Final Report

*Fraud prevention and compliance – Improve billing practices within public hospitals*

Inappropriate Billing Project

April 2017
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Executive summary

The ‘Fraud prevention and compliance – Improve billing practices within public hospitals’ Budget measure (known as the Inappropriate Billing Project) was implemented over a four year period from 1 July 2012 to 30 June 2016.

A total of $1.8 million was provided to review, understand and address inappropriate billing of Medicare by hospital emergency department patients for pathology and diagnostic imaging services. The Budget measure was expected to provide savings of $24.7 million.1

In late 2014, the scope of the project was expanded to include education and compliance interventions for a broader range of topics related to claims to Medicare in public hospitals. Feedback from public hospitals had identified a need to clarify Medicare billing in regard to rights of private practice, outpatient claims and claims for personal attendance items. There was also a need to explore whether legislative amendments may be required to resolve operational issues with undertaking compliance interventions in the public hospital sector.

As a result of Machinery of Government changes on 30 September 2015, responsibility for the health provider compliance function, including the Budget measure, moved from the Department of Human Services to the Department of Health (the department) on 5 November 2015.

Objectives

The primary objective of the project was to build the capacity of the department to identify and treat risks associated with incorrect Medicare billing practices within public hospitals funded under Commonwealth or State arrangements.

Methodology

The project comprised three key activities:

Education

- To publish education material for public hospital practitioners, hospital administrators and Local Hospital Networks (LHN) about Medicare billing requirements.

Exploring possible legislative change

- To explore possibilities for strengthening the Health Insurance Act 1973 (the Act).

Compliance inventions

- To conduct compliance interventions in relation to inappropriate billing in public hospitals.

Findings

1. There is a need for a strong focus on providing education on correct Medicare billing practices in public hospitals.
   - LHNs expressed a need for education and clarity on what is compliant and non-compliant practice. They displayed an eagerness and willingness to learn their responsibilities in relation to billing under Medicare and to increase their knowledge of Medicare requirements.
   - The ‘Public Hospital Compliance’ webpage designed as a single site for health practitioners and hospital administrators to electronically access information about legal responsibilities and requirements for billing services under Medicare in public hospitals was well received.
   - Articles published in the Department of Human Services online subscription ‘News for Health Professionals’ (previously ‘Forum’) promoting the resources resulted in a significant increase in the number of webpage views.

2. The Act and the National Health Reform Agreement (NHRA) require amendment to address limitations which constrained compliance management of incorrect Medicare billing.
   - Relevant terms in the Act were open to different interpretations by LHNs, including variations of when a patient was considered admitted and who had accountability for out-sourced public hospital services.
   - Definitions and rules in the NHRA lack the clarity that the department requires to establish that non-compliance due to double billing has occurred.
   - The Act, including its subordinate regulations, is primarily directed at the actions of individual health practitioners. Medical practitioners who render services under Medicare at a public hospital have the same legal obligations as exists for services rendered in their private rooms or private hospital.
   - Feedback from stakeholders during the project indicated that hospitals commonly make claims to Medicare on behalf of practitioners and subsequently receive the benefits. As a general rule, a hospital billing on behalf of the practitioner will not be liable for the Medicare debt in circumstances where a false or misleading statement has been made. This means that in the event of an audit, medical practitioners would be asked to repay regardless of whether or not they did or did not have control over the billing or whether or not they personally received the Medicare payment.
   - There is no legislative or administrative requirement for LHNs and public hospitals to capture all information necessary to substantiate whether a Medicare benefit was correctly claimed. Absence of such information results in difficulties with
determining compliance or non-compliance and impacted on the ability of individual providers to substantiate claims.

3. The outcome of the personal attendance items audit was a 57% non-compliance rate, with services provided by 16 of the 28 specialists and consultant physicians assessed as non-compliant. This was primarily attributed to lack of sufficient documentation and/or evidence to substantiate the requirement to personally render attendance item services.

- The responses to a survey sent to all specialists and consultant physicians at one hospital indicated a desire for training in Medicare billing. Of particular concern was the number of respondents who thought that their provider number can be appropriately used by other junior staff to bill Medicare when this is not allowed.

4. Effective targeting of audit activities relies upon the ability to accurately identify practitioners who have rendered services of concern. The project found that Medicare claims data could not be used to accurately identify private patient status, location at which the service was rendered or who personally rendered the service.

5. Use of a secure email capability helped to reduce the red tape for hospitals participating in an audit of large volumes of services claimed under Medicare. This capability existed at the Department of Human Services but currently is unavailable at the Department of Health. This capability has been planned for implementation at the department in 2017.

**Savings**

As at 31 March 2017, the department had achieved savings of $22.52 million. This is $2.18 million below the targeted savings of $24.7 million. Of the savings achieved, 98 per cent ($21.98 million) was attributed to behaviour change following compliance interventions and education. The LHNs repaid approximately $0.54 million in incorrect claims through self-assessment of claims data provided.
**Recommendations**

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<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
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<tr>
<td><strong>Recommendation 1</strong></td>
<td>That the department continues to provide clarity about the use of Medicare in public hospitals through the ongoing development of on-line education resources.</td>
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<td><strong>Recommendation 2</strong></td>
<td>That terms in the <em>Health Insurance Act 1973</em> and Business Rules for the NHRA regarding the use of Medicare in public hospitals be reviewed for clarity and consistency, and are amended where necessary.</td>
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<td><strong>Recommendation 3</strong></td>
<td>That the department liaise with the Department of Human Services about ways to enhance the accuracy of provider and service location data.</td>
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<td><strong>Recommendation 4</strong></td>
<td>That the department consider how the NHRA may be used to enhance data capture by public hospitals for the purpose of substantiating services rendered under Medicare.</td>
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<td><strong>Recommendation 5</strong></td>
<td>That the department liaise with the Administrator of the National Health Funding Pool for access to public hospital patient matched data for compliance purposes.</td>
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<td><strong>Recommendation 6</strong></td>
<td>That the department develop on-line education for hospital practitioners about the requirements for them to make adequate and contemporaneous records of services they initiate or render to private patients in public hospitals.</td>
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<td><strong>Recommendation 7</strong></td>
<td>That the department develops a secure email capability for the purpose of communicating with external stakeholders when conducting compliance interventions.</td>
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<td><strong>Recommendation 8</strong></td>
<td>That the department provides advice to the Minister on options to enhance powers to audit and/or recover incorrectly paid Medicare benefits directly from the entity (other than the rendering practitioner).</td>
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**Conclusion**

The department has gained a better understanding of Medicare billing practices within public hospitals. Significant barriers were identified during the compliance interventions that impact the ability to effectively identify and treat risks associated with double billing. Despite these, the department was able to significantly influence the billing of Medicare in public hospitals through its positive engagement with hospital administrators and targeted hospital compliance interventions. There is potential for much to be achieved from the department continuing to enhance Medicare program integrity in public hospitals.
1 Background

1.1 Introduction

Services to patients who attend public hospital emergency departments are funded by the Commonwealth through an arrangement with the states and territories, previously under the National Healthcare Agreement (NHA) and since 1 July 2012, under the National Health Reform Agreement (NHRA).

Medicare benefits are not payable for these services due to the operations of paragraph 17(1) (a) and subsection 19(2) of the Health Insurance Act 1973 (the Act). The intention of the Act is to prevent ‘double billing’ by ensuring that a service that is funded by some other mechanism does not also receive funding under Medicare.

During 2011-12, one major public hospital was found to have made incorrect claims under Medicare for diagnostic imaging services provided to patients attending the emergency department. The Department of Human Services recovered incorrectly paid benefits to an agreed amount of $2.27 million.

Analysis of Medicare data identified similar billing patterns in public hospitals across Australia. This raised the possibility of widespread double billing by public hospitals. In particular, it was assumed that inappropriate claims to Medicare were made by public hospitals for pathology and diagnostic imaging services rendered to emergency department patients.

As a result, the ‘Fraud prevention and compliance – Improve billing practices within public hospitals’ Budget measure (known as the Inappropriate Billing Project) was funded in the 2012–13 Budget and announced in the 2013-14 Budget.

A total of $1.8 million was provided for the department to review, understand and address inappropriate billing of Medicare by hospital emergency department patients for pathology and diagnostic imaging services. The Budget measure was expected to provide savings of $24.7 million over four years.

In late 2014, the scope of the project was expanded to include education and compliance interventions for a broader range of topics related to claims to Medicare in public hospitals. Feedback from public hospitals had identified a need to clarify Medicare billing in regard to rights of private practice, outpatient claims and claims for personal attendance items. There was also a need to explore whether legislative amendments could improve the operational effectiveness of undertaking compliance interventions in the public hospital sector.

As a result of Machinery of Government changes on 30 September 2015, the health provider compliance function, along with the Budget measure, moved from the Department of Human Services to the Department of Health (the department) on 5 November 2015.

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The following report describes the activities undertaken as part of the Inappropriate Billing Project and the findings from those activities. The discussion examines the implications of new knowledge gained from the project and proposes recommendations to assist with the development of future programmes and compliance activities promoting voluntary compliant behaviour.

1.2 Objectives

The primary objective of the Inappropriate Billing Project was to build the capacity of the department to identify and treat risks associated with incorrect Medicare billing practices within public hospitals funded under Commonwealth or State arrangements. It also aimed to promote voluntary compliance with Medicare billing requirements in relation to specific issues.

