this to the proper authorities. In cases where the matter has been brought to the attention of the proper authorities I completely understand an application being delayed while that process is ongoing. However if the HSE does not have the grounds to bring the matter to the attention of the relevant authorities then it is my opinion that the application should be examined and processed as normal and the patient should not be left in any sort of limbo with the HSE neither making a decision nor reporting the issue to the relevant authority.

Finding 8: Proof of payment

It is my opinion that the HSE is seeking excessive documentation from patients in order to satisfy its proof of payment requirement. This practice is proving an unnecessary obstacle for patients who are seeking reimbursement under the Cross Border Directive scheme and I consider this to be maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

+ Recommendation 8: Proof of payment

A patient who provides any of the five examples of proof of payment that are listed on the HSE website should be deemed to have satisfied the proof of payment criteria that the HSE requires for reimbursement.

26 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/apply-for-repayment/
27 I believe the term "cash register receipt" to be outdated and would expect the HSE to treat this as any printed receipt from the treating clinic.

Proof of Travel

The HSE seeks proof of travel such as as plane tickets, toll receipts or petrol receipts when processing CBD applications. It is a basic component of CBD that the patient must travel to another EU/EEA country for the treatment and the HSE's position is that by requesting these documents it is simply asking for evidence of that travel. The Cross Border Directive scheme does not provide reimbursement for the cost of travel for treatment, which is borne by the applicant.

The HSE has assured me that these documents are not absolutely required, they are requested as they are a very simple way for someone to show that they have travelled. If the patient does not have documents such as these, the HSE has other ways, such as contacting the Hospital abroad directly, to confirm that the treatment was accessed abroad.

However the Pro Forma invoice which patients use to apply for reimbursement implies that these documents are absolutely required and that patients may not be reimbursed if they do not provide them.

> *"getting this procedure done was hard enough without being treated like a common criminal who's been treated like I'm telling lies and trying to catch me out with the truths of my operation etc. I was alone in a foreign country and flew home extremely ill and in pain"*

The checklist at the end of the application form begins by advising patients that "When submitting a claim for reimbursement of healthcare provided under the provisions of the Cross Border Directive scheme please ensure you include the following". The list that then follows includes "Proof of travel abroad e.g. flight/ferry tickets, accommodation receipts in patients/applicants name, toll/parking charges or a till receipt from a shop in the locality". Later in the document there is an actual tickbox checklist which asks patients "Have you included?" and then provides a list of documents to be checked off as included. As with the list earlier in the form it includes Proof of Travel such as "Flight/ferry tickets, accommodation receipts, toll/parking charges or a till receipt from a shop".

In my opinion it would appear to a patient reading the application form that those documents are absolutely required. Indeed there are times on the form where the HSE identifies documents as "optional but recommended" and the lack of such a qualifier in relation to the proof of travel requests further implies that they are not optional.

The HSE website also implies that the documents are an absolute requirement[28] . In a section titled "Documents you need to send" the HSE says that "You must send us your" followed by a list which includes "proof of travel such as a plane ticket receipt - this is to show you travelled abroad for your healthcare". The use of "need" and "must" clearly imply that the documents are absolute requirements.

I believe that by requiring these documents the HSE is creating a difficulty for patients seeking to access a reimbursement under the CBD. I am concerned that patients reading the application form may be discouraged from applying for reimbursements to which they may be entitled due to a lack of documentation which is not actually required. The information contained in all the supporting documentation (e.g. documents showing the dates of the outpatient appointment, dates of the surgery,

28 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/apply-for-repayment/ - accessed 19 January 2023.

payment receipt etc.) and the details of the clinic where the treatment took place should be enough to satisfy the HSE that the patient travelled in order to have the treatment. If the HSE is not satisfied by the contents of the file it has previously advised that it retained the option to contact the Hospital directly to verify that a patient actually travelled for the treatment and that option remains available.

As with the proof of payment issue discussed earlier, if the HSE has genuine concerns about money laundering or fraud in relation to an application then it should report this to the proper authorities. In those circumstances I completely understand an application being delayed while that process is ongoing. However this should be addressed in the individual cases in which these concerns arise and the HSE should not continue to ask all patients for documents such as toll receipts, ferry tickets etc.

Finding 9: Proof of travel

The HSE policy of asking all patients for proof of travel is excessive in the circumstances and in my opinion creates an obstacle for patients seeking to apply for reimbursement under the Cross Border Directive scheme. I believe this is maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 9: Proof of travel

The HSE should discontinue its practice of asking all patients seeking reimbursement under the Cross Border Directive scheme to provide documents such as "flight/ferry tickets, accommodation receipts in patients/applicants name, toll/parking charges or a till receipt from a shop in the locality" in order to prove they travelled for treatment. The HSE should also amend its website and application form to reflect this change.

III. Appeals process

Article 9(4) of the Directive says "Member States shall ensure that individual decisions regarding the use of cross-border healthcare and reimbursement of costs of healthcare incurred in another Member State are properly reasoned and subject, on a case-by-case basis, to review". Based on Article 9(4) the HSE has implemented an administrative appeals process wherein patients who are not happy with a decision of the CBD Office, in relation to the reimbursement of costs of healthcare incurred in another Member State, may appeal that decision. The general principles of fair procedures also require that an independent appeal is available to applicants.

When the CBD Office makes a decision in relation to an application for reimbursement it informs the complainant of the decision by letter. In that letter the HSE says that "this decision may be appealed" and that "appeals should be made to the A/Assistant National Director and must be received within two weeks (10 working days) from the date of this letter". The Assistant National Director referred to is the Acting Assistant National Director of the Commercial Unit (ANDCU). As mentioned previously, it is my understanding that the ANDCU position is currently occupied by the General Manager of the Commercial Unit.

Timeframe to Appeal

The HSE has advised my Office that if and when a patient requests an extension of time within which to appeal the decision of the CBD Office that an extension is granted "without exception". I have not had any complaints to my Office from patients who have been refused the opportunity to appeal on account of them being outside of the 10-day limit. I have however had complainants note that the timeframe within which to appeal is very short.

> *"Timeframe of Appeal to HSE is very, very short – 10 working days, when you have to collate documents it is not enough. For example, issuing copies of documents requested under the Freedom of Information Act gives the provider 20 working days. So the HSE presumes that we keep all the copies of everything. And that we are at home all the time? This is very unfair."*

It is also worth noting that the CBD Office communicates its decisions to patients by post. In those circumstances, the best-case scenario is that the patient will receive the decision the following day by which time they are already one day into the 10 days within which they can appeal. In other circumstances it may be two or more days before a patient receives notification of the decision which given the tight timeframe to appeal is far from ideal. There does not appear to be any option to receive a decision by email. In fact when my Office has specifically requested to receive replies to case queries by email the replies have continued to come by post.

> *"I have only received this letter in the post today (17th May), but it is in fact dated Friday 9th of May. This is challenging given that appeals must be made within 10 working days from the date of this letter. A week has already passed"*

While the HSE has been clear that, if sought, an extension will be granted without exception, this is not communicated to the patients either in the original decision letter or on the HSE website. In order to properly organise an appeal of a decision a patient needs time to understand and consider that decision. In CBD cases, an appeal may involve obtaining documents from clinics abroad and/or financial intuitions and these are not quick processes. It would appear to me to be entirely plausible that a patient who is refused reimbursement by the CBD Office may be deterred from appealing the decision due to the difficulty in organising this within the 10 working day time limit.

The HSE's National Appeals Service operates as part of the Quality Assurance and Verification team and provides an internal and impartial review of decisions relating to applications for specified services and entitlements. For some unknown reason, this does not include appeals of CBD decisions but does include a number of schemes with non-statutory appeals. The National Appeals Service advises that for most schemes patients have 21 days from the date of the decision in which to lodge the appeal. It appears to me that 21 days is a more reasonable amount of time to allow a patient to properly consider and prepare an appeal.

Finding 10: Time to appeal

The current 10 day time frame to appeal a decision of the Cross Border Directive Office is inappropriately short and may deter patients from appealing decisions. I consider the failure to provide a sufficient length of time to appeal is an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 10: Time to appeal

The time to appeal a decision of the CBD Office should be extended to at least 21 days and patients should be informed in the decision letter of how they can request an extension of time to appeal if appropriate. This change should take place as soon as possible and by the end of Quarter 3 of 2023 at the latest.

Appeals of Diagnosis Related Grouping Code Decisions

In order to calculate the amount of reimbursement a patient may be entitled to under CBD the HSE must know the cost of that treatment in Ireland. In Ireland the cost of a treatment is identified based on what is known as a Diagnosis Related Grouping (DRG) Codes. There is more detailed information on DRG codes and how they are calculated in Appendix 3. My Office has seen a number of complaints from patients who have been successful in receiving a CBD reimbursement from the HSE but who are disappointed by the level of that reimbursement. In the majority of cases, that disappointment occurs as the patient has been reimbursed under a different DRG code than they had hoped or expected. When the HSE receives an application for reimbursement it usually sends the matter to the Health Pricing Office (HPO) in the HSE for coding by a trained coder[29]. The level of reimbursement is then based on that coding. The CBD office does not have the expertise to code medical procedures and therefore I believe it is appropriate that it sends queries to the trained coders to produce appropriate DRG codes.

However when a complainant is unhappy with the reimbursement and they query the DRG code in an appeal, the HSE simply relies on the original coding and explains that the matter was sent to the HPO and therefore the code is appropriate. The HSE has stated that coding is essentially a "black box process" and the outcome will always be the same when the inputs are the same. It feels that sending a matter for recoding would simply mean a different coder entering the same information and therefore the result simply cannot change. For that reason, the HSE is not prepared to assume additional costs when the result cannot change.

I accept the position that the coding software will not produce a different DRG code when presented with the same inputs. However the HSE has been clear that as part of the process the coder reviews the information on the application form and medical records and determines the principal diagnosis, additional diagnosis and procedures (if relevant). The process is not entirely automated, there is a human element to the process and therefore there is always the possibility that errors may occur when a human interprets the information on the application and file.

29 Not in the case of standard applications e.g. cataracts

At the moment the HSE is simply re-explaining its original decision and I do not believe that constitutes an actual appeal. Where there is a disagreement about DRG codes, I believe the file should be sent for re-coding in the same way that when a difference of opinion over medical issues exists an opinion from a separate medical expert is requested at appeal stage. It is possible that a coder may have made a mistake and, even if such a scenario is rare, having the treatment re-coded would provide an additional layer of certainty and some reassurance to patients that the code is in fact correct.

Finding 11: Diagnosis Related Grouping Code appeals

Appeals related to Diagnosis Related Grouping codes do not provide for the Health Pricing Office of the HSE to recode or check the original assigned code. In my opinion such appeals are not meaningful if the treatment is not sent to have the coding checked and confirmed by the Health Pricing Office. I consider the failure to double check the coding of a treatment on appeal to be an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 11: Diagnosis Related Grouping Code appeals

All Diagnosis Related Grouping appeals should be sent to the Health Pricing Office to be checked and confirmed. This change should take place as soon as possible and by the end of Quarter 3 of 2023 at the latest.

Need for an Independent Appeals Process

An effective appeals structure in any system should offer applicants a right to have the basis for a decision considered in an informed, impartial, meaningful and fair manner. With CBD scheme decisions, the person charged with making appeal decisions is the Appeals Officer. The Appeals Officer is the Assistant National Director of the Commercial Unit (ANDCU). As well as acting as the Appeals Officer, according to the HSE organisational chart the ANDCU is also the General Manager of the Commercial Unit and has direct management responsibility for the CBD Office.

The role of the ANDCU includes setting the policy for the CBD Office and dealing with any queries on those policies and their implementation that may come from the CBD Office. By way of example, when the issue with the UK pensions arose in 2019 it was the ANDCU who liaised with the Department of Health and the European Commission (DG Santé) to establish how the CBD Office would deal with these complaints. When the resulting policy was implemented by the CBD Office, all appeals on the subject went to the ANDCU. I do not believe it is possible to describe the ANDCU as an independent appeals officer in those circumstances.