1.3 Scope

1.3.1 Within scope

Activities within scope of the project included:

- Development and delivery of education products for public hospitals in relation to billing Medicare, with topics of education limited to:
  - pathology and diagnostic imaging services in public hospital emergency departments
  - claiming of referred consultation services under Medicare in public hospitals
  - claiming Medicare in public hospital when exercising right of private practice and
  - services provided under rights of private practice at public hospital outpatient departments

- Exploring possible legislative change to strengthen the Act. In particular, regarding ability to determine non-compliance and power to recover benefits from a third party.

- Conduct of compliance interventions in relation to inappropriate billing in public hospitals as follows:
  - pathology and diagnostic imaging in emergency department of public hospital self-assessment
  - personal attendance items targeted education
  - personal attendance items audit (one hospital)
  - recoveries from interventions relating to rights of private practice tip-offs

- Calculation of savings associated with compliance interventions, including change in billing behaviour.

1.3.2 Out of scope

Activities out of scope of the project included:

- Health practitioners/agencies holding an exemption to subsection 19(2) of the Act.
• Health practitioners referring from private practices and private hospital locations.
• Emergency practitioners who provide a referral to a patient who then has the service rendered by an external group not associated with the hospital.
• Practitioners who do not work at public hospitals or hospitals not funded under the NHRA.
• Educating on or auditing the clinical content of the service.
• Rural public hospitals and public hospitals located in the Northern Territory.

1.4 Outcomes, Key deliverables and Performance Indicators

1.4.1 Expected outcomes

Expected outcomes of the project were to:
• Identify and treat misuse of the Medicare Benefits Schedule (MBS) by public hospitals.
• Provide clarity for health practitioners and hospital administrators about their responsibilities under the MBS and the NHRA.
• Provide the department with greater knowledge of the use of the MBS by public hospitals. This will assist with the development of future programmes and compliance activities promoting voluntary compliance with Medicare billing requirements.
• Explore possible legislative change to strengthen the Act.

1.4.2 Key deliverables

Key deliverables for the project were:
• **Education** delivered to public hospital practitioners, hospital administrators and Local Hospital Networks (LHN) about Medicare billing requirements. Education products included:
  - Health Professional Guidelines (HPG)
  - eLearning modules
  - webpage content
  - case studies
  - published articles
• A **report** providing evidenced based recommendations to address any identified risks associated with incorrect Medicare billing.
• **Recommendations for possible legislative change** to strengthen the Act.
• **Compliance inventions** in relation to inappropriate billing in public hospitals, included:
  - compliance strategy for pathology and diagnostic imaging services rendered to emergency patients in public hospitals.
  - personal attendance items targeted education strategy followed by a compliance audit strategy
- recoveries from interventions relating to rights of private practice tip-offs

- **Savings** associated with compliance interventions.

1.4.3 Financial management

The budget allocation for the project was $1.8 million over four years.

The Department of Human Services classified this project as financially simplified and funding for its implementation and ongoing stages was directly allocated to the operating budget of relevant divisions in the department.

As the project has been managed in accordance with the financially simplified project methodology, financial management of the project was not required to be reported.

1.4.4 Key Performance Indicators

The project’s Key Performance Indicators (KPIs) were to:

1. Achieve the targeted savings of $24.7 million.
2. Progress to timelines.

1.5 Assumptions, Risks and Constraints

1.5.1 Assumptions

Project assumptions:

- The government of the day and legislation will support the project during its lifecycle.
- The department’s data is effective in identifying health practitioners who appear to be non-compliant in their MBS billing.
- Internal and external stakeholders would be satisfied with the timeliness and nature of consultations.
- State health departments, hospitals and staff will co-operate with the project’s compliance activity.
- Provisions in the Act would enable the department to issue a formal request to produce documents where there is a reasonable concern that benefits have been paid under the Act that exceed the amount that should have been paid\(^3\) (for services rendered after 9 April 2011).
- Documents produced can demonstrate that the health practitioner was salaried under other arrangements when they received Medicare benefits and therefore establish non-compliance.
- Agreed interpretation of the former NHA, current NHRA and the Act with the policy areas.
- The funding allocation would be sufficient.

\(^3\) See s129AAD *Health Insurance Act 1973*
Outlays will be reduced in forward years through indirect savings relating to changed health practitioner behaviour and public hospital billing processes.

Savings would result from changed health practitioner behaviour and changed public hospital billing processes after compliance interventions.

Staff with the required skills would be available and able to be retained on the project.

Timeframes allocated would be adequate to complete the work.

1.5.2 Risks and constraints

The following risks to the project were identified:

- The project would not deliver on planned administered savings.
- The project would not meet key milestones and would not be completed on time.
- The Minister and Executive would not be informed in a timely manner of sensitive project issues.
- The products developed under the project would not achieve the desired change in billing behaviour.

Constraints identified at the beginning of the project included:

- An operational budget of $1.8 million allocated over the four financial years from 2012-13 to 2015-16.
- A timeline for project delivery of four financial years (1 July 2012 – 30 June 2016).
- Legal constraints in regard to the powers, provisions and administrative procedures of relevant legislation, for example the Act, the NHA and NHRA (noting that the agreements are not legislation and are not legally binding).
- Some stakeholders may oppose implementation of compliance interventions due to the sensitivity of this project.

1.6 Governance

1.6.1 Project management

Best practice project management principles and practices were followed in the planning, execution and closure of the Budget measure.

Project governance was implemented to provide a structure to support decision making as well as the day to day performance of activities under the project.

A project team with an Executive Level 2 Project Manager was established. The Project Manager reported to the Senior Executive Service Band 1 Senior Responsible Official (SRO),

4 The Department of Human Services’ Project Management Framework was applied throughout the project’s lifecycle. The framework was based on best practice standards of P3M3 (Portfolio, Programme and Project Management Maturity Model).
who reported to the First Assistant Secretary, Health Provider Compliance Division. Roles and responsibilities of each staff member were defined in relevant project documents.

A Health Compliance Project Board (the Board) was established to provide governance and direction at the Senior Executive Service Band 2 level for the management of two 2012-2013 Health Compliance Budget measures. The Board membership comprised:

- General Manager, Debt, Appeals and Health Compliance Division, Department of Human Services (First Assistant Secretary, Health Provider Compliance Division, Department of Health from 5 November 2015) (Chair)
- General Manager, Health Programmes Division, Department of Human Services (Deputy Chair)
- First Assistant Secretary, Research, Data and Evaluation Division, Department of Health
- First Assistant Secretary, Medical Benefits Division, Department of Health

The Board provided the project with overall strategic direction and governance; reviewed and approved all key project documentation including project plans and performance reports; monitored and evaluated progress of the project; approved any significant variations to the scope, cost, time, quality, or stakeholder engagement requirements of the projects; and resolved issues as required.

Board meetings were held quarterly from August 2012, with papers distributed out-of-session when required. All meetings and out-of-session distributions have been conducted in accordance with the Health Compliance Project Board Operation.

To engage with the policy owners of the National Agreements, a working group was established with members from the Research, Data and Evaluation Division of the Department of Health. The working group met regularly to discuss the implementation of the department’s compliance position so that it would align with the intent of the National Agreements.

1.6.2 Project reporting

In accordance with project management principles and practices, a project plan, stakeholder engagement and communication plan, risk management plan, and deliverables schedule were developed and approved by the Board. Project status reports were provided to the department’s Executive monthly. These reports provided visibility, accountability and updates of issues, risks, budget and schedule and explanations for any variations. Change controls in respect of each project stage were documented and approved by the SRO and the Board.

The SRO received weekly written reports from the project manager. The key elements of these reports were communicated to the Board through monthly status reports and formal quarterly reports.

In addition to formal reporting, stakeholders were kept informed through the Working Group and through direct communication from the project manager.
Any changes to project objectives, protocols or methodology were sent to the Board for approval. In this way, key stakeholders from both departments were progressively informed and involved in issues affecting the project methodology, findings and conclusions.

2 Methodologies

2.1 Education

Education activities for the project aimed to raise the awareness of public hospital practitioners, hospital administrators and LHNs about legal obligations when billing under Medicare for private patients in public hospitals.

Education was delivered in accordance with the project’s education strategy. The objectives of the strategy were to:

• support the broader departmental business objective of developing resources to foster voluntary compliance
• provide information to stakeholders about inappropriate billing and specifically about compliance with subsection 19(2) of the Act
• measure behaviour change of hospital practitioners
• increase awareness of the availability of education resources for health practitioners billing under Medicare in hospitals provided with funding under the NHRA

Under the strategy the project team worked closely with department’s policy area to interpret the NHRA and the Act as a basis of the education messages.

The primary education messages were:

• practitioners who initiate or render services under Medicare are legally responsible for benefits paid for these services
• recovery of benefits will be sought by the department for incorrect claims under Medicare
• practitioners who bill under Medicare for services provided in public hospitals should be aware of the Business Rules for the NHRA, as Medicare benefits may not be payable for services in public hospitals when these services are funded under this Agreement
• practitioners who bill under Medicare have obligations under the Act, in particular subsection 19(2)

The strategy provided for the development and delivery of:

• a range of public hospital specific education resources, including new webpages, case studies, HPGs, eLearning activities, a fact sheet, articles and a presentation package
• education provided during compliance interventions

It was anticipated that by providing education, there may be some change in the billing behaviour of practitioner’s providing services to private patients in public hospitals.
2.1.1. Education resources

The ‘Public Hospital Compliance’ webpage was published as a single entry point for education resources developed under the project and covered the following topics:

- Billing Medicare in public hospitals (containing overarching content)
- Claiming of referred consultation services under Medicare in public hospitals
- Pathology and diagnostic imaging services in public hospital emergency departments
- Claiming Medicare in public hospitals when exercising rights of private practice
- Services provided under rights of private practice at public hospital outpatient departments

Web access numbers were monitored on a monthly basis.