The fact that the role of the ANDCU includes management responsibility for the CBD Office means that they are obviously entwined with the CBD Office. On the day that the investigations team visited the CBD Offices in Kilkenny, the Office staff took any requests for files or copy documents from the investigations team to the ANDCU before releasing them. The ANDCU has appeared in front of

Oireachtas and Seanad committees and spoken in the national media in relation to their responsibility for the operation of cross border schemes. They have also spoken at the Annual General Meeting of the ICGP about the operation of cross border schemes. It is clear to me that the ANDCU has an influence on the day-to-day operations of the CBD Office, it is a fundamental part of the job. A truly independent appeals officer would have no involvement in the cases before they are appealed or in the management of the Office in which the original decisions are made.

Finding 12: Independent CBD appeals process

I do not believe the appeals process as currently constructed is truly independent of the Cross Border Directive Office. I consider the absence of an independent appeal to be an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

+ Recommendation 12: Independent CBD appeals process

The appeals process should be entirely separate from the CBD Office and not within the remit of the management of the CBD Office. The HSE should move the entire appeals process to its National Appeals Service by the end of 2023.

Signposting in Appeal Decision Letters

In its appeal decision letters the HSE informs complainants that they "have the right to make a complaint to the Office of Ombudsman, 6 Earlsfort Terrace, Dublin 2". There are a number of ways other than by post that a complainant may bring a matter to my Office but the decision letter does not contain any additional or alternative contact information or explanation of the role of my Office.

In August 2022 my Office wrote to the HSE's Quality Assurance and Verification Division reminding it that Section 4A of the Ombudsman Act 1980 (as amended) places an obligation on bodies to provide information on rights of appeal or review, including their right to complain to the Ombudsman. It then asked the HSE to amend its closing letters to improve the signposting to my Office. However, that change has not been made in CBD cases and the letters continue to simply provide a postal address for my Office.

Finding 13: Signposting to the Ombudsman

The decision letters from the Appeals Officer contain limited information regarding a complainant's right to bring a complaint to my Office and how they may do so. I consider the lack of detail being provided to patients on this matter is contrary to fair and sound administration and as such amounts to maladministration under section 4(2)(b)(viii) of the Ombudsman Act 1980 (as amended).

+ Recommendation 13: Signposting to the Ombudsman

The HSE should amend its appeal decision letters to include the following paragraph.

"If you remain unhappy with our response then you can refer your complaint to the Office of the Ombudsman.

The Ombudsman is fair, independent, and free to use. The Ombudsman will ask you for details of your complaint and a copy of this letter/email (our final response to your complaint). The best way to contact the Ombudsman is by:

- Clicking on the 'Make A Complaint' link at www.ombudsman.ie
- Writing to: Office of the Ombudsman, 6 Earlsfort Terrace, Dublin 2, D02 W773
- Calling the Ombudsman on 01 639 5600 if you have any queries."

This change should take place as soon as possible and by the end of Quarter 3 of 2023 at the latest.

IV. Communication

As set out at beginning of Chapter 1, the HSE as the National Contact Point in Ireland has a number of statutory obligations:

1. To ensure the accessibility of information on the scheme, including information for healthcare providers and information on patients' rights and complaints procedures.
2. To cooperate with National Contact Points in other Member States.
3. To reimburse patients entitled to such reimbursement under the Directive and Regulations.
4. To identify specific treatments that will require Prior Authorisation.

These obligations are all either specifically about communication or require good communication in order for them to be implemented effectively. It is simply not possible for the HSE to properly fulfil its obligations as National Contact Point without effective communications with all the individuals and professions it interacts with.

In order to assist National Contact Points when performing their functions under the CBD and to provide patients with information on their rights, the EU Commission developed a suite of guiding documents referred to as "a toolbox". The toolbox can be accessed on the Commission website[30] and part of its aim is to highlight how National Contact Points can improve their communication with patients, providing them with clear and accessible information on all aspects of accessing medical treatment abroad.

Additionally, in 2018, the document "Guiding Principles and Indicators for the practice of NCPs" was developed and can also be found on the Commission website[31]. This document sets out the key principles for good National Contact Point services, in line with National Contact Points obligations under Directive 2011/24/EU. The Guiding Principles are designed to assist National Contact Points in their daily public task of providing clear and accurate information on the main aspects of cross-border healthcare. The principles aim to contribute to a National Contact Point practice that is (1) more uniform, (2) of high quality, and (3) always patient oriented.

30 https://health.ec.europa.eu/cross-border-healthcare/toolbox-cross-border-healthcare_en - accessed 17 January 2023
31 https://health.ec.europa.eu/system/files/2019-12/2019_ncptoolbox_ncp_guiding_principles_crossborder_en_0.pdf - accessed 17 January 2023

These tools and documents are valuable resources for National Contact Points and ones that I am sure the HSE is aware of. The reason I am drawing attention to them is to highlight the emphasis that the EU Commission rightly places on a National Contact Point's ability and willingness to communicate with relevant parties and the National Contact Point's absolutely central role in contributing to the effective administration of the Cross Border Directive scheme.

Outside of its specific responsibilities as the National Contact Point, the HSE has general responsibilities as a public body. In order to ensure that as many patients as necessary can access treatment abroad, through the CBD and other schemes, the HSE has a duty to make all the information it possibly can available.

This would be in line with the commitments set out in the HSE Corporate Plan 2020-24[32]. On page 16 of this plan, the HSE notes "effective communication and engagement is fundamental to how we manage, deliver and improve our services" and commits to communicate openly and effectively to build confidence in the health services.

Therefore, in administering the CBD scheme the guiding principle should always be to publish as much information as possible and to interpret any duties imposed by legislation regarding its role as National Contact Point widely rather than narrowly. This would better demonstrate the spirit of the directive for National Contact Points to be a gateway rather than gatekeeper to accessing health services within the EU/EEA. With this in mind, I strongly believe that the HSE should be providing every assistance to patients possible this should include providing full information, in their role as National Contact Point.

Communicating only with "eligible people"

In its communications with my investigations team, the HSE repeatedly stated that its obligations in relation to provision of information extended only as far as providing information to "eligible" patients. The HSE's position was that if a patient is not eligible to apply for reimbursement from the HSE, or is unsure of their eligibility, then the HSE has no obligation or responsibility for providing that patient with information on the scheme. This is a most peculiar position adopted by the HSE.

The Directive clearly recognises that it would be very difficult for patients to exercise their rights under the Directive without adequate information. Article 5(b) puts an obligation on the Member State of Affiliation to provide information to patients on their rights and entitlements to cross border healthcare, in particular in relation to the terms and conditions for reimbursement and for any appeal or redress procedure. Article 6(4) then puts that responsibility on the National Contact Point within the Member State of Affiliation. In Ireland, that means the responsibility lies with the HSE[33]

I understand that in order to identify the appropriate Member State of Affiliation a patient would have to establish their eligibility for the CBD scheme. Therefore, an EU/EEA state can only be a Member State of Affiliation for patients who have established their eligibility to apply for CBD reimbursements in that country. The HSE's position is that it's responsibilities only kick in once a patient has established their eligibility to apply to the HSE and the HSE has no obligation or responsibility to patients who are unsure of their eligibility in the State or are seeking to ascertain it.

Section 6 of SI 203/2014 sets out in domestic legislation the obligations of the HSE in relation to providing information on cross border healthcare in other Member States. It sets out the topics that the HSE must provide information on and the obligations or otherwise to do so. One of the topics is "the

32 (https://www.hse.ie/eng/services/publications/corporate/hse-corporate-plan-2021-24.pdf - accessed 17 January 2023)
33 Section 4 of S.I. No. 203/2014 - European Union (Application of Patients' Rights in Cross-Border Healthcare) Regulations 2014.

rights and entitlements of patients resident in the State to receive healthcare in another Member State". The same section says that the HSE's responsibility to provide information is "in so far as it considers it is necessary or desirable for the purposes of enabling patients resident in the State to exercise their rights in relation to access to cross-border healthcare in other Member States". It would appear from the approach that the HSE is taking that the "necessary" element of that statement covers the HSE's obligations under Article 5(b) of 2011/24/EU.

> *"In my opinion, the HSE have done nothing to assist me in successfully claiming the reimbursement, rather my claim has been continually thwarted by their failure to accept documentary evidence, third party confirmation, or my own statements. Other than one email from the HSE to the treating clinic, no other assistance or support has been forthcoming. Any correspondence from the HSE has been confusing, contradictory, and appears to have been 'copied and pasted' each time"*

However, the SI extends the HSE's remit beyond doing simply what it is obliged to do. It also includes what it is desirable to do. In my opinion, this simply must cover the provision of information for patients resident in the State who are seeking to establish their eligibility to apply for CBD reimbursements through the HSE. To think otherwise would be to promote a situation whereby patients who are unsure of their eligibility have no state body to turn to for assistance. As I have said at several points throughout this report, the legislation governing the CBD is extremely complicated and to say that patients are left to themselves until such time as they can establish their own eligibility is simply absurd.

Finding 14: National Contact Point engagement with patients

National Contact Points have a responsibility to assist patients resident in the State who are seeking to understand their rights and entitlements to receive healthcare in another Member State. I do not believe the HSE's position that it only provides information for "eligible" patients is in keeping with the role of a National Contact Point in particular, or the role of a public body in general, when it interacts with members of the public. I consider the failure to adequately assist patients who are seeking assistance establishing their entitlements to be an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

+ Recommendation 14: National Contact Point engagement with patients

The HSE should expand the level of provision of information to patients about their rights and entitlements under CBD. The HSE must change its approach of limiting itself to providing information exclusively to "eligible people" and should assist all patients who are seeking assistance establishing their entitlements.

Information available to the general public

There are a number of aspects to the HSE's communication with the public that concern me. In general, these can all be summed up as a failure to provide the public with accurate information regarding the CBD Scheme and how the HSE administers it.

The first of these issues that was brought to my attention is no longer ongoing but highlights my concerns. Up until June 2019, the HSE's website and information in relation to CBD said that outpatient appointments must take place prior to admission/treatment. The ordinary meaning of prior is simply before in time. However, the HSE was administering the scheme differently and required the outpatient appointment to take place on a date prior to admission/treatment. This is a clear example of the HSE providing information to the public that was not in keeping with the reality of how the HSE administered the Scheme. It should be acknowledged that when my Office highlighted the issue to the HSE, it changed the wording on its website. While this improved the situation for those accessing information after this change, it did not acknowledge or remedy the situation for those already impacted. This is a reoccurring issue in our engagement with the HSE on the provision of accurate information on its website and forms.

As a result, my Office received complaints wherein patients relied on the information provided by the HSE as the public body with responsibility to provide information on the scheme. Those patients then had their applications for reimbursement rejected by that same body as it was administering the scheme in a different manner to the information it was publically providing.

> *"This is really cruel. It makes it impossible for us to plan financially for months, leaves us in financial distress while recovering from surgery, and in addition it leads us to making the original financial decisions based on incomplete, inaccessible, information"*

The lack of accurate information continues today. At the time of writing the HSE's website[34] says that "prior authorisation is only required for inpatient care". This is incorrect as Prior Authorisation is only required for one specified treatment, Enzyme Replacement Therapy. It adds that "not securing prior authorisation may not of itself preclude a claim for reimbursement being processed" which implies that Prior Authorisation is the norm when in fact the HSE has never received an actual Prior Authorisation application which could only be for Enzyme Replacement Therapy as stated above.

The same page then makes references to prior approval which is not a term under the regulations and could be interpreted as either Prior Authorisation or Prior Notification. The page then again makes inaccurate statements about prior "approval" saying that "Prior approval will be required for all hospital care involving overnight accommodation" when this is simply not correct. Prior Authorisation applies to one treatment only and Prior Notification is optional but recommended for care involving overnight stays. Finally, under the "Terms and conditions for reimbursement of costs" the website again states that in order to be entitled to reimbursement you must have Prior Authorisation if the healthcare involved an overnight stay. This is simply inaccurate information being provided to the public by the HSE. I have concentrated on highlighting the issues on this one particular page but there are also other pages on the HSE's website which display similarly inaccurate information[35].

34 https://www.hse.ie/eng/services/list/1/schemes/cross-border-directive/appreimbursement/ - accessed 17 January 2023
35 https://www.hse.ie/eng/services/list/1/schemes/cross-border-directive/faqs/ - accessed 17 January 2023

The EU Commission "Guiding Principles and Indicators for the practice of NCPs" document is very clear about its belief that "NCPs have an accessible website that is informative and contains clear, structured and understandable information." Unfortunately, on various pages and in relation to various topics, the HSE website contains vague statements and uses inaccurate terms which are of no assistance and only serve to further muddy the waters around this already complicated scheme.