A separate webpage was developed for each topic, to clearly explain the eligibility criteria when billing Medicare. These webpages were complemented by:

- case studies to support understanding of the eligibility criteria
- HPGs to help medical practitioners prepare for future audit activities

The ‘Billing Medicare in Public Hospitals’ eLearning module has been developed and focuses on the billing and claiming requirements for consultation services in public hospitals; exercising rights of private practice; and services provided under rights of private practice at outpatient departments. Pathology and diagnostic imaging content has also been developed for inclusion in this module. The module is undergoing Web Content Accessibility testing with the anticipation that it will be published on the Public Hospital Compliance webpage pending results of this testing.

A fact sheet, ‘Medicare benefits billing compliance activity’, was sent with letters to LHNs/hospitals during the pathology and diagnostic imaging services in public hospital emergency departments’ compliance intervention, and provided to professional association stakeholders.

Continued promotion of the Public Hospital Compliance education resources has occurred through articles published in Department of Human Services’ online publications: ‘Forum’ and ‘News for Health Professionals’.

A presentation on ‘Medicare and Public Hospital Services’ was provided at a forum for Victorian public hospital finance officers.

2.1.2. Education provided during compliance interventions

Following provision of sample data to LHNs for the pathology and diagnostic imaging services in public hospital emergency departments compliance intervention, the department met with LHNs to review the data sent and to discuss Medicare processing procedures. These visits provided an opportunity for participants to receive education on the appropriate billing of Medicare services for emergency department patients in public hospitals.
The implementation of the personal attendance items compliance interventions provided further opportunities to:

- explain the legislative requirements on billing Medicare for personal attendance items
- explain the basic criteria needing to be met across all services billed to Medicare in public hospitals
- promote published education material to help voluntary compliance

2.2 Exploring possible legislative change

The combination of the *Health Insurance Act 1973*, the National Health Reform Agreement and Business Rules and the *Public Governance, Performance and Accountability Act 2013* forms the regulatory framework (Appendix 1). The aim of this deliverable was to highlight key gaps within the relevant sections and provisions of the existing regulatory framework that, through legislative/regulatory change, could be strengthened to enhance regulatory compliance and better protect the integrity of the Medicare programme.

Gaps and limitations with the current framework were identified during the conduct of the education and compliance intervention activities and legal advice was sought as required for interpretation of the regulatory framework.

2.3 Compliance Interventions

**Compliance interventions** conducted for the project included:

- pathology and diagnostic imaging services in public hospital emergency departments self-assessment
- personal attendance items targeted education
- personal attendance items audit
- recoveries from interventions relating to rights of private practice tip-offs

2.3.1 Pathology and diagnostic imaging services in public hospital emergency departments self-assessment

The aim of this compliance intervention was to review, understand and address inappropriate billing of Medicare by hospital emergency departments, in relation to pathology and diagnostic imaging services that were already funded under another arrangement with the Commonwealth or State.

The intervention included the following key activities:

**Identification of the risk and extraction of data**

Analysis of Medicare claims data for the period of 1 July 2011 to 30 June 2012 identified 77 hospitals in 49 LHNs, across all states and territories (except the Northern Territory), where pathology and/or diagnostic imaging services provided to emergency department patients may have been claimed under Medicare when they had already been funded under an arrangement with the Commonwealth or State. Data for Northern Territory did not show the claiming pattern seen in other regions.
The data analysed by the department was extracted based on the following approved data selection criteria:

- all pathology and diagnostic imaging services within the date range of 1 July 2011 and 30 June 2012 (Note: the project was not to impede in any way with the introduction of the NHRA on 1 July 2012, therefore restricting any review of data past 30 June 2012)
- requesting medical practitioners with Emergency Medicine specialities only (as indicated either in the Australian Health Practitioner Regulation Agency online database and/or the Medicare Provider Directory System)
- a threshold of $1,000 and more on the rendering practitioners claiming benefits was applied to ensure minor billing errors were excluded
- rendering and requesting relationships existed within the same hospital location
- practice locations that can be identified as public hospitals
- services requested and rendered on the same day
- inclusion of non-admitted and admitted patients (some diagnostic services may have erroneously been labelled as being provided to an admitted patient to facilitate payment of Medicare benefits)

Informing the state and territory health departments and the LHNs about the department’s compliance concerns

On 4 February 2013, the department wrote to state and territory health departments and LHNs to notify them of the pending review on billing Medicare for pathology and diagnostic imaging services provided to public hospital emergency department patients. The letters identified the hospitals of concern as relevant to each state and territory as well as the amount of Medicare benefits under review. All letters were sent by 12 February 2013.

Consulting with key external stakeholders including related colleges and associations

By 14 February 2013, the department had completed stakeholder meetings with nine relevant medical professional groups to notify them of the review and discuss the project. Stakeholders consulted were the Australian Medical Association; Royal College of Pathologists of Australasia; National Council of Public Pathologists; Australian Association of Pathology Practices; Royal Australian and New Zealand College of Radiologists; Australian Diagnostic Imaging Association; Avant Mutual Group Ltd; Royal College of Medical Administrators; and the Australasian College of Emergency Medicine.

Sending Medicare claims data to LHNs and the NSW Ministry of Health

Commencing March 2013, the department sent Medicare claims data to 49 LHNs, representing 77 public hospitals, and requested that each LHN review their own records prior to completing a self-assessment on whether the claims were made correctly. While the Victorian Department of Health preferred that the department speak with LHNs directly, the NSW Ministry of Health advised they would be the central contact point and distribute the data to their LHNs.
Sample data was sent to 59 hospitals (where the total number of patients was greater than or equal to 50) and full data was sent to 18 hospitals (with less than 50 patients) in accordance with approved business rules.

Sample data was sent because of the associated administrative burden for the hospitals of reviewing large amounts of data. For example for one public hospital there were 26,994 lines of data.

In preparing a sample of services for a hospital, a random selection of patients was made for the period 1 July 2011 to 30 June 2012 in accordance with either one of the following:

- five per cent of the total number of patients, if five percent is more than or equal to 50; or
- 50 patients, if the total number of patients is more than 50; and five percent of the total number of patients is less than 50

**Meeting with LHNs, the NSW Ministry of Health and the Victorian Department of Health**

During the period April to September 2013, follow up meetings (both face to face and teleconferences) were held with 34 individual LHNs and the NSW Ministry for Health (representing 15 LHNs) to discuss their hospitals’ billing and admission processes, together with the results of their data review.

The department also met with the Victorian Department of Health during June 2013 to discuss billing and admission processes for their hospitals.

**Letter to LHNs providing opportunity to voluntarily repay any incorrectly claimed Medicare benefits**

On completion of the meetings, the department sent a letter to LHNs and the NSW Ministry of Health to advise they should voluntarily repay any incorrectly claimed Medicare benefits identified from their self-assessment of the data, after which the matter would be finalised.

**2.3.2 Personal attendance items targeted education**

This intervention aimed to address concerns raised that some specialists or consultant physicians in public hospitals may be incorrectly claiming Medicare for referred consultation services or subsequent attendances that are rendered by junior medical staff.

The intervention comprised writing to LHNs about Medicare billing requirements for consultation services for specialists and consultant physicians in public hospitals.

The letter also:

- invited LHNs to provide the department with their policy documents and/or staff directives in relation to claiming of consultation services under Medicare, to assist the department to gain an understanding of public hospital policies and their effect on billing practices
- provided information about the department’s online education resources that explain obligations for billing consultation services in public hospitals
Following discussion with policy areas, the distribution of the letters was limited to 10 randomly selected LHNs, representing 47 public hospitals across Australia.

The selection targeted LHNs with a greater number of junior medical staff and consultant medical officers and was stratified to provide a nation-wide distribution, broadly representative of population proportions.

The 10 letters were sent in October 2015 following a courtesy phone call to the relevant senior representatives in state and territory health departments, to provide details on the activity and the selected LHNs in their state and territory. A copy of the letter(s) sent to their LHN(s) was also provided if requested.

2.3.3 Personal attendance items audit

The focus of this audit was to assess whether specialists and consultant physicians at St George Public Hospital (St George) had met the personal attendance requirements for MBS items under Groups A3, A4, A29, A28, A12 and A26 as stipulated in the Health Insurance (General Medical Services Table) Regulation 2014 (GMST) - that is, that they had personally rendered the service to the patient.

This hospital was targeted for audits as a result of two tipoffs about personal attendance billing issues.

The audit included the following key activities:

**Informing St George Executive about the department’s compliance concerns**

On 26 October 2015, the department wrote to the Director of Clinical Services at St George and the Chief Executive, South Eastern Sydney Local Health District, requesting a meeting to discuss policies used at St George that may be incorrectly directing medical practitioners to bill Medicare for consultation services that are not eligible for payment of benefits.