The HSE website also contains links to the DRG codes ready reckoner to provide patients with an idea of the reimbursement they may receive, based on the proposed treatment. Making this information available allows the patient to understand the likely difference between cost of the proposed treatment and the available reimbursement. The patient can then use that information to make an informed decision of the financial impact accessing the treatment through CBD may have on them. Unfortunately, the HSE website displays at least three different versions of the ready reckoners.

On what appears to be the HSE's most recently updated page[36] there are ready reckoners for day and inpatient cases that are current and identified as such. There are also ready reckoners that directly proceeded the current updated versions available for patients that had their treatments prior to the update. Both these ready reckoners are clearly labelled and I would consider them to be very useful for patients who are engaging with the CBD process.

However there are two other pages on the HSE website[37] that provide information on the CBD that contain links to what appear to be outdated DRG code ready reckoners. Furthermore if you Google "CBD DRG code ready reckoners" the very first search result links to an undated pdf of an outdated ready reckoner on the HSE website[38].

It is perfectly reasonable to believe that any patient accessing any of those ready reckoners would believe them to be current and accurate and use them as a consideration in their decision making process.

As I have already addressed in this report, the information and support available to patients in receipt of an EU/EEA income or pension is sorely lacking on both the HSE website and on the CBD application form. While it has improved slightly since the issue came to light in 2019 it is still nowhere close to sufficient to help a patient navigate such a complicated area.

On the CBD application form there is also an issue with the checklist that is designed to ensure patients applications are complete when sent to the HSE. That checklist asks the patient to make sure that their referral letter is "to a named consultant abroad" and "addressed to the treating hospital abroad". However it is the stated practice of the HSE that neither of these are requirements. The HSE does not require the referral letter to be addressed to a named consultant and it allows for a referral letter to be to a different hospital to where treatment is received as long as the letter is addressed to the correct speciality. While the HSE may prefer that a referral letter is "to a named consultant abroad" and "addressed to the treating hospital abroad" they are not requirements and listing them as such on the checklist may lead to confusion for patients and may even deter some patients from engaging with the scheme.

https://www.hse.ie/eng/services/list/1/schemes/cross-border-directive/cbd.html - accessed 17 January 2023
https://www.hse.ie/eng/services/list/1/schemes/cross-border-directive/acchealthcareabroad/ - accessed 17 January 2023
36 https://www2.hse.ie/services/schemes-allowances/cross-border-directive/apply-for-repayment/ - accessed 18 November 2022
37 https://www.hse.ie/eng/services/list/1/schemes/cross-border-directive/cbd.html - accessed 18 November 2022 and https://www.hse.ie/eng/services/list/1/schemes/cross-border-directive/appreimbursement/ - accessed 18 November 2022
38 https://assets.hse.ie/media/documents/cross-border-directive-ready-reckoner_VB4b6lm.pdf - accessed 18 November 2022

Finding 15: HSE Website

The HSE's website contains several instances of inaccurate, outdated and vague information. It is also lacking in information in relation to crucial issues, such as patients who are in receipt of income from other EU/EEA countries. There are similar issues with the CBD application form albeit to a lesser extent. I consider the inclusion of inaccurate, outdated and vague information on the HSE website is the result of negligence or carelessness and as such amounts to maladministration under section 4(2)(b)(iii) of the Ombudsman Act 1980 (as amended).

+ Recommendation 15: HSE Website

By the end of Quarter 3 of 2023 the HSE should review the content of its website and application form to remove all inaccurate information related to the scheme. It should seek to ensure the website and application form provide all the information patients need to make an informed decision about engaging with CBD. All information related to CBD should be centralised and not spread out over several different webpages which provide inconsistent versions of the same information.

The use of the terms Prior Authorisation v Prior Notification

Up until mid-2022 the HSE had been using the term Prior Authorisation for both Prior Authorisation and Prior Notification applications. Prior Authorisation and Prior Notification have clear and specific meanings under the legislation and to call all pre reimbursement applications Prior Authorisation is clearly incorrect. However, it appears to me that the use of Prior Authorisation when it should have been Prior Notification was a terminology issue.

The HSE processing of applications and documentation provided to patients clearly shows that the applications that were in fact for Prior Notification but were made on forms titled "Prior Authorisation" were always treated as Prior Notification applications and processed in accordance with the applicable rules. The letters that were sent to the patients when they were granted the mistitled "Prior Authorisation" were very clear about what they were being granted at that time. It explained, "this prior authorisation [sic] is in respect of the treatment as proposed in that your application has demonstrated compliance with the public patient pathways".

The European Commission document titled "Data on cross-border patient healthcare following Directive 2011/24/EU"[39] for the year 2020 records that "A system for prior notification concerning requests for healthcare not subject to prior authorisation" is implemented by a number of countries including Ireland.

It says the objective of such a prior notification is to allow a patient to receive a written statement of the amount to be reimbursed based on an estimate. This is an optional element and has been adopted by some countries to support patients who may wish to have greater clarity on the costs they might incur. The document goes on to clarify that the Prior Notification system may apply for any type of care or treatment, whereas Prior Authorisation can only be applied to only certain types of care.

39 https://health.ec.europa.eu/system/files/2021-12/2020_msdata_en.pdf - accessed 17 January 2023

While the document recognises that what Ireland has in place is a Prior Notification system, it also recognises that it has been naming it incorrectly. The report records that "IE has what they call an optional prior authorisation system in place, which could be argued as being in line with the requirements of a voluntary prior notification system according to Article 9(5) of Directive 2011/24/EU".

Since mid-2022 the HSE has amended the terminology and all Prior Notification application forms are now correctly titled. However there is in fact a CBD application form still available on the HSE website which continues to refer to Prior Authorisation when it actually means Prior Notification[40]. I think it is important to highlight this issue as it provides yet another example of the lack of clear and accurate information being provided to patients by the HSE.

Communicating with patients

I am struck by the comments that complainants have made to my Office in relation to their interaction with the HSE on matters related to their applications for reimbursement. Quotes from complainants are peppered through this report to illustrate the deep distress that many people, and their families, have had to endure as part of this process.

Many applicants complained about how shocked and upset they were that the HSE simply did not fully consider their circumstances or provide them with any assistance to rectify matters that were outside their control. At the heart of any application that the HSE receives, is a person who is in serious need of care that is not being provided in a timely manner in Ireland. In one complaint to my office a complainant received a letter informing them that the wait for their initial consultation in Ireland would be 4 years. It can be very stressful for patients who are forced to seek medical care abroad. To have to deal with a reimbursement scheme administered by the HSE that does not appear to take an empathetic approach to their circumstances, compounds the huge stress they face. The HSE core values of care, compassion, trust and learning are not just important words. They should be reflected in all their interactions with patients. It is clear from the comments made by complainants to my Office that these patients did not feel they were treated with trust or compassion.

On a further note, in correspondence to my Office of 15 February 2022 the HSE stated that "Even if it was to be presumed that a patient who lives in Ireland did not understand the information provided by the HSE, which we do not accept, it must be presumed that such a patient must have effectively lived in a healthcare vacuum throughout his/her life." This statement by the HSE demonstrates to me that in relation to the operation of these schemes the HSE is either uncaring or unaware of the difficulties patients are having in negotiating the schemes. I am of the view that this language does not reflect a HSE that is practising their core values and focusing on delivering a patient focused service.

Communications with clinicians

Section 8(b) of SI 203 of 2014 says that "In so far as it considers it is appropriate for the purposes of giving effect to the Directive, including giving effect to the measures implementing the Directive in these Regulations, the Health Service Executive shall consult with…such healthcare providers or organisations representing healthcare providers as it considers appropriate".

Likewise, the EU Guidance document "Guiding Principles and Indicators for the practice of NCPs" says that National Contact Points should provide healthcare providers with information on patients' rights

40 https://assets.hse.ie/media/documents/cross-border-directive-pro-forma-invoice_nJaKIw5.pdf - accessed 17 January 2023

and entitlements in cross-border health services under Directive 2011/24/EU and the Social Security Regulations. A key indicator of this is that National Contact Points try to be engaged in campaigns to inform the general public of their existence. Examples of these that are provided include participation in conferences or events of patient organisations, healthcare providers or other stakeholders.

In meetings with the investigation team the HSE stated that it has spoken at ICGP Conferences, at Winter Meetings and at local forum meetings, it also stated that it has published articles in Forum, the ICGP journal. However, the HSE was clear that it could only do these things at the request of the ICGP and essentially had to wait to be asked. The HSE does not proactively seek to promote the scheme or interact with healthcare providers or their representatives in order to keep them informed on the operation of the scheme or developments in the area.

When discussing the pension's issue that has been prominent throughout this report the HSE confirmed that when the issue became apparent it did not contact the ICGP at all to inform it of the possible effect on patients. The reason it gave for this was that a patient's GP may not be aware of the patient's eligibility status under the Directive. This may well be true but it appears to me to be a wholly unsatisfactory explanation. GPs are at the coalface of CBD applications, they are interacting with patients and they are usually the ones directing them towards the CBD. They need to be informed by the HSE about important developments. It would be extremely beneficial to a patient being referred for cross border treatment by their GP if they were informed there and then by that same GP that having a pension from abroad is an extremely important issue and they should be aware of it before moving forward with this process. The HSE's position that the GP would not be able to advise a patient of their entitlements is correct, I have already discussed how difficult it is to unpack the regulations and establish entitlements when pensions are involved. However, nobody is expecting the GP to be able to establish the patients' entitlements but to simply be informed enough to bring the possible issue to the attention of the patient.

In the course of this investigation, my investigation team spoke to a GP operating near to the border between Ireland and Northern Ireland. He informed my Office that he had not been provided with any information on cross border referrals. He said patients were coming to him with criteria from Facebook support sites or Northern Ireland hospitals. It is my view that patients receiving information from these sources is far from ideal and comes with a significant risk of misinformation. The HSE should be doing everything in its power to put GPs and any healthcare providers interacting with patients in a position to fully inform those patients of their rights under CBD and any issues they may need to consider before engaging with CBD.

Finding 16: National Contact Point engagement with healthcare providers

The HSE, as National Contact Point in Ireland, is not fulfilling its role in relation to the provision of information to healthcare providers. The HSE appears to engage with healthcare providers in a reactive rather than a proactive manner. I consider that the passive nature of the HSE's interactions with healthcare providers is not in keeping with its role and as such is an undesirable administrative practice and amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

+ Recommendation 16: National Contact Point engagement with healthcare providers

The HSE needs to put in place a plan to proactively engage with clinicians and their representative bodies, specifically GPs given their importance to the CBD pathway, in order to ensure they are fully aware of patients' rights under CBD and the issues that may affect those rights.

Chapter 3

The Northern Ireland Planned Healthcare Scheme

On 31 January 2020, the UK left the European Union. As a result, from 01 January 2021 the CBD no longer applied to the UK and Irish patients could no longer apply for a reimbursement of the cost of treatment received in the UK. In order to mitigate the loss of access to care from private providers in Northern Ireland under the CBD, the Minister for Health introduced the Northern Ireland Planned Healthcare Scheme (NIPHS). NIPHS began operating on 01 January 2021.

Similarly, to CBD, NIPHS allows people resident in the State to access and be reimbursed for private healthcare in Northern Ireland by the HSE, provided such healthcare is publicly available within Ireland. Such healthcare will be reimbursed at the cost of providing that treatment in the State or the cost paid for the treatment in Northern Ireland, whichever is the lesser. There is no equivalent scheme for the rest of the UK.

The NIPHS was set up on an administrative basis by the Minister for Health, who has since indicated that plans are underway to place this scheme on a statutory basis. As of the date of the publication of this report no General Scheme has been published for this planned legislation.

In 2021, the first year of NIPHS, there were 2,233 applications under NIPHS and 2,381 under CBD. However due to the transitional period, 75% of all CBD reimbursements processed in 2021 actually related to treatments that were received in Northern Ireland[41]. It is clear from the demographics of previous CBD applications that NIPHS will now become the predominant scheme for patients seeking treatment abroad and it is therefore vital that any issues arising can be ironed out at the earliest possible stage.

Terms and Conditions of the Scheme

At present, the operation of the scheme is based upon a Department of Health produced document titled "Guidance on the NI Planned Healthcare Scheme for HSE". The document is short, with just over five pages of information. It does not appear to be available publically so any patients who wish to access the NIPHS cannot access the actual document which sets out the terms of the scheme. From reading the document, it appears to me, although it is never expressly stated, that the NIPHS is to be administered in line with the administration of the CBD.

41 All figures provided to the Ombudsman by the HSE.

Unfortunately, the lack of detail in the guidance document leaves a lot of questions unanswered. Is it the case that the document envisages the NIPHS being administered in line with the CBD? If so, what does that mean for the development of NIPHS? Will it change in line with developments in CBD? Will it follow any European Court of Justice cases that develop the CBD? Or is it the case that the NIPHS is administered in line with the CBD at a particular moment in time, that is 31 January 2020? The guidance document does not contain sufficient detail to deal with questions such as these and the lack of clarity within the document risks causing confusion and disputes in the future.

Finding 17: Terms and Conditions of the NIPHS

The "Guidance on the NI Planned Healthcare Scheme for HSE" lacks detail and is not a complete set of terms and conditions. Decisions in relation to the Scheme appear to be based on incomplete information and this amounts to maladministration under section 4(2)(b)(iv) of the Ombudsman Act 1980 (as amended).

+ Recommendation 17: Terms and Conditions of the NIPHS

The Northern Ireland Planned Healthcare Scheme should be put on a legislative footing as soon as possible. In the meantime, there should be clear terms and conditions of the scheme that are publicly accessible. All recommendations made in this report in relation to the administration of the Cross Border Directive scheme should also be applied to the Northern Ireland Planned Healthcare Scheme.

Prior Authorisation and Prior Notification

As discussed above, it is not clear if the NIPHS is being administered in line with CBD and therefore also developing in line with CBD. In mid-2022 the HSE stopped using Prior Authorisation for pre reimbursement CBD applications that were not related to Enzyme Replacement Therapy. The change of terminology was necessary to bring the HSE in line with the terminology used in EU Legislation. However, the NIPHS guidance only refers to Prior Authorisation. It is not clear what Prior Authorisation is, as it is not properly described in the guidance document. Prior Authorisation appears to be entirely optional unlike CBD where some procedures, only ERT at this time, require Prior Authorisation. The NIPHS procedure is a divergence from the CBD and appears to be in line with how the HSE was administering the CBD when the NIPHS was created. The HSE continues to only use the term Prior Authorisation when dealing with NIPHS cases leading to a disconnect between the two schemes. It is not clear if this disconnect was intentional which again highlights the lack of clarity in the guidance document and the potential for confusion and disputes in the future.

Finding 18: Prior authorisation in the NIPHS

The Prior Authorisation aspect of the Northern Ireland Planned Healthcare Scheme is poorly explained and the failure to change the terminology in the Northern Ireland Planned Healthcare Scheme when the terminology was changed in Cross Border Directive scheme will inevitably cause confusion for patients. I consider having different procedures for two schemes which are apparently meant to be administered the same way to be an undesirable administrative practice and amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 18: Prior Authorisation in the NIPHS

In order to ensure a consistency for patients, the Department of Health should consider bringing the Prior Authorisation procedure in the Northern Ireland Planned Healthcare Scheme in line with the Prior Notification and Prior Authorisation procedure in the Cross Border Directive scheme when the Northern Ireland Planned Healthcare Scheme legislation is being drafted.

Pensions Issue

As detailed throughout this reports discussion of the CBD Scheme, patients in receipt of pensions from other EU/EEA states have faced, and continue to face, great difficulty in establishing where their entitlement to apply for reimbursement lies. Fortunately, the NIPHS has avoided this problem by putting eligibility for NIPHS on the same basis as eligibility for accessing public health care in Ireland. That means that anyone who is ordinarily resident in Ireland is entitled to seek reimbursement under the NIPHS regardless of any pensions they may be in receipt of from outside of Ireland. This is a most welcome development and ensures that it is actually possible for a patient to easily understand the very first test of their eligibility for NIPHS.

Finding 19: NIPHS residency requirement

The eligibility requirement for the Northern Ireland Planned Healthcare Scheme that a person simply be ordinarily resident in the State is clear and removes a layer of difficulty that patients seeking reimbursement under the Cross Border Directive scheme are faced with.

✚ Recommendation 19: NIPHS residency requirement

The impact of patients being in receipt of EU/EEA pensions on the CBD and the benefit of its exclusion from NIPHS should be noted by the Department of Health and borne in mind when the Northern Ireland Planned Healthcare Scheme legislation is being drafted.

Proof of Travel

In the previous chapter I recommended that the HSE discontinue its practice of asking all patients seeking reimbursement under the Cross Border Directive scheme to provide documents such as "flight/ferry tickets, accommodation receipts in patients/applicants name, toll/parking charges or a till receipt from a shop in the locality" in order to prove they travelled for treatment. I have also recommended in this chapter that "All recommendations made in this report in relation to the Cross Border Directive scheme should also be applied to the Northern Ireland Planned Healthcare Scheme".

However I do want to further highlight this issue again in relation to NIPHS as it has mainly come to my attention in CBD cases, pre Brexit, where patients travelled to Northern Ireland for treatment. Often in these cases, patients may drive to the hospital and would not have proof of travel such as a plane/train/boat ticket. If the procedure was a day case the patient may not have had an overnight stay and simply driven, or been driven, home on the same day. In those circumstances, the HSE was seeking a copy of a toll receipt, a receipt for petrol or a purchase in a shop in Northern Ireland etc. as proof of travel. It

was not always clear to patients why documents such as these are being requested and was often seen as excessive. As discussed in relation to CBD, it may also appear to patients that these documents are absolutely required and a reimbursement will be refused without them.

I am noting the issue as the NIPHS solely concerns patients that travel to Northern Ireland for treatment and the Department of Health as owners of NIPHS and the NIPHS Office as administrators may wish to include specific directions in relation to proof of travel when the Northern Ireland Planned Healthcare Scheme legislation is being drafted.

NIPHS Appeals

In the first recommendation in this chapter I said that any recommendations made in this report in relation to the CBD that also apply to the NIPHS should also be implemented in that scheme. That includes the recommendations that the time to appeal is extended, that DRG codes are recoded on appeal and that decision letters are amended. It also includes the recommendation that the appeals process be moved in its entirety to the HSE's National Appeals Service. However, I feel it is important to make this recommendation again, separately and distinctly in relation to NIPHS. The reason for that is due to the fact that my predecessor made a similar recommendation in the 2018 TAS report which in my opinion, as I will discuss in the next chapter, has not been satisfactorily implemented.

Finding 20: Independent NIPHS Appeal

I do not believe the appeals process as currently constructed is truly independent of the Northern Ireland Planned Healthcare Scheme Office. I consider the absence of an independent appeal to be an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 20: Independent NIPHS Appeal

The appeals process should be entirely separate from the NIPHS Office and not within the remit of the management of the Northern Ireland Planned Healthcare Scheme Office. The HSE should move the entire appeals process to its National Appeals Service. This change should take place as soon as possible and by the end of 2023 at the latest.

Chapter 4

The Treatment Abroad Scheme

The Treatment Abroad Scheme (TAS) was introduced to ensure that all EU/EEA patients, including Irish patients, have access to the same level of medical expertise and treatments regardless of their state of residence. Where treatments and remedies they need are available in the EU/EEA, but not in Ireland, (or not available within a reasonable time-frame) Irish patients may apply for funding under the TAS to travel for the treatment.

In January 2018 my predecessor published an investigation report titled Treatment Abroad. The report was an investigation into the administration of the TAS by the HSE. The investigation had been prompted by a complaint the Office received from a patient who experienced significant difficulty and delay in accessing treatment abroad under the TAS. After conducting a preliminary examination of that complaint the Ombudsman decided to initiate a wider-ranging systemic investigation of the actions of the HSE in administering the scheme and the processing of TAS referrals by Irish-based consultants.

The Treatment Abroad report made 11 distinct recommendations. These recommendations were shared with, and accepted by, the HSE. The final recommendation was that the HSE prepare a time frame for the implementation of the recommendations and provide progress reports to the Ombudsman.

Post publication of the Treatment Abroad report the HSE established a working group to address the implementation of the recommendations. The working group met on four occasions through 2018 with the final meeting on 19 December 2018. In December 2018 the working group produced a final report on the implementation of the recommendations. There is a note in the 16 May 2018 meeting of the Working Group that it would consider inviting a representative from my Office to the final meeting of the group so the group could explain the rationale for its decisions but this never took place. There is also a note in the 19 December 2018 meeting of the Working Group that the HSE would consider providing a copy of the report to the Ombudsman but in the end a copy was never actually provided to my Office. My understanding is that the HSE wanted to provide my Office with a copy of the report in person so that its content could be discussed. However attempts to arrange this meeting throughout 2019 proved difficult with a number of scheduled meetings unfortunately being cancelled at a late stage. Understandably early 2020 focused the attentions of the HSE elsewhere and efforts to arrange a meeting were put to one side. As such it was not until the current investigation team sought copies of all working group notes as part of this follow up that my Office was actually provided with a copy of the implementation report.

The final report of the working group addressed each of the 11 recommendations individually. When I decided to investigate the implementation and administration of the Cross Border Directive, I also decided that, in parallel with that investigation, I would follow up on the progress by the HSE of the implementation of the 11 recommendations of the 2018 Treatment Abroad report.

In general I am satisfied with the consideration given to the 2018 recommendations and the implementation of them by the HSE where appropriate. In terms of the actual application and impact of the HSE's implementation, I have recently had sight of a case where the HSE sought medical advice when processing a TAS application. The application was rejected based on the opinion of a medical expert and the applicant was provided with a detailed letter explaining the basis for the decision and how it could be appealed. This was in line with recommendation 5 of the 2018 report. The applicant appealed that decision and on appeal the HSE sought medical advice from a different expert. The procedure whereby a different medical opinion would be sought when a patient disagreed with the original finding stemmed from the HSE's implementation of recommendation 3 of the 2018 report. I believe the changes in procedure are positive for TAS applicants and it is reassuring to see them in operation in real cases.

That being said I am not satisfied with the HSE's implementation of recommendation 6 of the 2018 report. Recommendation 6 stated that "The HSE should establish an appeals process, which is independent of the original decision makers and which has the necessary expertise and competence to arbitrate on any clinical and non-clinical matters under appeal."

The HSE's position in the final report of the working group was that such a structure was already in existence. I do not agree that this is the case. As is the case with appeals in CBD cases, the appeals officer in TAS cases is the Assistant National Director of the Commercial Unit (ANDCU). I have explained my position on this in Chapter 2 when discussing appeals in CBD and it remains the same where TAS is concerned. I do not believe it is possible to describe the ANDCU as an independent appeals officer in TAS cases. A truly independent appeals process would require a decision maker who had no involvement in the cases before they are appealed or in the management of the Office in which the original decisions are made.

Finding 21: Independent TAS Appeal

I do not believe the appeals process as currently constructed is truly independent of the Treatment Abroad Scheme Office. I consider the absence of an independent appeal to be an undesirable administrative practice and as such amounts to maladministration under section 4(2)(b)(vi) of the Ombudsman Act 1980 (as amended).

✚ Recommendation 21 – Independent TAS Appeal

The appeals process for TAS should be entirely separate from the TAS Office and not within the remit of the management of the TAS Office. The HSE should move the entire appeals process to its National Appeals Service. This change should take place as soon as possible and by the end of 2023 at the latest.

Appendix 1

Cross Border Directive Pro Forma Invoice

From July 2022.

PFi from July 11th 2022.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive Cross Border Directive: Pro-Forma Invoice

The HSE operates a Cross Border Directive (CBD), for persons entitled to public patient treatment in Ireland who seek to avail of that treatment in another EU/EEA member state under Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patient's rights in cross border healthcare, as per the procedures set out in governing EU Regulations and Directives and Irish legislation.