This meeting was held on 25 November 2015, during which St George administrators and representatives from their local hospital district were advised of:

- the legislative requirements for personal attendance items when billing under Medicare
- the upcoming audit of specialists and consultant physicians providing services at the hospital
- the availability of compliance audit resources on the department’s website

A communique was provided to St George on 15 December 2015 for distribution to specialists and consultant physicians at the hospital, to:

- assist with their understanding the audit process
- provide advice where they could go within the hospital for assistance to access documentation
- outline the legislative requirements when billing consultation services
- provide information about available education material
Extraction of data

Twenty eight specialists and consultant physicians working at St George (except for those identified as working in the emergency department) were selected for audit, because they were identified in the top claiming medical practitioners (by number of services) of personal attendance services. A total of 1197 transaction lines for the period 1 April 2015 to 30 June 2015 relating to these specialists and consultant physicians were randomly selected for audit.

Conduct of the desk audit

From 6 January 2016, the 28 specialists and consultant physicians were asked to supply documentation to substantiate that personal attendance requirements were met (i.e. that the specialist or consultant physician personally rendered the service to the patient) for randomly selected services claimed during the audit period.

Where services were not substantiated, recoveries of incorrectly claimed Medicare benefits were progressed.

Public hospital billing survey (the survey)

The department also provided hospital administrators with a survey to send to specialists and consultant physicians working at St George (Appendix 2).

The aim of the survey was to understand who benefits from the publication of education resources and what topics may be useful as part of the department’s continued approach to developing education resources.

The survey was sent out to specialists and consultant physicians at the hospital on 24 May 2016 by the Director of Clinical Services and respondents were encouraged to answer the questions based on their experiences of billing Medicare in public hospitals.

At closure of the survey there were 37 responses received.

2.3.4 Recoveries from interventions relating to rights of private practice tip-offs

In late 2012 the Queensland Minister for Health engaged the Queensland Auditor-General to undertake a performance audit into Queensland Health’s right of private practice arrangements in the public health system.

In June 2014 the Queensland Audit Office referred four medical practitioners to the Department of Human Services that may have breached subsection 19(2) of the Act.

In this instance, the project aimed to establish the value of any direct savings (achieved through repayment of incorrectly claimed Medicare benefits or debts raised) that had been made from compliance activities in relation to the four medical practitioners. Learnings from the compliance activities were also used to inform the recommendations under rights of private practice.
3 Findings

The three methods used to review, understand and address inappropriate billing of Medicare by public hospitals included education, review of possible legislative changes and compliance interventions. The following describes findings from each type of activity.

3.1 Education

3.1.1 Stakeholder engagement

LHNs expressed a need for education and clarity on what is compliant and non-compliant practice. They displayed an eagerness and willingness to learn their responsibilities in relation to billing under Medicare and to increase their knowledge of Medicare requirements. LHNs also appreciated the opportunity to have face-to-face engagement with the department to discuss Medicare claiming.

The Victorian Department of Health had provided their LHNs with written instructions for admission billing according to that state’s interpretation of the Business Rules for the NHRA. They believed admission was based on the clinical diagnosis and time spent in the emergency department related to meeting the National Emergency Admission Target ‘four hour rule’. This admission policy appeared to be taken by a number of hospitals as a justification to charge all services to Medicare from the time the patient presented at the emergency department, if the patient subsequently elected to be treated as a private patient.

Following face-to-face discussion with the department, this admission policy was amended in 2012. One LHN repaid Medicare benefits as a consequence of the revised policy advice they received from the state health department. However discussion with various LHNs within the state found variability in interpretation and thus compliance with their own state policy.

In response to a request from the Victorian Department of Health, the department gave a presentation on ‘Medicare and Public Hospital Services’ at a monthly meeting of approximately 50 public hospital finance officers from across the state. Questions raised by attendees and debate amongst attendees confirmed there was variable interpretation of the NHRA and lack of knowledge of requirements for billing under Medicare by personnel tasked with doing Medicare billing in the state’s public hospitals.

The distribution of education letters regarding Medicare requirements for personally rendering attendance item service (sent to 10 LHNs) was also well received by the corresponding state and territory health departments. The Queensland and Tasmanian departments in particular expressed an eagerness to provide consistent messages and policy across all hospitals in their state and requested copies of these letters to provide to their private practice managers to include in their own (state government) education material.

The department liaised closely with administrators of a major metropolitan public hospital in New South Wales, St George, for the audit of personal attendance items. Information provided by the department prompted a review of the hospital’s policies and procedures in relation to use of Medicare. The hospital administrators stated their intention “to be stricter
with doctors who have had a more casual attitude in billing Medicare for services rendered by registrars; to set an expectation that doctors were expected to write in the clinical notes; to request doctors to check that the correct item number is being billed; and to initiate a bi-annual review of a sample of services claimed to check whether they were being correctly claimed”.

3.1.2. Education resources

The ‘Public Hospital Compliance’ webpage was designed as a single site for health practitioners and hospital administrators to electronically access information about legal responsibilities and requirements for billing services under Medicare in public hospitals. Increased web activity was noted in the months following publication of new education material (Appendix 3). Online promotion of the education resources resulted in spikes to unique web views to published content. The results were as follows:

- 7 May 2014 an article published in the ‘Forum’ advising of the ‘Pathology and diagnostic imaging services in public hospital emergency departments’ webpage was associated with 502 more unique views of the webpage than the previous month.
- 9 July 2015 an article published in ‘News for Health Professionals’ advising of the ‘Providing services to your private patients in public hospitals’ webpage was associated with up to 118 more unique views from the previous month.
- 30 June 2016 an article published in ‘News for Health Professionals’ advising of the ‘New online resources to help with billing Medicare in public hospitals’ webpage was associated with up to 207 more unique views from the previous month.

The education letter about Medicare requirements for personally rendered attendance item services, sent in October 2015, made reference to the education resources developed by the department. A corresponding increase in unique views of the ‘Claiming of referred consultation services under Medicare in public hospitals’ website was observed during the months of October, November and December 2015.

3.2 Review of possible legislative changes

The Health Insurance Act 1973 (the Act) and the National Healthcare Reform Agreement (NHRA) provide the framework to guide billing for services rendered at public hospitals. The Act, including its subordinate regulations, is primarily directed at the actions of individual health practitioners. Medical practitioners who render services under Medicare at a public hospital have the same legal obligations as exists for services rendered in their private rooms or private hospital. This includes the necessity to fulfil requirements outlined in the MBS and to be responsible for repayment of Medicare benefits that have been paid incorrectly. Compliance is supported by the provision of legally enforceable investigative, recovery and offence provisions.

The NHRA is primarily directed at public hospital authorities (state and territory governments, LHNs and hospital administrators). The NHRA is supported by a number of Schedules, including Business Rules that reflect policy intent for actions at public hospitals.
The Business Rules are not based in legislation and are not legally enforceable. Compliance with the Business Rules relies on the interpretation by and goodwill of participating parties. Issues related to both the Act and the NHRA were found to constrain compliance management of incorrect Medicare billing.

3.2.1 Health Insurance Act 1973

Interpretation of “under an arrangement”

Under subsection 19(2) of the Act, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with the Commonwealth; a State; a local governing body; or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory. This provision is intended to prevent double billing, for example where public hospital services funded by the Commonwealth via the State are also billed under Medicare. The term ‘arrangement’ in subsection 19(2) of the Act is open to interpretation. This was evident during discussions with LHNs.

The department found that some LHNs out-source the provision of all their pathology and/or diagnostic imaging services to state or privately operated companies. This was particularly evident in Victoria and Queensland. These LHNs believed they were not accountable for the third parties billing services to Medicare and therefore not responsible for repayment of incorrectly claimed Medicare benefits. In the absence of documents to demonstrate a direct financial contract between the Commonwealth and the LHN or hospital, or between the state and the LHN specifying an amount for pathology or diagnostic services, they regarded that there was no ‘arrangement’ and subsection 19(2) did not apply.

The department considers out-sourcing services to a third party does not remove the obligation on the state or territory to provide services to emergency department patients free of charge. It is the department’s view that LHNs have responsibility to repay debts owed due to double billing claims under Medicare. Whether or not the LHN then chooses to recoup the money from their out-source service provider would be a matter between the LHN and the third party.

A private hospital in Queensland that receives funding to provide hospital services to public patients considered they are not subject to subsection 19(2) of the Act because in their view they are not bound by the NHRA. Furthermore, once block funding from their state department had been completely used, the hospital considered that, because they were a privately run institution, they were then free to bill any further services for the remainder of the year under Medicare to make up the shortfall in funding.

However, public services provided by private hospitals are funded under an arrangement with the state or territory, who in turn have an arrangement with the Commonwealth. Public services provided by private hospitals are therefore subject to the Act.

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5 Business Rules A52, A53 and A57 of the NHRA
**Power to enable debt recovery from a hospital authority or business entity**

Section 129AC of the Act provides a statutory basis for the recovery of Medicare benefits and subsection 129AC (1) relates specifically to circumstances where benefits are paid as a result of the making of a false or misleading statement. Excess amounts paid as a result of a false or misleading statement constitute a debt to the Commonwealth and are recoverable from the person by or on behalf of whom the false or misleading statement was made (the medical practitioner or in certain cases the hospital). This applies regardless of whether or not the person who made the statement has actually received the Medicare benefit. The department has an obligation under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) to recover monies where a debt to the Commonwealth has been established.

Feedback from stakeholders during the project indicated that hospitals commonly make claims to Medicare on behalf of their practitioners and subsequently receive the benefits. Depending on the private arrangement between the practitioner and the hospital, all or a portion of the Medicare benefit may flow to the practitioner.

As a general rule, under section 129AC, a hospital that is billing on behalf of the practitioner will not be liable for the Medicare debt in circumstances where a false or misleading statement has been made. It is only if the hospital is not acting on behalf of the practitioner that section 129AC can be relied on to recover the benefit from the hospital and not the practitioner. The Australian Medical Association raised a concern that in the event of an audit, medical practitioners could feel unfairly targeted for billing over which they had no control and from which they received no Medicare payment.

Although Medicare payments are made to the practitioners via their nominated bank account, the department has no visibility of any payment arrangements that may exist between practitioners and their LHNs and/or hospitals. In some cases Medicare payments may be made into bank accounts that are not directly controlled by the practitioner.

**Requirement to capture information to substantiate claims under Medicare**

There is no legislative or administrative requirement for LHNs and public hospitals to capture all information necessary to substantiate whether a Medicare benefit was correctly claimed.

Information required in an audit should establish the eligibility of the patient, the practitioner and the service. Absence of such information results in difficulties with determining compliance or non-compliance and thus affects the accuracy of audit findings and amounts recoverable. Examples of lack of information and limitations encountered are described below.

**Information systems**

Information management systems and types of information recorded differ between different hospitals, and even within different departments of the same hospital. For example, an information system used in the emergency department may differ to that used in the rest of the hospital. As the systems were not linked, there was no ability to automatically cross-check Medicare claims data and quickly substantiate claims for audit
purposes. The resultant manual process proved too burdensome for the hospitals, and in response the department limited the amount of line by line patient data for self-assessment.

**Patient eligibility – admitted private patient**

There is often a lack of sufficient detail in hospital records to determine whether a patient was a public or private patient and whether they were admitted or not admitted at the time a service was rendered.

Despite the admitted patient making a formal election (in writing) to be treated as a private patient, the time of day of the transition was not documented in hospital records. Without this necessary detail, the department was unable to successfully substantiate if claimed services were rendered before or after the patient elected to be treated privately. Similar challenges were experienced in relation to the lack of records showing the time at which a patient was admitted after presenting at an emergency department.

Hospitals contacted as part of this project advised they did not record the time of clinical decision to admit a private patient, or the time when the patient elected to be treated as a private patient, both of which are required to determine the point in time at which the patient becomes eligible as an admitted private patient.

**Practitioner eligibility – right of private practice agreements**

The existing regulations provide no direction on the operation of right of private practice agreements in relation to eligibility for payment of Medicare benefits.

A right of private practice agreement between a medical practitioner and the engaging hospital or health service generally detail the distribution of MBS benefits as well as provision of services and facilities use by the practitioner. The nature and scope of the right of private practice varies depending on the terms that are agreed under a formal agreement and can be influenced by state boundaries and associated state legislation and statutory instruments.

The disparity in how rights of private practice are written and implemented is evidenced by the multiple models of operation that exist across Australia. It has been found that different states may be operating with two or more different models at any time. New South Wales operates with five different models of private practice; whereas the Australian Capital Territory has three general models and the remainder of the states operate with two models. Private practice arrangements may also differ between specialties within the same hospital.

In order to be able to determine if a practitioner is eligible to render services under Medicare to a private patient while exercising their right of private practice, the department needs to establish that the medical practitioner has a right of private practice agreement;

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6 For example, in Queensland under s47 of the *Queensland Hospital and Health Boards Act 2011*, the chief executive may issue health service directives relating to the delivery of health care. Health Service Directive #QH-HSD-015:2012 is entitled “Terms and Conditions for Contractors Providing Health Services and Employees Exercising a Right to Private Practice”. This directive mandates the use of particular contract templates for different categories of medical practitioners.
and was exercising their right of private practice (without being paid by the public hospital or health service) at the time when the service was rendered.

It appears that formal agreements governing rights of private practice do not contain the level of detail needed by the department to effectively determine double billing, that is, that the practitioner was not in receipt of a salary at the time of service. For example, terms specifying which days or week/times of day/sessions the practitioner can exercise their right of private practice are not included in either the formal agreement, or the hospital records.

Medicare claims data analysis for the four medical practitioners referred by the Queensland Auditor-General included data for services claimed during and after the Queensland Audit Office audit. The Medicare billing was generally not substantial or consistent, dropping to nearly zero at times including during and after the audit period.

External legal advice was also sought to confirm whether the private practice arrangements in place for the medical practitioners were consistent with the Act. The scope of the legal advice included establishing whether in the first instance a formal agreement with the hospital could fall under the definition of an ‘arrangement’ under subsection 19(2). Clarity was also sought in relation to what happens if the other funding arrangement under subsection 19(2) is recovered. In particular, would a Medicare benefit paid still be a breach of subsection 19(2) if the provider had their state salary recovered.

It was clear that subsection 19(2) relates to the time when the service was rendered, therefore any recovery of salary by the hospital after that time did not preclude the operation of the subsection. However, the legal advice did not provide sufficient clarity on the remaining question to proceed with any audit activities.

**Service eligibility – requirement for personally rendering the service**

Subsection 82(3) of the Act provides that a Professional Services Review Committee must, in determining whether a practitioner’s conduct in connection with rendering or initiating services was inappropriate practice, have regard to whether or not the practitioner kept adequate and contemporaneous records of the services. The standard to be met is set out in the *Health Insurance (Professional Services Review) Regulations 1999*. This includes that each entry be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient’s ongoing care and that the record must be completed at the time, or as soon as practicable after, the practitioner rendered the service.

It is expected that the rendering practitioner will make their own records in respect of the services they render to private patients, whether those services are provided in rooms, at a private hospital, or at a public hospital. A personal entry made by the rendering practitioner may serve to substantiate that the service was personally rendered by the practitioner. Although the requirement for a practitioner to have adequate and contemporaneous clinical records is set out in the Act, there is no standard described in the regulations that stipulates a rendering practitioner must be the one to make the notes in respect of the service they rendered.

The audit of personal attendance items demonstrated that a variety of public hospital staff, including junior medical, nursing and allied staff, were the ones to make entries in the clinical records in regard to consultation services rendered by specialists and consultant
physicians. Reasons for this included convenience and time-saving during a busy ward round or outpatient session. It was difficult for compliance officers to assess documents provided to substantiate that a given practitioner personally rendered the service where the entry in the clinical record was made by a third party, especially if the entry contained no mention of the practitioner's name or description of what the practitioner did.

Some specialists and consultant physicians are billing under Medicare when they have not personally rendered the service to the private patient. Instead these services have been rendered by junior medical or other hospital staff, as they would for public patients. Personal attendance items cannot be claimed for services rendered in a public hospital by a third party on behalf of the medical practitioner, even if the medical practitioner supervised the services being rendered. Unfortunately clinical records, including letters written back to referring general practitioners, rarely contained sufficient information to establish a debt for non-performance.

**Service eligibility – after admission**

Determination of the point in time when a patient becomes eligible as an admitted private patient in a public hospital is required to assess whether pathology and diagnostic imaging services performed before the patient leaves the emergency department are eligible for Medicare benefits. In the absence of records to show the point in time of eligibility, some hospitals billed under Medicare for all hospital services if at any stage a patient elected to be treated as a private patient, irrespective of the timing and relationship to emergency department care. Hospitals that considered all patients to be admitted after four hours in the emergency department billed Medicare once the four hour limit was reached, regardless of whether a clinical decision to admit had been made or the patient had made a written election.

### 3.2.2 The National Health Reform Agreement

Discussions with the LHNs and legal consultation identified that ambiguities in the Business Rules for the NHRA made the NHRA open to interpretation. The NHRA currently lacks the clarity in definitions and rule applications required to establish non-compliance due to double billing.

**Patient status**

The NHRA requires that an eligible patient presenting at a public hospital emergency department be treated as a public patient, before any clinical decision to admit.

For Medicare benefits to be payable for services rendered in a public hospital emergency department the following must be evident at the time the service was rendered:

- there must have been a clinical decision to admit the patient
- the patient must have elected (in writing) to be treated as a private patient
- the patient must have been admitted at the time the service was rendered

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7 Subsection 19(6) of the Act, paragraph 13(13)(b) of the *Health Insurance Regulations 1975*, Rules 1.2.4 and 1.2.5 of the General Medical Services Table (GMST) and MBS Items Category 1
In most cases the period between patient’s written election and the clinical decision to admit is negligible.

The timing of when a service is rendered impacts on whether the service has been funded under the NHRA. Services may be requested by an emergency practitioner but rendered at different stages of the admission process, thus affecting the eligibility of particular services. The diagram below shows services requested by an emergency practitioner rendered at different stages of the admission process.

In this example:

Service 1 – the service is not eligible for Medicare benefits
Service 2 – the service is not eligible for Medicare benefits
Service 3 – the service is eligible for Medicare benefits

Services 1 and 2 are not eligible for Medicare benefits pursuant to paragraph 17(1) (a) and subsection 19(2) of the Act. The patient should be treated as a public patient until they have signed the election form stating they elect to be treated as a private patient. It is not sufficient alone that the emergency doctor has formed an opinion or that the Registrar has made a clinical decision to admit the patient.

The NHRA does not generally allow for a patient’s election as a private patient to retrospectively cover any services rendered before that time (services 1 and 2 above). However Business Rule G24l of the NHRA does provide for when a patient or their legal representative has not been able to make an election, the patient is treated as a public patient until a valid election is made. The election takes effect from the commencement of admission.

Service 3 is eligible for Medicare benefits as it is the department’s view that once a patient signs an election form to be treated as a private patient, they should no longer be treated as a public patient in accordance with Business Rule G14.