A copy of the Directive and EU Regulations are available on the website for inspection at **http://europa.eu**. Within these governing EU Directive and Regulations, the CBD provides for the cost of publicly funded healthcare in Ireland to be availed of and the costs to be reimbursed subject to compliance with the applicable administration processes adopted by the HSE in the administration of the CBD. Patients should familiarize themselves with the administration requirements of the HSE prior to availing of healthcare under the Cross Border Directive scheme (CBD) in order to confirm entitlement or otherwise to reimbursement of treatment costs. The HSE has established a National Contact Point (NCP) office for the administration of the CBD in Ireland and the contact details for the NCP are: HSE Cross Border Directive – National Contact Point, St Canice's Hospital Complex, Dublin Road, Kilkenny, Ireland, Tel: 056 7784546 or 056 7720551. Email: crossborderdirective@hse.ie
Webpage: **https://www2.hse.ie/services/schemes-allowances/cross-border-directive/**

The CBD allows patients ordinarily resident in Ireland and who require public healthcare services to be referred to and avail of such healthcare in another EU/EEA member state. It will be a matter for the patient and/or his/her referring clinician to identify the clinician abroad and satisfy him/herself in relation to the qualifications, quality and safety of the services being availed of in the other jurisdiction. Each country within the EU/EEA has established NCPs and information relating to services in each country may be accessed through these NCPs. Details of the NCPs in Europe are available on http://europa.eu. Funding will only be reimbursed for healthcare that is publicly available and/or funded in Ireland and which is not contrary to Irish legislation. Reimbursement will be at the cost of the treatment availed of abroad or the cost of the treatment in Ireland whichever is the lesser. Please note that in the case of inpatient care abroad, the HSE will deduct the statutory inpatient levy per day as applies as if the patient was accessing the inpatient care in Ireland (except where that maximum has already been reached within the preceding 12 months in Ireland or the patient holds a valid medical card). Healthcare in Ireland is funded through general taxation so the cost of the provision of that care is funded through general taxation plus the statutory payment the patient would have made here in Ireland.

Payments will only be made to the patient or in the case of a child his/her parent or guardian. No payments will be made to third parties. In the case of a patient's death, reimbursement of the healthcare costs will be subject to the executor of the estate providing evidence of the outstanding liability.

The invoice and receipt submitted for reimbursement must be from the providing hospital/consultant abroad. Only the cost of the medical treatment provided is eligible for reimbursement. The HSE will not reimburse an invoice from a third party e.g. a medical tourism facilitator. If you use one of these companies to organise your treatment abroad, you should be aware that all fees associated with their services are not eligible for reimbursement by the HSE.

Prior notification for all hospital care involving overnight accommodation is recommended but not a requirement.

This pro-forma invoice should be completed by you and your healthcare provider abroad in English in order to facilitate your claim for reimbursement. The aim of this form is to ensure all the information required by the HSE to process your reimbursement claim in a timely and efficient manner is provided. If the pro-forma invoice is not completed in English, the patient/applicant may be required to provide a certified translation at his/her own cost. The completed pro-forma invoice should be submitted with the healthcare provider's original invoice and the original receipt, the referral letter used to access the healthcare and proof of payment. Reimbursements will be made in line with the governing legislation and criteria for this scheme. The HSE accepts no liability for healthcare costs availed of abroad which fail to meet the governing legislation, criteria and the HSE's administration requirements. The HSE reserves the right to seek any additional documentation deemed necessary to confirm the bona fide of the reimbursement claim and/or ensure the smooth transition of the patient back to the Irish healthcare system. Please also retain some form of proof of travel to submit with your documentation.

Completion of Pro-Forma Invoice: Applicant/Patient

No liability shall attach to the Health Service Executive, its servants or agents in respect of any costs or expenses incurred by the Patient or Applicant prior to a determination by the Health Service Executive on this application and the results of such determination being communicated to the Applicant. Any arrangements made by the Applicant or Patient prior to such determination may not subsequently be ratified by the Health Service Executive.

It is recommended the patient/applicant submits a fully completed pro-forma invoice accompanied by the supporting documentation to the HSE in order to claim reimbursement for the cost of treatment. The onus is on the patient to submit all the necessary original documentation to progress the claim for reimbursement. Incomplete documentation will be returned to the patient/applicant for provision of the appropriate information prior to re-submitting to

the CBD office. We strongly recommend you print off the pro-forma invoice and take it with you to the treating facility abroad so that the treating consultant can complete it for you prior to your discharge back to Ireland.

Section A

This part of the form is to be fully completed by the patient/applicant. All parts of the section must be completed, if a question is not relevant to you please mark same N/A e.g. if you do not hold a medical card mark that section N/A (not applicable).

Where a patient is under 18 years of age or is incapacitated, the form may be submitted on their behalf by a Parent/Guardian/Spouse/Partner.

Patients seeking reimbursement for inpatient care treatment abroad must provide evidence of assessment at an outpatient consultation in person on a date prior to the date of admission for the inpatient treatment either with the consultant abroad or with a consultant treating the patient in a public capacity in Ireland.

In completing this pro-forma invoice, you must ensure the information you provide is accurate and true. Where false, misleading or inaccurate information and/or documentation is included or where relevant information is withheld or failed to be submitted, the CBD Office will reserve the right to refer the matter to the appropriate authority. If monies have been issued on the basis of false, misleading or inaccurate information and/or documentation, or on the basis of information withheld or not submitted which would have been relevant to the decision to reimburse, the HSE will pursue the immediate recoupment of same from the payee. The CBD office reserves the right to review a patient's medical chart to clarify any information as appropriate.

If you are in receipt of an income e.g. pension, salary, etc., from another EU/EEA country but live in Ireland you may not be entitled to reimbursement from Ireland. This provision extends to dependents of persons who are in receipt of an income from another EU/EEA country. You should contact the NCP of the country from which you receive the income to confirm your eligibility for reimbursement.

Section B

This part of the pro-forma invoice is to be fully completed by the patients/applicants treating clinician.

CODE OF ETHICS FOR CLINICAL CODERS

It is expected that all clinicians identifying a DRG code for the purpose of reimbursement under the provisions of the Cross Border Directive would be familiar with and adhere to the Code of Ethics for Clinical Coders. The identification of a DRG code for the purpose of reimbursement requires the clinician to be ethical and transparent in his/her selection. The selection of an incorrect code may lead to a patient being reimbursed an amount less than that applied for and confirmed at prior approval stage. Any such occurrence will be a matter for the patient to pursue with the clinician who identified the incorrect code and not for the HSE. The HSE reserves the right to have any DRG code identified and independently assessed to confirm its appropriateness, this may include our accessing the patient's medical record for this purpose. Therefore, in line with the Code of Ethics for Clinical Coders, a clinician identifying a code for the purpose of reimbursement will ensure that clinical record content justifies selected DRG code.

When the pro-forma invoice has been fully completed, please return it to the above mentioned CBD office.

Processing

Pro-forma invoices will be processed as quickly as possible and on receipt of the fully completed paperwork, the target time frame will be 30 working days. Please note that the Cross Border Directive does not provide for reimbursement of travel or subsistence costs incurred by patients.

Only healthcare accessed abroad is eligible for reimbursement. An outpatient appointment takes place on a date prior to inpatient treatment and must be in-person.

Reimbursement will be at the cost of the treatment you availed of abroad, or the cost of providing the healthcare in Ireland, whichever is the lesser. Please note that in the case of inpatient care abroad, the HSE will deduct the inpatient levy charge as if the treatment were availed of in the public healthcare system in Ireland. Healthcare in Ireland is funded through general taxation, therefore the cost of the provision of that care is funded through general taxation plus the inpatient levy that would have been charged here in Ireland. Please also note that where healthcare is provided on an inpatient basis abroad but on an outpatient basis in Ireland, the reimbursable rate will be the outpatient rate. Where the healthcare would have been provided on a day case basis in Ireland but was provided on an inpatient basis abroad, the reimbursable rate will be the day case rate. The public healthcare system is not required to assume costs it would not have otherwise assumed if the treatment had been provided in Ireland.

Where proof of the exchange rate as accessed by the applicant is evidenced in the application for reimbursement, that is the rate that will be used for calculating the reimbursement.

Orthodontic Treatment

All claims for reimbursement will be processed when the patient enters the retainer stage of their treatment. Please ensure that all the required documentation has been submitted to allow your claim to be processed. Please ensure that you obtain a proof of travel for each appointment attended abroad such as a till receipt, parking ticket, etc. Failure to provide proof of travel for each appointment may result in your application being declined for payment. If any element of the treatment is provided in the private sector in Ireland, the treatment will not be eligible for reimbursement.

PRO FORMA INVOICE

APPLICATION FORM FOR REIMBURSEMENT TOWARDS THE COST OF MEDICAL TREATMENT UNDER THE PROVISIONS OF THE CROSS BORDER DIRECTIVE

SECTION A- To be completed in full by Patient/Applicant

Patient Details

NAME:		ADDRESS:	
DATE OF BIRTH:			
TEL NO:		MOBILE NO:	
PPS NO:		MEDICAL CARD NO: *Submit Photocopy also	

Are you in receipt of a pension or other income from another country? If so which other country and please provide details to include the nature and value of the income.

NAME PRIVATE HEALTH INSURANCE COMPANY		MEMBERSHIP NO.	

HAVE YOU APPLIED TO YOUR HEALTH INSURANCE COMPANY FOR FUNDING?

IF YES, HAS FUNDING BEEN APPROVED BY YOUR HEALTH INSURANCE COMPANY? Please submit a copy of the decision letter with your application.

GP's Details

The details of the referring clinician below are required or you may attach a copy of the referral letter as an alternative.

Name of Patient's GP	
GP's Address	
GP's Telephone Number	

Please read in full before signing the declaration.

No liability shall attach to the Health Service Executive, its servants or agents in respect of any costs or expenses incurred by the Patient or Applicant on this application and the results of such determination being communicated to the Applicant. Any arrangements made by the Applicant or Patient prior to such determination may not subsequently be ratified by the Health Service Executive and may invalidate the application.

In completing this application form, you must ensure the information you provide is accurate and true. The inclusion of false, misleading or inaccurate information or the omission of information relevant to the decision on reimbursement will mean the CBD office will reserve the right to refer the matter to the appropriate authority and the repayment of any reimbursement accessed will be required without exception. The CBD office reserves the right to review a patient's medical records to clarify any information as appropriate. I accept that in the event of the submission of false, misleading or inaccurate information or documentation or the failure to submit relevant information for the purposes of seeking reimbursement from the HSE, that the claim will be disqualified for any further consideration and that all outstanding costs will be a matter for myself.

In submitting this Pro Forma Invoice (complete or incomplete), I the undersigned give my permission for my medical records or other clinical information to be accessed and copied for the purposes of processing this claim by the HSE. I understand and accept my clinical information can and may be provided to other hospitals, healthcare facilities or clinical advisors in the assessment of the reimbursement claim. In signing my name hereunder, I acknowledge and accept this position and give my consent for same.

I declare that the above particulars are true and correct. I am aware that reimbursement is based on the information provided by me and that any additional information coming to light may impact on the monies reimbursed and I will be liable to repay any monies secured by me on the basis of incorrect, misleading or omission of information.

I also agree to notify and arrange to refund to the HSE immediately should I receive any refund from the provider or any other party e.g. insurance provider in respect of the treatments for which the costs were reimbursed to me by the HSE. Such reimbursement will be due to the HSE without delay and in the case of undue delay, I understand that the HSE may seek interest on monies due.

Applicant's signature **Date**

Pro-Forma Invoice 3

Parent/Guardian Details

*Only complete the next section if you are making an application on behalf of a patient under 18 years of age or over 18 years of age and dependant.

RELATIONSHIP TO PATIENT:		ADDRESS:	
NAME:			
TEL NO:		MOBILE NO:	
NAME PRIVATE HEALTH INSURANCE COMPANY		MEMBERSHIP NO.	
HAVE YOU APPLIED TO YOUR HEALTH INSURANCE COMPANY FOR FUNDING?			
IF YES, HAS FUNDING BEEN APPROVED BY YOUR HEALTH INSURANCE COMPANY? Please submit a copy of the decision letter with your application.			

It is policy of the HSE to ensure that therapeutic and medical facilities abroad where children are placed are fully compliant with their local child protection laws and policies and that they are signatories to the Hague Convention. In signing this application form, you are confirming that you are satisfied the facility in which the child's care is being provided meets the requirements of the policy.