Uncertainty about the status of the patient when a service is rendered impacts the department’s ability to determine if the service has been funded under the NHRA and is therefore ineligible for Medicare benefits.
Admission and clinical decision to admit

The NHRA refers to the definition of admitted patient as having the meaning in the National Health Data Dictionary (NHDD) however this meaning is inconsistent with the NHRA Business Rules. The NHDD defines admission as the process whereby the hospital accepts responsibility for the patient’s care and/or treatment, either by recording the commencement of treatment and/or care and/or accommodation of a patient, or by recording the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

The NHRA does not provide a formal definition of ‘admission’ or ‘clinical decision to admit’. Hospitals are tailoring their processes based on their own interpretation. For example, hospitals differ in who has authority to make the clinical decision to admit – the triage nurse, the emergency specialist, the specialty registrar, or the admitting specialist. Admission status may be conferred by virtue of the patient bed location – observation ward, acute management ward, general ward. In some instances, there is a clinical process whereby the nursing staff do not consider the patient admitted until the admitting junior medical staff have taken a history, completed an examination and written it up in the patient’s record.

The phrase ‘clinical decision to admit’ in the NHRA Business Rule G18 is not defined in the Business Rule. The interpretation of a clinical decision to admit and admission, and the distinction between the two are unclear.

Business Rule G18 of the NHRA:

G18. An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the State to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient. However:

a. A choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice; and

b. Hospital employees will not direct patients or their legal guardians towards a particular choice.

It is not clear whether G18 requires a patient to be treated as a public patient before a clinical decision to admit or before admission, which are considered as two separate events.
Business Rule G14 of the NHRA:

**G14.** ‘Election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the minimum standards set out in this Agreement’.

Business Rule G14 addresses one of the practical outcomes that can occur in an emergency department when admission processes may be out of sequence. It does not impact on the principle that Medicare benefits are not payable until the person makes an election to be a private patient. However, the fact that an election can occur before admission may make it more difficult for an audit to precisely pinpoint the time from which Medicare benefits may be payable.

### 3.3 Compliance Interventions

#### 3.3.1 Pathology and diagnostic imaging services in public hospital emergency departments self-assessment

The department identified 330,090 pathology and diagnostic imaging services provided across all states and territories (except the Northern Territory) that may have been claimed under Medicare when they had already been funded under an arrangement with the Commonwealth or State. These services were provided by 520 rendering practitioners over 77 hospital locations (represented by 49 LHNs) totalling $11.97 million in Medicare benefit paid. The overall data is summarised in Table 1.

**Table 1 – Overall data**

<table>
<thead>
<tr>
<th>State</th>
<th>No. of LHNs</th>
<th>No. of Hospitals</th>
<th>Volume of Services</th>
<th>Total Medicare Benefits ($)</th>
<th>No. of Rendering Practitioners *</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>1</td>
<td>1</td>
<td>392</td>
<td>13,176.95</td>
<td>2</td>
</tr>
<tr>
<td>NSW</td>
<td>15</td>
<td>35</td>
<td>211,256</td>
<td>6,617,649.25</td>
<td>352</td>
</tr>
<tr>
<td>QLD</td>
<td>12</td>
<td>13</td>
<td>13,804</td>
<td>723,200.30</td>
<td>40</td>
</tr>
<tr>
<td>SA</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>1,011.95</td>
<td>1</td>
</tr>
<tr>
<td>TAS</td>
<td>2</td>
<td>2</td>
<td>7,070</td>
<td>277,230.45</td>
<td>18</td>
</tr>
<tr>
<td>VIC</td>
<td>16</td>
<td>22</td>
<td>97,198</td>
<td>4,319,956.01</td>
<td>248</td>
</tr>
<tr>
<td>WA</td>
<td>2</td>
<td>3</td>
<td>364</td>
<td>21,147.20</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>77</td>
<td>330,090</td>
<td>11,973,372.11</td>
<td>672</td>
</tr>
</tbody>
</table>

* These figures are based on specific provider (Prov7) locations. An individual practitioner may be counted multiple times depending on the number of Medicare registered provider locations. There were 672 locations for 520 practitioners.
Analysis of the number of services per rendering practitioner (based on provider location) indicates the following (see Table 2):

- the majority of the practitioners identified (68 per cent) have claimed less than 100 patient level claim data
- 212 practitioners (32 per cent) have rendered more than 100 patient level claim data each which equates to $10,179,342.91 (85 per cent)
- eight practitioners (1.2 per cent) have rendered more than 10,000 patient level claim data. One possible explanation for this large volume of services is figurehead billing

Table 2 – Number of services per rendering practitioners

<table>
<thead>
<tr>
<th>No. of Practitioners</th>
<th>% of total no.</th>
<th>Number of service claimed range</th>
<th>Total Medicare benefits ($)</th>
<th>Total number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>1.2</td>
<td>more than 10,000 patient level claim data</td>
<td>1,902,559.25</td>
<td>136,459</td>
</tr>
<tr>
<td>8</td>
<td>1.2</td>
<td>more than 5,000 but less than 10,000 patient level claim data</td>
<td>1,307,316.35</td>
<td>55,732</td>
</tr>
<tr>
<td>28</td>
<td>4.2</td>
<td>more than 1,000 but less than 5,000 patient level claim data</td>
<td>3,208,002.20</td>
<td>77,235</td>
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<tr>
<td>21</td>
<td>3</td>
<td>more than 500 but less than 1,000 patient level claim data</td>
<td>786,067.30</td>
<td>14,173</td>
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<tr>
<td>147</td>
<td>22</td>
<td>more than 100 but less than 500 patient level claim data</td>
<td>2,975,397.81</td>
<td>33,267</td>
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<td>460</td>
<td>68.4</td>
<td>less than 100 patient level claim data</td>
<td>1,794,029.20</td>
<td>13,224</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>672</strong></td>
<td></td>
<td><strong>11,973,372.11</strong></td>
<td><strong>330,090</strong></td>
</tr>
</tbody>
</table>

In January 2014 the department sent a letter to LHNs providing an opportunity for them to voluntarily repay any incorrectly claimed Medicare benefits identified through their self-assessment and to provide closure to the compliance activity. As a result of this letter 14 out of 49 LHNs considered that they had been compliant when billing Medicare for pathology and diagnostic imaging in emergency departments. Six LHNs advised that services
had been out-sourced to third parties, one related to pathology services and five related to diagnostic imaging services. Repayments were received from 29 LHNs with Victoria repaying $494,615 across nine LHNs; New South Wales repaying $17,490 across twelve LHNs; Australian Capital Territory repaid $2,209; and Queensland repaying $15,088 across seven LHNs. A total of $529,403 was receiving into a nominated Commonwealth bank account. A summary is provided in Table 3.

Table 3 – Summary of outcomes from self-assessment

<table>
<thead>
<tr>
<th>State</th>
<th>LHNs</th>
<th>No of hospitals</th>
<th>Repayments received and number of LHNs ($)</th>
<th>LHNs that consider that they are compliant</th>
<th>Advised service is out-sourced to a 3rd party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>16</td>
<td>22</td>
<td>494,615.30</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>New South Wales</td>
<td>15</td>
<td>35</td>
<td>17,490.25</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>1</td>
<td>1</td>
<td>2,209.65</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>12</td>
<td>13</td>
<td>15,088.65</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>South Australia</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Western Australia</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Tasmania</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>49</td>
<td>77</td>
<td>529,403.85</td>
<td>29</td>
<td>14</td>
</tr>
</tbody>
</table>

3.3.2 Personal attendance items audit

Commencing on 6 January 2016, targeted desk audits were conducted on 28 specialists and consultant physicians working at St George public hospital. The audit aimed to ensure that the personal attendance requirements, as stipulated in the GMST, were being adequately met.

The outcome of the audit was a 57% non-compliance rate, with services provided by 16 of the 28 specialists/consultants assessed as non-compliant. Instances of non-compliance were primarily attributed to:
• a lack of sufficient documentation and/or evidence to substantiate the service and/or the personal attendance requirements of Rule 1.2.4 and Rule 1.2.5 of subclause (2) of the GMST
• incorrect claiming of services (claims made with the incorrect date of service or as the incorrect provider) and/or
• receipt of a voluntary acknowledgement from the specialist/consultant physician to confirm that benefits had been paid incorrectly

Where documentation was provided in response to the audit, cases were often assessed as non-compliant due to the following reasons:

• notes, signed by the registrar, made no mention of the claiming specialist/consultant physician
• third party notes were endorsed as “seen by” or “discussed with” the claiming practitioner
• notes were not written or signed by the claiming specialist/consultant physician
• date of service could not be verified
• admission documents did not substantiate the details of the services being claimed
• documents indicated that the patient was seen by another practitioner/registrar on behalf of the claiming specialist/consultant physician and/or
• patient reports to the referring practitioner were written and signed by a practitioner other than the claiming specialist/consultant physician

Of the 28 audited specialists and consultant physicians, 12 were assessed as compliant. Ten of the 12 compliant specialists and consultant physicians supplied a Statutory Declaration, in the absence of documented evidence, to substantiate some or all of their claims.

3.3.3 Public Hospital Billing Survey

In April 2016, the survey was sent out to approximately 100 specialists and consultant physicians working at St George that was subject to the audit of personal attendance items. A total of 37 responses were received. For some questions, respondents may have selected more than one response as they were asked to select all options that applied (Appendix 4).

Responses indicated that the majority of information about billing Medicare was gained through informal channels such as colleagues and practice or administrative staff (31 responses), or Medicare online resources (21 responses). Only seven responses indicated that they referred to their hospital’s policy or procedure documents for billing information.

In regard to delegation by medical practitioners of their billing responsibilities to hospital staff, 21 per cent of respondents indicated that the decision on which MBS item number was billed to Medicare was made by the hospital; and 62 per cent of respondents did not check that the MBS items numbers billed to Medicare were correct, with most respondents never reviewing their billing history.

Overall, responses demonstrated a desire for training in billing accurately under Medicare, including as part of their specialist training pathway. For example, 57 per cent of respondents advised that they would like more education resources on Medicare and rights to private practice. Respondents were also uncertain about the actual requirements for
billing personal attendance items, including whether they needed to personally write the clinical notes and letters to referring practitioners; and whether services rendered by registrars are eligible for Medicare. Of concern was that 21 per cent of respondents advised that their provider number can be used to bill Medicare by registrars and other junior hospital staff.

3.3.4 Recoveries from interventions relating to rights of private practice tip-offs

Four medical practitioners were referred to the Department of Human Services by the Queensland Audit Office for possible breach of subsection 19(2) of the Act. On the basis of data analysis and lack of legal certainty, it was considered that there would be a high risk of challenge to any audit finding in relation to this matter, therefore no compliance intervention proceeded.

4 Savings measurement

The project was expected to achieve targeted savings of $24.7 million over four years from 2012-13 by identifying and treating inappropriate billing of Medicare in public hospitals.

Savings attributed to the project included:

- direct savings achieved through debts raised for recovery of incorrectly claimed Medicare benefits; and
- indirect savings from the change of claiming behaviour of the medical practitioners as a result of the compliance interventions

4.1 Direct savings

Pathology and diagnostic imaging services in public hospital emergency departments self-assessment

Each of the 49 LHNs involved in the self-assessment of pathology and diagnostic imaging claims under Medicare was provided with a unique repayment reference number and invited to repay any Medicare benefits that they had identified as incorrectly paid. Direct savings for this intervention comprised the total repayments received from LHNs.

LHNs made repayments by direct deposit to a specified Department of Human Services Official Administered Recovery receipts account. The ability to make electronic payments provided stakeholders with more convenience and less red tape. It also decreased administrative burden on the department to create and process debt advisory notices and cheques.

A total of $0.53 million was repaid to the department by 29 of the 49 LHNs across all states and territories excluding Northern Territory. The amounts received from LHNs were unrelated to the number of services or to the size or location of the hospital.
Personal attendance items audit

Direct savings for the intervention were determined through debts raised where:

- Medicare claims for personal attendance services were not substantiated by the health practitioner or
- the health practitioner acknowledged that they had incorrectly claimed a personal attendance service under Medicare

A total of $12,651.30 in direct savings occurred in relation to non-compliance with personal rendering of attendance item services by specialists and consultant physicians in a public hospital.

Of this amount, $9,179.50 in direct savings was achieved from debts raised for the 162 services found to be non-compliant from the audit of 1197 services rendered by 28 specialists and consultant physicians. In addition, $3,471.80 in incorrectly paid Medicare benefits was repaid by one practitioner for a related tip-off.

Recoveries from interventions relating to rights of private practice tip-offs

As the audits of services rendered by four medical practitioners referred by the Queensland Audit Office were unable to proceed, no savings were therefore attributed to this tip-off.

4.2 Indirect savings

Indirect savings were calculated using the trends method. The trends method is a statistical modelling process that demonstrates a trend in the data prior to the occurrence of the intervention. This trend is then extrapolated to produce forecasts for a given period of time. These forecasts are assumed to represent what would have occurred had the intervention not happened.

After an intervention has occurred and sufficient time has passed for valid data analysis, the difference between the expected and observed data is calculated. Indirect savings result when the difference between the expected and observed values are positive, reflecting a successful intervention. Alternatively, a negative difference implies an increase in Medicare expenditure.

The approach used to identify savings from behaviour change was reviewed by PricewaterhouseCoopers in June 2015 as part of a broader review of Health Provider Compliance savings methodologies.

Pathology and diagnostic imaging services in public hospital emergency departments self-assessment

Indirect savings of $18.97 million were attributed to behaviour change following the pathology and diagnostic imaging compliance intervention. Of this total, $14.58 million represents behaviour change in diagnostic imaging claims and $4.39 million for pathology claims.

In regard to diagnostic imaging servicing, 65 per cent of the savings from behaviour change occurred in Victoria, with the remainder occurring mostly in New South Wales and Queensland.
In regard to pathology servicing, nearly 78 per cent of the savings from behaviour change occurred in New South Wales.

Overall, the ratio of savings for diagnostic imaging to pathology was approximately 3 to 1.

The intervention showed signs of sustained impacts over more than two years, from February 2013 to November 2015.

**Personal attendance items audit**

As at 31 March 2017, savings from behaviour change consequent to the personal attendance items audit completed in June 2016 totalled $0.31 million.

**Personal attendance items targeted education**

The education letter ‘Claiming of consultation services under Medicare’ was initially intended to be distributed in January 2015 to 597 hospitals across Australia. Liaison with internal stakeholders resulted in the recipient list being reduced to 10 randomly selected LHNs, representing 47 public hospitals, and a delay in distribution of the education letter until October 2015.

As at 31 March 2017, a total of $2.7 million in behaviour change savings had been identified as a result of the education letters.

**4.3 Total savings**

As at 31 March 2017, the department had achieved savings of $22.52 million. This total comprises $0.54 million in direct savings from recovery of incorrectly paid benefits, and $21.98 million in indirect savings due to behaviour change following compliance interventions and education. (Appendix 5)

The $22.52 million achieved was just under the target savings of $24.7 million.

**5 Discussion**

Prior to the Budget measure there been anecdotal evidence of incorrect billing under Medicare for patient services provided in public hospitals and one case of repayment of benefits by a major metropolitan public hospital. The Budget measure provided an opportunity to explore the issues relevant to double billing in public hospitals so as to inform possible prevention and treatment strategies for the future. The three areas of significance that emerged were education, the regulatory framework and issues with undertaking compliance interventions.

**5.1 Education**

There was variation between the state health departments in their influence on financial policy setting and implementation by their LHNs. Whilst the Victorian Health Department had developed and distributed its policy on when to bill Medicare, there was inconsistent use of the policy by different hospitals. The NSW Ministry of Health preferred to engage on behalf of its LHNs, but without sighting any policy document or being allowed to engage with individual LHNs, it was difficult for the department to ascertain what billing directives the LHNs in New South Wales have received or how well they follow them. In order to promote the consistent use of correct policies on use of Medicare, it may be preferable for
the department to distribute information to all state and territory health departments, as well as to all hospitals, rather than relying on cascading within state-based structures.

Engagement with health departments, hospital administrators, hospital finance officers and individual medical practitioners all showed that there was a desire and a need for education about Medicare billing across the public hospital sector. The majority of medical practitioners learn how to bill under Medicare through informal channels such as colleagues, or practice managers, or administrative hospital staff. Practitioners suggested that Medicare education should be introduced to junior medical officers during their training pathway. This may influence positive billing behaviours before incorrect habits are established or learned from non-compliant staff in the workplace. The request for early education is also consistent with feedback received from medical specialty colleges unrelated to this project.

Topics to be prioritised for development of education resources were identified from risks and tip-offs reported to the department; compliance casework; correspondence with stakeholders; media articles; external reports; and enquiries received from practitioners and hospital administrative staff. Responses from the survey of specialists and consultant physicians indicated that the existing topics of education are still a particular area of interest, in particular Medicare and rights to private practice. Respondents were also uncertain about the actual requirements for billing personal attendance items, including whether they needed to personally write the clinical notes and letters to referring practitioners; and whether services rendered by registrars are eligible for Medicare. Of concern was that 21 per cent of respondents advised that their provider number can be used to bill Medicare by registrars and other junior hospital staff.

The department is already pursuing development of an on-line module to be used by practitioners prior to them being given a Medicare provider number. It is usual practice for hospitals to make new employees undertake online education on topics such as Work, Health and Safety; Bullying, Harassment and Discrimination; and Privacy. Further discussion with state health departments and hospital administrators may promote the accessing of the department’s hospital-related education modules. The aim would be to have all hospitals introduce a requirement for all practitioners and finance officers to complete the Medicare module annually. Staff would then be reminded of their obligations and made aware of any changes to Medicare requirements or NHRA Business Rules.

Based on the surveys’ findings and the positive response to the promotion of published education resources, there would be merit in the development of education material to cover a broader range of topics relevant to use of Medicare in public hospitals. For example, additional topics could cover rules about referrals for specialist or allied services and requests for diagnostic investigations written to or by hospital staff. A better understanding of the education requirements could be gained through extending the survey of hospital specialists and consultant physicians to other hospitals across Australia.

**Recommendation 1** That the department continues to provide clarity about the use of Medicare in public hospitals through the ongoing development of online education resources.
5.2 Regulatory framework

One of the best ways to promote voluntary compliance is to make it easy for practitioners to know how to comply. Development of useful education material is currently hampered by the absence of clear definitions, and the presence of ambiguous and even contradictory statements within the current regulatory framework. Not only does this make it harder for practitioners to know what is right and what is wrong, but it also increases the risk that compliance officers may not be able to determine when benefits have been paid incorrectly.