Signature of Parent or Guardian: _____ **Date:** _____

This section should only be completed if you are making a claim for compensation for your injury from a third party.

Is the patient a victim of a road traffic incident or other accidental injury?	Yes ☐	No ☐
Is there a claim for compensation against a third party?	Yes ☐	No ☐

If yes, please provide the details of your solicitor:

Solicitors Name (acting for the patient)	
Solicitors Address	

Please note that solicitors who are making a legal claim for compensation on behalf of victims of road traffic accidents or other accidental injuries are required to include in the claim the cost of treatment received outside the state, as provided by the HSE Cross Border Directive, resulting from the road traffic accident or accidental injury.

However, please note that it is the patient who is obliged to make sure that the treatment costs provided by the HSE under the Cross Border Directive are reimbursed to the HSE. Unsuccessful claims must be brought to the attention of the HSE Cross Border Directive.

I agree to repay to the HSE the gross amount of the money spent by the HSE when the claim I am pursuing against a third party has been finalised.

Applicant's Signature: _____ **Date:** _____

Signature is required where the patient has been a victim of a road traffic accident or other accidental injury and a claim for compensation against third party is/will occur.

SECTION B - (to be completed in full by the treating clinician abroad)

The treating clinician must fully complete Section B and provide sufficient information including details of the treatment provided to the patient. Reimbursement of healthcare is based on the evidence of the medical necessity which has been appropriately demonstrated.

Applications for reimbursement must be accompanied by a copy of the referral letter from the referring clinician to the accepting clinician. In the case of a reimbursement for inpatient or day case treatment, evidence of the outpatient consultation which took place on a date prior to the inpatient or day case procedure and at which the medical necessity was determined must also be included for the purposes of reimbursement.

The onus is on the treating/referring consultant to seek, provide and certify the answer to each question in Section B.

Details of Healthcare provider abroad

Name of clinician

Clinician's address/Hospital Address

Contact details – telephone, fax and email

Clinician's professional registration details – registering body and registration number

Patient Name

Patient Address

Date of Birth

Type of treatment – i.e. outpatient/day case/inpatient

Outpatient attendance date: In person: ☐ Telephone: ☐ Video: ☐

Day case Only: Date of Treatment:

Inpatient Treatment Only: Date of Admission: Discharge Date:

Specific Treatment/Procedure Provided:

DRG CODE OF TREATMENT PROVIDED
(DRG codes only apply to inpatient and day case treatments and not to outpatient care. It is the Hospital abroad which is responsible for identifying the DRG. DRG are identified using an appropriate IT system and trained DRG coders). The relevant ABF Price list is available on the HSE website by following the link below.

Day case Treatment from 01st July 2022: https://assets.hse.ie/media/documents/Admitted-Patient-Price-List-Daycase_2022.pdf
Inpatient Treatment from 01st July 2022: https://assets.hse.ie/media/documents/Admitted-Patient-Price-List-Inpatient_2022.pdf

Daycase Treatment carried out up to 01st July 2022: https://assets.hse.ie/media/documents/admitted-patient-price-list-summary-daycase_lMpt7Dj.pdf
Inpatient Treatment carried out up to 01st July 2022: https://assets.hse.ie/media/documents/admitted-patient-price-list-summary-inpatient_cdl9qTO.pdf

How was the DRG Code arrived at: ICD 10 SYSTEM OPERATED BY TRAINED CODERS ☐ BEST GUESS ☐

Cost: (original invoice and receipts must be submitted, these will be copied for file purposes and returned to you)* €

Treatment Provided (secondary):

Type of the (secondary) treatment – i.e. outpatient/day case/inpatient

Specific (secondary) Treatment/Procedure provided:

DRG code of secondary treatment (where appropriate):

Cost: (original invoice and receipts must be submitted, these will be copied for file purposes and returned to you) €

SECTION B-Continued
Pro-Forma Invoice 5

Please set out hereunder a summary of the condition from which the patient suffers:

Please identify the specific treatment provided:

(Only treatments which are available in or are publicly funded in Ireland qualify for reimbursement under the CBD.)

Please confirm the reason for accessing the healthcare abroad?
(this information has no bearing on the application decision it is recorded for the purposes of information on the reasons why patients are opting for care under the CBD)

Length of wait for the treatment in Ireland: ☐

Quality of the service abroad: ☐

Proximity to my place of residence: ☐

Other ☐

If Other please provide details:

Is the patient currently receiving this treatment in Ireland? YES ☐ NO ☐

If yes, please provide details:

Is the treatment medically necessary? Yes ☐ No ☐

Will the treatment meet the patient's needs? Yes ☐ No ☐

Is the treatment regarded as a proven form of medical attention and not experimental or test treatment? Yes ☐ No ☐

Is the treatment required as a result of injuries received in a road traffic accident or other accidental injury? Yes ☐ No ☐

Does the proposed healthcare pose any public health risks for the patient and/or the public in general? Yes ☐ No ☐

If yes, please give details:

SECTION B-Continued

Pro-Forma Invoice 6

Is the treatment abroad being provided in a recognized hospital or other institution which is under the control of a Registered Medical Practitioner? Yes ☐ No ☐

Is that hospital a public hospital available to National Health Agencies for Public Patients in that country? Yes ☐ No ☐

THE ONGOING CARE OF A PATIENT WHO HAS AVAILED OF TREATMENT ABROAD REVERTS TO THE REFERRING PHYSICIAN IMMEDIATELY UPON THE PATIENT'S RETURN TO IRELAND.

I declare that the above particulars are to the best of my knowledge true and correct.

Signature of treating clinician: _____ Date: _____

Pro-Forma Invoice 7

IMPORTANT – CHECK LIST

Submitting a claim for reimbursement in respect of CBD healthcare

When submitting a claim for reimbursement of healthcare provided under the provisions of the Cross Border Directive Scheme please ensure you include the following:

- A valid path of referral i.e. a referral letter* or a copy of a waiting list letter for a public hospital in Ireland if same has not already been provided at prior authorisation stage. *See below for clarification on a valid referral letter.
- A fully completed Pro Forma Invoice** form (Pink in colour) in English only.
- The original invoice from the healthcare provider abroad.
- The original receipt of payment from the healthcare provider abroad.
- Proof of your payment of your healthcare costs e.g. Bank transfer, Credit Card Payment (statement)
- Proof of travel abroad e.g. flight/ferry tickets, accommodation receipts in patients/applicants name, toll/parking charges or a till receipt from a shop in the locality.

Checklist

Have you included?

- *Path of referral:

A valid GP/consultant (public) letter of referral:	Yes	No
1. Predating your consultation abroad	☐	☐
2. To a named consultant abroad	☐	☐
3. Addressed to the treating hospital abroad	☐	☐
4. Signed by your GP/consultant (public)	☐	☐
5. Detailing relevant personal and clinical information.		

Or

A waiting list letter from a public hospital in Ireland:	Yes	No
1. A waiting list letter confirming that you are on the public waiting list in Ireland at the time of your consultation abroad	☐	☐

- **Pro Forma Invoice, (optional but recommended)

A valid GP/consultant (public) letter of referral:	Yes	No
1. Section A completed in full by applicant	☐	☐
2. Section B completed in full by your treating consultant/clinician abroad.	☐	☐

**Please ensure that your treating consultant/clinician abroad provides the inpatient or day case DRG code from the list published on the HSE website. This can be accessed on the HSE ABF Price List, please follow these links:
Day case Treatment from 01st July 2022: https://assets.hse.ie/media/documents/Admitted-Patient-Price-List-Daycase_2022.pdf
Inpatient Treatment from 01st July 2022: https://assets.hse.ie/media/documents/Admitted-Patient-Price-List-Inpatient_2022.pdf
Daycase Treatment carried out up to 01st July 2022: https://assets.hse.ie/media/documents/admitted-patient-price-list-summary-daycase_IMpt7Dj.pdf h
Inpatient Treatment carried out up to 01st July 2022: https://assets.hse.ie/media/documents/admitted-patient-price-list-summary-inpatient_cdI9qTO.pdf

Pro-Forma Invoice 8

	Yes	No
• Invoice(s) for healthcare subject to claim for reimbursement	☐	☐
• Receipt(s) for each invoice submitted subject to claim for reimbursement	☐	☐
• Proof of your payment of your healthcare costs e.g. Bank transfer, Credit Card Payment (Statement)	☐	☐
• Proof of Travel	☐	☐
1. Flight/ferry tickets, accommodation receipts, toll/parking charges or a till receipt from a shop	☐	☐
• Evidence of your initial outpatient consultation with your treating clinician abroad on a date prior to your admission.	☐	☐
1. An invoice & receipt from your initial consultation.	☐	☐
2. A medical report which includes the date of your initial consultation.	☐	☐

Proof of an initial consultation is not required where a person has already been assessed by their public consultant in Ireland and subsequently been placed on an inpatient treatment waiting list and where this waiting list letter is being submitted as your path of referral for your treatment abroad. The initial consultation or outpatient consultation must pre-date any inpatient or day case treatment.

	Yes	No
• Medical Card Details		
1. Have you included a photocopy of your medical card?	☐	☐

For Orthodontic Treatment Only.

	Yes	No
1. A HSE Orthodontic Assessment* confirming the grade and category you have been assessed.	☐	☐

If you are currently on a HSE Orthodontic Assessment Waiting list in Ireland but have not yet been assessed then you can choose to have this assessment carried out abroad and claim up to €100.00 towards the cost of the assessment. The assessment abroad must be carried out in line with the HSE Orthodontic Assessment Tool. (Where the orthodontic assessment has already been carried out in Ireland, a claim for assessment abroad is not eligible for reimbursement under the scheme).

Appendix 2

Cross Border Directive Pro Forma Invoice Pre Pension Question

From June 2019.

PFi June 2019.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive Cross-Border Healthcare Directive: Pro-Forma Invoice

The HSE operates a Cross-Border Healthcare Directive (CBD), for persons entitled to public patient treatment in Ireland who seek to avail of that treatment in another EU/EEA member state under Directive 201/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patient's rights in cross-border healthcare, as per the procedures set out in governing EU Regulations and Directives and Irish legislation.

A copy of these Regulations and Decisions, and all other aspects of European Law are available on the website for inspection at **http://europa.eu**. Within these governing EU Regulations and Irish legislation, the CBD provides for the cost of publicly funded healthcare in Ireland to be availed of and the costs to be reimbursed subject to compliance with the applicable administration processes adopted by the HSE in the administration of the CBD. Patients should familiarize themselves with the administration requirements of the HSE prior to availing of cross border healthcare in order to confirm entitlement or otherwise to reimbursement of treatment costs. The HSE has established a National Contact Point (NCP) office for the administration of the CBD in Ireland and the contact details for the NCP are: HSE Cross Border Directive – National Contact Point, St Canice's Hospital Complex, Dublin Road, Kilkenny, Ireland, Tel: 056 7784547 or 056 7784546 or 056 7784556 Email: crossborderdirective@hse.ie
Webpage: http://www.hse.ie/crossborderdirective

The CBD allows people normally resident in Ireland and who require public healthcare services to be referred to and avail of such healthcare in another EU/EEA member state. It will be a matter for the patient and/or his/her referring doctor to identify the clinician abroad and satisfy him/herself in relation to the qualifications, quality and safety of the services being availed of in the other jurisdiction. Each country within the EU/EEA has established NCPs and information relating to services in each country may be accessed through these NCPs. Details of the NCPs in Europe are available on http://europa.eu . Funding will only be reimbursed for healthcare that is publicly available and/or funded in Ireland and which is not contrary to Irish legislation. Reimbursement will be at the cost of the treatment availed of abroad or the cost of providing the healthcare in Ireland whichever is the lesser. Please note that in the case of inpatient care abroad the HSE will deduct the statutory inpatient levy per day as applies if the patient was accessing the inpatient care in Ireland (except where that maximum has already been reached within the preceding 12 months in Ireland or the patient holds a valid medical card). Healthcare in Ireland is funded through general taxation so the cost of the provision of the care is that funded through general taxation plus the statutory payment the patient would have made here in Ireland.

Payments will only be made to the patient or in the case of a child his/her parent of guardian. No payments will be made to third parties. In the case of a patient's death, reimbursement of the healthcare costs will be subject to the executor of the estate providing evidence of the outstanding liability.

The invoice and receipt submitted for reimbursement must be from the providing hospital/consultant abroad. Only the cost of the medical treatment provided is eligible for reimbursement. The HSE will not reimburse an invoice from a third party e.g. a medical tourism facilitator. If you use one of these companies to organise your trip abroad for the necessary healthcare you should be aware that all fees associated with their services are not eligible for reimbursement by the HSE.

Prior authorisation for all hospital care involving overnight accommodation, is strongly recommended.

This pro-forma invoice should be completed by you and your healthcare provider abroad in English in order to facilitate your claim for reimbursement. The completion of the pro-forma invoice is optional. The aim of this form is to ensure all the information required by the HSE to process your reimbursement claim in a timely and efficient manner is provided. If the pro-forma invoice is not completed in English the patient/applicant will be required to provide a certified translation at his/her own cost. The completed pro-forma invoice should be submitted with the healthcare provider's original invoice and the original receipt and the referral letter from the referring Irish or clinician abroad. Reimbursements will be made in line with the governing legislation and criteria for this scheme. The HSE accepts no liability for healthcare costs availed of abroad which fails to meet the governing legislation, criteria and the HSE's administration requirements. The HSE reserves the right to seek any additional documentation deemed necessary to confirm the bone fides of the reimbursement claim and or ensure the smooth transition of the patient back to the Irish healthcare system. Please also retain some form of proof of travel to submit with your documentation.

Completion of Pro-Forma Invoice: Applicant/Patient

No liability shall attach to the Health Service Executive, its servants or agents, in respect of any costs or expenses incurred by the Patient or Applicant prior to a determination by the Health Service Executive, on this application and the results of such determination being communicated to the Applicant. Any arrangements made by the Applicant or Patient prior to such determination may not subsequently be ratified by the Health Service Executive, and may invalidate the application.

It is recommended the patient/applicant submits a fully completed pro-forma invoice accompanied by the supporting documentation to the HSE in order to claim reimbursement for the cost of treatment. The onus is on the patient to submit all the necessary original documentation to progress the claim for reimbursement. Incomplete documentation including the pro-forma invoices will be returned to the patient/applicant for provision of the appropriate information prior to re-submitting to the CBD office.

We strongly recommend you print off the pro-forma invoice and take it with you to the treating facility abroad so that the treating consultant can complete it for you prior to your discharge back to Ireland.

Section A
This part of the form is to be fully completed by the patient/applicant. All parts of the section must be completed; if a question is not relevant to you please mark same N/A e.g. if you do not hold a medical card mark that section N/A (not applicable).

Where a patient is under 18 years of age or is incapacitated, the form may be submitted on their behalf by a Parent/Guardian/Spouse/Partner.

Patients seeking reimbursement for inpatient care or day case treatment abroad must provide evidence of assessment at an outpatient consultation on a date prior to the inpatient or day case procedure either with the consultant abroad or with a consultant treating the patient in a public capacity in Ireland.

Section B
This part of the pro-forma invoice is to be fully completed by the patient's/applicant's treating clinician.

CODE OF ETHICS FOR CLINICAL CODERS
It is expected that all clinicians identifying a DRG code for the purpose of reimbursement under the provisions of the Cross Border Directive would be familiar with and adhere to the Code of Ethics for Clinical Coders. The identification of a DRG code for the purpose of reimbursement requires the clinician to be ethical and transparent in his/her selection. The selection of an incorrect code may lead to a patient being reimbursed an amount less than that applied for and confirmed at prior approval stage. Any such occurrence will be a matter for the patient to pursue with the clinician who identified the incorrect code and not for the HSE. The HSE reserves the right to have any DRG code identified, independently assessed to confirm its appropriateness this may include our accessing the patient's medical record for this purpose. Therefore in line with the Code of Ethics for Clinical Coders, a clinician identifying a code for the purpose of reimbursement will: ensure that clinical record content justifies selected DRG code.

When the pro-forma invoice has been fully completed, please return it to the above mentioned CBD offices.

Section C
This part of the pro-forma invoice is to be fully completed by the patient/applicant.

In completing this pro-forma invoice you must ensure the information you provide is accurate and true. Where false, misleading or inaccurate information and/or documentation is included the CBD Office will reserve the right to refer the matter to the appropriate authority. If monies have been issued on the basis of false, misleading or inaccurate information and/or documentation the HSE will pursue the immediate recoupment of same from the payee. The CBD office reserves the right to review a patient's medical chart to clarify any information as appropriate.

Processing
Pro-forma invoices will be processed as quickly as possible and on receipt of the fully completed paper work the target time frame will be 30 days. Please note that the Cross-Border Healthcare Directive does not provide for reimbursement of travel or subsistence costs incurred by patients.

PRO-FORMA INVOICE

APPLICATION FORM FOR REIMBURSEMENT FOR ASSISTANCE TOWARDS THE COST OF MEDICAL TREATMENT OUTSIDE THE STATE

SECTION A- To be completed in full by Patient/Applicant

FORENAME		SURNAME	
SURNAME ON BIRTH CERTIFICATE		DATE OF BIRTH	
ADDRESS			
TEL NO.		MOBILE NO.	
PPS/RSI NO.		MEDICAL CARD NO.	
NAME PRIVATE HEALTH INSURANCE COMPANY		MEMBERSHIP NO.	
HAVE YOU APPLIED TO YOUR HEALTH INSURANCE COMPANY FOR FUNDING?			
IF YES, HAS FUNDING BEEN APPROVED BY YOUR HEALTH INSURANCE COMPANY? Please submit a copy of the decision letter with your application.			

The details of the referring clinician below are required or you may attach a copy of the referral letter as an alternative.

NAME of referring clinician	
Referring clinician's address	
Referring clinician's telephone/email	

Only complete the next section if you are making an application on behalf of a Patient under 18 years of age or over 18 years of age and dependant.

RELATIONSHIP TO PATIENT			
FORENAME		SURNAME	
ADDRESS			
TEL NO.		MOBILE NO.	
NAME PRIVATE HEALTH INSURANCE COMPANY		MEMBERSHIP NO.	
HAVE YOU APPLIED TO YOUR HEALTH INSURANCE COMPANY FOR FUNDING?			
HAS FUNDING BEEN APPROVED BY YOUR HEALTH INSURANCE COMPANY? Please submit a copy of the decision letter with your application.			

No liability shall attach to the Health Service Executive, its servants or agents, in respect of any costs or expenses incurred by the Patient or Applicant on this application and the results of such determination being communicated to the Applicant. Any arrangements made by the Applicant or Patient prior to such determination may not subsequently be ratified by the Health Service Executive and may invalidate the application.

In completing this application form you must ensure the information you provide is accurate and true. The inclusion of false, misleading or inaccurate information will mean the CBD office will reserve the right to refer the matter to the appropriate authority and the repayment of any reimbursement accessed will be required without exception. The CBD office reserves the right to review a patient's medical records to clarify any information as appropriate

In submitting this pro-forma invoice (complete or incomplete) I the undersigned give my permission for my medical records or other clinical information to be accessed and copied for the purposes of processing this claim by the HSE. I understand and accept my clinical information can and may be provided to other hospitals or health care facilities or clinical advisors in the assessment of the reimbursement claim. In signing my name hereunder I acknowledge and accept this position and give my consent for same.

_____ _____

Applicant's signature (or parent or guardian's signature) **Date**

3

Is the patient a victim of a road traffic accident or other accidental injury?
YES ☐ NO ☐

If yes, is there a claim for compensation against a third party?
YES ☐ NO ☐

If yes, please provide the details of your solicitor:

Solicitors name (acting for the patient)

Solicitor's address

Please note that solicitors who are making a legal claim for compensation on behalf of victims of road traffic accidents or other accidental injuries are required to include in the claim the cost of treatment received outside the state, as provided by the HSE Cross-Border Healthcare Directive, resulting from the road traffic accident or accidental injury.

However, please note that it is the patient who is obliged to make sure that the treatment costs provided by the HSE under the Cross-Border Healthcare Directive are reimbursed to the HSE. Unsuccessful claims must be brought to the attention of the HSE Cross-Border Healthcare Directive.

I agree to repay to the HSE the gross amount of the money spent by the HSE when the claim I am pursuing against a third party has been finalised.

Applicant's signature **Date:**

Signature is required where the patient has been a victim of a road traffic accident or other accidental injury and a claim for compensation against third party is/will occur.

4

SECTION B - (to be completed in full by the treating clinician abroad)

The treating clinician must fully complete Section B and provide sufficient information including details of the treatment provided to the patient. Reimbursement of healthcare is based on the evidence of the medical necessity which has been appropriately demonstrated.

Applications for reimbursement must be accompanied by a copy of the detailed clinical referral letter from the referring clinician to the accepting clinician, outlining details and history of the patient's condition and the type of treatment envisaged. In the case of a reimbursement for inpatient or day case treatment evidence of the outpatient consultation which took place on a date prior to the inpatient or day case procedure and at which the medical necessity was determined must also be included for the purposes of reimbursement.

The onus is on the treating/referring consultant to seek, provide and certify the answer to each question in Section B.

Details of the healthcare provider abroad:

NAME of clinician	
Clinician's address/Hospital address	
Contact details – telephone, fax and email.	
Clinician's professional registration details – registering body and registration number	
PATIENT NAME	
PATIENT ADDRESS	
DATE OF BIRTH	/ /
Treatment Date(s)	
Admission Date:	Discharge Date:
Type of the treatment – i.e. outpatient/daycase/inpatient	
Specific Treatment/Procedure provided	
DRG CODE OF TREATMENT PROVIDED (DRG codes only apply to inpatient and day case treatments and not to outpatient care. It is only the treating consultant abroad who can identify the DRG for the treatment he or she has provided). The relevant ready reckoner is available on the HSE website by following the link below.	
http://www.hse.ie/eng/services/list/1/schemes/cbd/Ready%20Reckoner.pdf	
Cost*	€_____* (original invoice and receipts must be submitted, these will be copied for file purposes and returned to you)*
Treatment provided (secondary)	
Type of the (secondary) treatment – e.g. outpatient/day-case/inpatient	
Specific (secondary) Treatment/Procedure provided	
DRG code of secondary treatment (where appropriate)	
Cost*	€_____* (original invoice and receipts must be submitted these will be copied for file purposes and returned to you)*

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SECTION B-Continued

Please set out hereunder a summary of the condition from which the patient suffers:

Please certify the specific treatment that the patient required outside the State:

Is this treatment available within the State? YES ☐ NO ☐
(only treatments which are available in or publicly funded in Ireland qualify for reimbursement under the CBD)

Please confirm the reason for accessing the healthcare abroad?
(this information has no bearing on the application decision it is just for the purposes of information on the reasons why patients are opting for care under the CBD)

Length of wait for the treatment in Ireland: ☐
Quality of the service abroad: ☐
Proximity to my place of residence: ☐
Other ☐

If Other please provide details: _____

Is the patient currently receiving this treatment in Ireland? YES ☐ NO ☐

If yes, please provide details:

Is the treatment medically necessary? YES ☐ NO ☐

Will the treatment meet the patient's needs? YES ☐ NO ☐

Is this treatment contrary to the Irish Constitution or any legislation, to your knowledge? YES ☐ NO ☐

Is the treatment regarded as a proven form of medical attention and not experimental or test treatment? YES ☐ NO ☐

Is the treatment required as a result of injuries received in a road traffic accident or other accidental injury? YES ☐ NO ☐

Does the proposed healthcare pose any public health risks for the patient and/or the public in general? YES ☐ NO ☐

If yes, please give details:

6

SECTION B-Continued

Is the treatment abroad being provided in a recognized hospital or other institution which is under the control of a Registered Medical Practitioner? YES ☐ NO ☐

Is that hospital a public hospital available to National Health Agencies for Public Patients in that country? YES ☐ NO ☐

THE ONGOING CARE OF A PATIENT WHO HAS AVAILED OF TREATMENT ABROAD REVERTS TO THE REFERRING PHYSICIAN IMMEDIATELY UPON THE PATIENT'S RETURN TO IRELAND.

I declare that the above particulars are, to the best of my knowledge true and correct.

It is policy of the HSE to ensure that therapeutic and medical facilities abroad where children are placed are fully compliant with their local child protection laws and policies and that they are signatories to the Hague Convention. In signing this application form I the referring consultant am confirming that I am satisfied the facility to which I am referring this child meets the requirements of the policy.

Signature of treating clinician: _____ Date: _____

SECTION C- (to be completed in full by Patient/Applicant)

I accept that in the event of the submission of false, misleading or inaccurate information or documentation for the purposes of seeking reimbursement from the HSE that the claim will be disqualified for any further consideration and that all outstanding costs will be a matter for myself.

I declare that the above particulars are true and correct. I am aware that reimbursement is based on the information provided by me and that any additional information coming to light may impact on the monies reimbursed and I will be liable to repay any monies secured by me on the basis of incorrect, misleading or omission of information.

I also agree to notify and arrange to refund to the HSE immediately should I receive any refund from the provider or any other party e.g. insurance provider, in respect of the treatments for which the costs were reimbursed to me by the HSE. Such reimbursement will be due to the HSE without delay and in the case of undue delay I understand that the HSE may seek interest on monies due.

Applicant's signature _____ **Date:** _____

* Reimbursement will be at the cost of the treatment you availed of abroad or the cost of providing the healthcare in Ireland whichever is the lesser. Please note that in the case of inpatient care abroad the HSE will deduct the inpatient levy charge as if the treatment were availed of in the public healthcare system in Ireland.. Healthcare in Ireland is funded through general taxation therefore the cost of the provision of the care is that funded through general taxation plus the inpatient levy that would have charged here in Ireland. Please also note that where healthcare is provided on an inpatient basis abroad but on an outpatient basis in Ireland the reimbursable rate will be the outpatient rate. Or where the healthcare would have been provided on a day case basis in Ireland but was provided on an inpatient basis abroad the reimbursable rate will be the day case rate. The public healthcare system is not required to assume costs it would not have otherwise assumed if the treatment had been provided in Ireland.

Patient Check List of Required Documentation Have you included:	
The completed pro-forma invoice in English (optional but highly recommended – are all sections completed?	
The referral letter from the Irish physician who referred you abroad or copy of letter of place on public waiting list in Ireland.	
Proof of initial consultation with treating consultant abroad (which must have been undertaken on a date prior to treatment date)	
The original invoice from the healthcare provider abroad	
The receipt of payment from the healthcare provided abroad	
Proof of travel has been provided.	

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For Office Use Only

Reimbursement Approved		Reimbursement Denied		Partial Reimbursement Approved	

Comment:

Signature: _____ Date: _____
HSE, Designated Officer

Approved ☐ Not Approved ☐

Signature: _____ Date: _____

Grade: _____

*** Please ensure that the HSE National Financial Regulations are adhered to in this regard.**

8

IMPORTANT

Submitting a claim for reimbursement in respect of CBD healthcare.

When submitting a claim for reimbursement of healthcare provided under the provisions of the Cross Border Directive Scheme please ensure you include the following:

- A valid path of referral i.e. a referral letter* or a copy of waiting list letter for a public hospital in Ireland if same has not already been provided at prior authorisation stage. *See below for clarification on a valid referral letter.
- A fully completed Pro-Forma Invoice** form (Pink in colour) – optional but recommended.
  ** *Use of the pro-forma invoice is optional but it will ensure we have all the information we need to process the reimbursement as efficiently as possible. In the instance where a Pro-forma Invoice is not submitted the DRG code for the healthcare you are accessing abroad must be provided on the invoice provided from your treating hospital/clinic.*
- The original invoice from the healthcare provider abroad.
- The original receipt of payment from the healthcare from the provider abroad.
- Proof of travel abroad e.g. flight/ferry tickets, accommodation receipts, toll/parking charges or a till receipt from a shop in the locality.

Checklist

Have you included?

- *Path of referral:

A valid GP/consultant (public) letter of referral:	Yes	No
1. Pre-dating your consultation abroad	☐	☐
2. To a named consultant abroad	☐	☐
3. Addressed to the treating hospital abroad	☐	☐
4. Signed by your GP/consultant (public)	☐	☐

Or

A waiting list letter from a public hospital in Ireland:	Yes	No
1. A waiting list letter confirming that you are on the public waiting list in Ireland at the time of your consultation abroad	☐	☐

- Pro-forma Invoice (Pink Form), (optional but recommended)

	Yes	No
1. Section A completed in full by applicant	☐	☐
2. Section B completed in full by your treating consultant/clinician abroad***.	☐	☐
3. Section C completed by applicant.	☐	☐

**Please ensure that your treating consultant/clinician abroad provides a valid HSE DRG code. This can be accessed on the HSE Ready Reckoner, please follow this link (http://www.hse.ie/eng/services/list/1/schemes/cbd/Ready%20Reckoner.pdf). The rate of reimbursement will be up to the maximum of the DRG code applicable in your case or the cost of your treatment abroad, whichever is the lesser.

	Yes	No
• Invoice (s) for healthcare subject to claim for reimbursement	☐	☐
• Receipt (s) for each invoice submitted subject to claim for reimbursement	☐	☐

• Proof of Travel	Yes	No
1. flight/ferry tickets, accommodation receipts, toll/parking charges or a till receipt from a shop	☐	☐

• Evidence of your initial consultation with your treating clinician abroad prior to your treatment.	Yes	No
1. An invoice & receipt from your consultation. Or 2. A medical report which includes the date of your initial consultation.	☐	☐

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Proof of an initial consultation is not required where a person has already been assessed by their public consultant in Ireland and subsequently been placed on an inpatient treatment waiting list and where this waiting list letter is being submitted as your path of referral for your treatment abroad. The initial consultation or outpatient consultation must pre-date any inpatient or day case treatment.

For Orthodontic Treatment Only

	Yes	No
• A HSE Orthodontic Assessment* confirming the grade and category you have been assessed.	☐	☐

If you are currently on a HSE Orthodontic Assessment Waiting list in Ireland but have not yet been assessed then you can choose to have this assessment carried out abroad and claim up to €100.00 towards the cost of the assessment. The assessment abroad must be carried out in line with the HSE Orthodontic Assessment Tool. (Where the orthodontic assessment has already been carried out in Ireland, a claim for assessment abroad is not eligible for reimbursement under the scheme).

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Appendix 3

Diagnosis Related Grouping Codes

In Ireland the amount of reimbursement a patient may be entitled to is either the price paid for the treatment abroad or the cost of providing that treatment in Ireland, whichever is the lesser. The cost of providing the treatment in Ireland is identified using what are known as Diagnosis Related Grouping (DRG) Codes. Countries throughout the world use different formats of coding and costing for the purpose of healthcare costing. Healthcare is recognised as a national competency and is not required to conform to a single international coding mechanism. As such each country uses a system which best reflects the mechanisms of healthcare provision in that country.

Annex 3 to Regulation (EC) No 987/2009 lists Ireland as one of the Member States that provides reimbursement on the basis of fixed amounts. This is due to the fact that Ireland is not in a position to provide individual patient costs in the same way that countries which operate insurance model healthcare can.

Irish hospitals are funded through direct taxation with a statutory charge that patients are liable to pay. Hospitals are not funded by individual treatments or procedures. Hospitals receive block funding in the form of annual budgets from which all services provided in the hospital are funded. The HSE does not have the ability to cost healthcare on an individual basis and, like many other countries, uses Hospital In-Patient Enquiry (HIPE) coding for average costing.

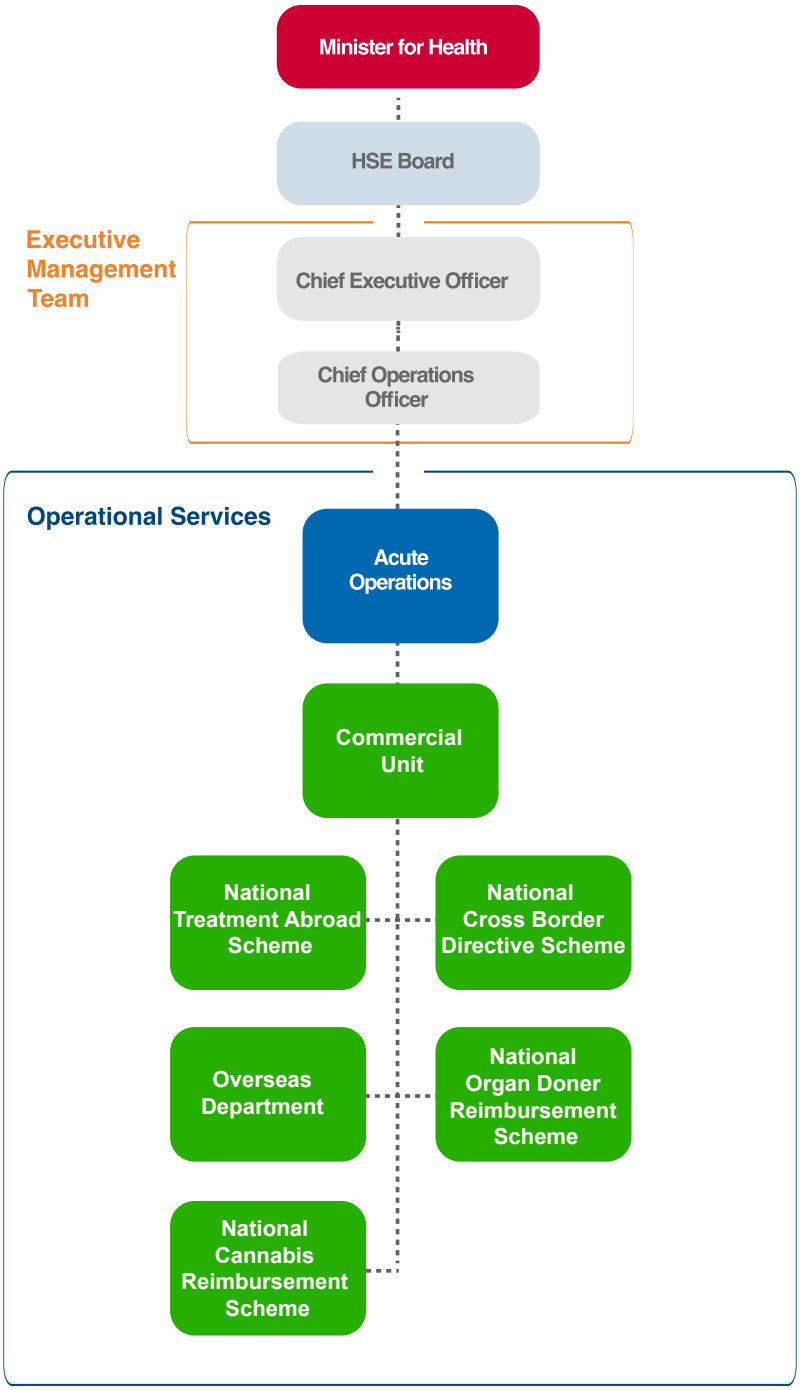
HIPE coding is used internationally by public hospitals as a mechanism of costing the provision of treatment. HIPE collects activity data on Inpatient and Day cases in all Acute Public Hospitals in Ireland based on the information available in a patient's healthcare record. From the information collected a HIPE record is created when a patient is discharged from hospital. Each HIPE record contains administrative, demographic and clinical information. The information from all the hospitals is collated by the Health Pricing Office (HPO) and from the collated information the average DRG costs are determined. These are the DRG costs, which are used by each country to determine the cost of healthcare in the public acute hospital setting. Different countries use different versions of DRG coding.

A DRG code is arrived at by inputting personal and medical data into the ICD 10 Coding System which runs that information through an algorithm to identify the correct DRG code. In CBD and NIPHS cases, if the hospital abroad wishes to ensure it is identifying the correct code for an Irish patient then that Hospital would be required to have access to the ICD 10 Coding system operated by a trained coder. Without this facility the reality is that the hospital is simply making, as the HSE puts it, a "best guess". So in these situations, while the hospital is simply seeking to assist the patient, the fact that it does not have access to the coding system can, and does, lead to situations where a patient has unrealistic expectations of the value of reimbursement they may be entitled to.

The DRG coding system is the costing mechanism used in the Irish public system. The HSE is required to use the same mechanism of costing for a CBD patient as it does for a public patient. On that basis the HSE correctly uses DRG codes for CBD and NIPHS applications too.

Appendix 4

Extract from HSE Organisational Chart 2022



Ombudsman

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