The most basic clarification required to determine the operation of section 19(2) of the Act is the definition of an ‘arrangement’. Complexity increases with each layer of financial exchange as distance increases from the original Commonwealth/state model. This is particularly so in situations of public-private partnerships, either where private hospitals are paid to provide public hospital services, or where specified services are out-sourced to private companies.

The development of a HPG on ‘Right of Private Practice’ did not proceed due to lack of information and clarity within the regulatory framework around contracts and arrangements between practitioners and their hospitals, and how to establish whether double-billing had occurred at a particular point in time.

With respect to a medical practitioner who is employed to work in a public hospital, a right to private practice can be provided as a term of the employment services contract between the hospital and the practitioner. The nature and scope of the right varies depending on the terms that are agreed under the formal agreement. The hospital may grant a practitioner the ability to engage in private practice during employed time and retain billings after paying applicable service fees which is usually referred to as a private practice retention arrangement; or the hospital may grant a practitioner the ability to engage in private practice during employed time and assign all billings to the hospital or its service provider, which is referred to as a private practice assignment arrangement. As an agreement between a practitioner and their hospital is commercial-in-confidence, the department has no visibility of their content. Furthermore, it is unclear whether the department would have a legal right to access such documents through the current notice to produce audit provisions.

A HPG provides guidance to all practitioners on the type of documentation that may be used to substantiate a claim for specific services in the event of an audit. Without the clarity on how rights of private practice should work within the regulatory framework, each circumstance would need to be addressed case by case to determine what documents may be available to substantiate the services claimed.

To demonstrate the complexities, consider the circumstance of a practitioner who has an arrangement whereby 25 per cent of services rendered during normal working hours may be to private patients under Medicare. How could it be substantiated that an attendance service in the outpatient clinic occurred at a point in time when the practitioner chose to exercise a right to private practice; or that the patient had chosen to be treated as a private patient in a public hospital outpatient clinic for that particular service; or that the service rendered was within the 25 per cent limit of total services; or that a salary was being paid to the practitioner at the time the service was rendered and billed under Medicare?
Anecdotal evidence shows that formal arrangements between hospitals and practitioners are deliberately vague to accommodate flexibility in billing and service delivery. Although this is understandable for practical reasons, it would certainly be much easier to assess for double-billing if a formal arrangement stated the day of week and session times when a right of private practice took effect; or simply provided that a right of private practice could not apply during public hospital outpatient clinic times.

Another example of regulatory complexity relates to billing under Medicare for pathology and diagnostic imaging services provided to emergency department patients in public hospitals. There is ambiguity in the Business Rules for the NHRA on whether services are eligible for Medicare benefits when rendered between the time a clinical decision to admit is made and when a formal election is made by the patient to be treated privately.

A claim is eligible for Medicare for services rendered in a public hospital emergency department where there is clear evidence that a clinical decision was made to admit the patient and that the patient was admitted as a private patient at the time the service was rendered. But there are no regulatory definitions to specify what constitutes a hospital admission, to know when it takes effect. Interpretations of ‘admission’ have included a process or point in time when a ward bed has been arranged; when the patient has been received on the ward; when the patient has had a history and examination recorded by the admitting medical officer on the receiving ward; when the admitting specialist has formally accepted responsibility for the care of the patient (written in the patient notes or phone message documented); or when the patient has spent four or more hours in the emergency department. If the point at which patient eligibility exists cannot be determined with certainty, then this creates a risk that Medicare benefits may be paid for services to a non-admitted, ineligible patient.

Importantly, there is no requirement in the Act or NHRA for a nationally consistent hospital document which can be date and time stamped and signed by both the patient (or parent/spouse/legal guardian) and the admitting specialist to confirm when admission occurred.

Another issue arises when the patient is admitted as a public patient, or is to attend an outpatient department as a public patient. Although as a public patient the services should be offered as free of charge, there is nothing in the regulatory framework to prevent a patient from exercising their right to have tests performed as a private patient. If those diagnostic services are bulk-billed, the patient may be persuaded to assign benefits because there will be no out of pocket expense, or may unknowingly sign the assignment form, especially when it is a matter of routine for hospitals to take Medicare card details upon presentation to an emergency department. Such billing under Medicare may occur within hospital departments, but appears to be especially the case where pathology or diagnostic imaging services are out-sourced.

Consideration should be given to defining the terms, admission and clinical decision to admit under the NHRA, this will provide clarity on when a service is eligible for Medicare in a hospital emergency department.
Recommendation 2  That terms in the *Health Insurance Act 1973* and Business Rules for the NHRA regarding the use of Medicare in public hospitals be reviewed for clarity and consistency, and are amended where necessary.

5.3 Compliance interventions

Issues with data, documentation and debt recovery were identified during the project’s compliance interventions.

Effective targeting of audit activities relies upon the ability to accurately identify practitioners who have rendered services of concern. In order to target services rendered at a particular public hospital, it is essential that claims data accurately reflects the location at which the service was rendered. This relies on practitioners to provide the correct location details, and for Medicare data systems to record the required details.

Practice locations recorded in the Medicare provider database include free text entry fields and many of these fields are not mandatory. Whilst practitioners may provide an accurate street address for a hospital campus location, there may be nothing to identify that services were rendered in the public hospital, private hospital, or private rooms when such facilities are co-located. This impaired the identification of practitioners at a public hospital using geocode coordinates. As the Medicare claims system does not validate practice locations addresses, the process of verifying whether a practitioner’s location is at a public hospital had to be conducted manually by checking open source data, or through personal contact with the practitioner. This is inefficient and resource intensive and may result in additional re-working to triage cases, or auditing of practitioners who should not have been included. Compliance operations require the ability analyse large amounts of data quickly, accurately and through data mining automation. Until the a solution is implemented to remove the risks inherent in free text address fields, the current Medicare data systems are unable to provide an integrated picture of Medicare billing behaviours by location.

Another issue is that a practitioner may record a wrong practice location on their accounts for services rendered. A practitioner with a right to private practice at a public hospital may have provided services to in an emergency department, but may bill from their private rooms using the private practice address on the account. This may mask ineligible services provided in the emergency department. Although practitioners are meant to record on an account the location at which the service was rendered, this is not always seen by practitioners as a priority, and may be confusing for those practitioners who have co-located rooms, or consider the provision of the service is not completed until the final follow-up appointment in the private rooms.

Recommendation 3  That the department liaise with the Department of Human Services about ways to enhance the accuracy of provider and service location data.

Determination of an audit finding relies upon the provision of documents to substantiate patient, practitioner and service eligibility (Appendix 6). Whilst patients must sign an election form when being admitted to a public hospital, there is no such requirement for a
written election for non-admitted patients who attend a hospital outpatient department, including for pathology or diagnostic imaging. So whilst the NHRA Business Rules refer to the patient choosing to be treated as a private patient in an outpatient department, hospitals retain no documents to substantiate that the patient was a private patient at the time of the service.

Hospitals contacted during the project advised that they did not record the point of time at which a patient was admitted. The apparent lack of documentation was surprising given that under the NHRA, public hospitals are required to capture National Emergency Access Target data about the length of time a patient spends in an emergency department until discharge or the time of admission. This data is required to substantiate that the patient was eligible for Medicare services by being an admitted patient at the time the service was rendered.

For a practitioner to be eligible to bill for attendance services rendered under Medicare, they must personally render the attendance item service and be exercising their right to private at the time the service is rendered. The audit of specialists and consultant physicians found that the hospital retained no documentation that could substantiate that a right of private practice was being exercised at a particular point in time. In an outpatient department setting where a private patient may be seen within the same clinic servicing many public patients, it is difficult to ascertain when a practitioner who is receiving a salary one minute for attending a public patient, suddenly ceases to receive a salary and thus not be double billing when the next minute they are attending a private patient in the same clinic.

**Recommendation 4** That the department consider how the NHRA may be used to enhance data capture by public hospitals for the purpose of substantiating services rendered under Medicare.

The Administrator of the National Health Funding Pool (NHFP) referred to similar issues with the lack of time of day data held by hospitals in two reports, ‘Business rules for determining 2012-13 hospital services eligible for commonwealth funding, and 2013-14 Data matching Part One: Outcomes report - January 2016’. The Administrator NHFP has developed a process to compare hospital patient-level data with MBS claims data. The Administrator NHFP also identified that it is difficult to substantiate that an emergency patient was an admitted private patient at the time the MBS service was rendered. Similarly, it is difficult to substantiate services provided on the day of separation. The NHPF’s data matching therefore only included services provided to public patients between the day after admission and the day before separation. Even so, it is highly likely that data matched by the NHFP could assist the department to more accurately identify double billing in public hospitals, especially when considered with other compliance data and tip-off information held by the department.

**Recommendation 5** That the department liaise with the Administrator of the National Health Funding Pool for access to public hospital patient matched data for compliance purposes.
It is common practice in public hospitals for the patient’s clinical notes or outpatient letters to be written up by junior medical or other staff on behalf of the specialist or consultant physician. Notes written by a third party often failed to substantiate that the specialist or consultant physician was not only present at the time, but also personally rendered the service. Compliance with the requirement to personally render an attendance item service is best substantiated by adequate and contemporaneous notes made by the rendering practitioner. This is the usual practice and standard for private patients attending private rooms. It may be expected that the same standard should apply in regard to services to a private patient in any location, including a public hospital. Certainly a practitioner’s records are taken into consideration in determining whether a practitioner has engaged in inappropriate practice under the Professional Services Review scheme. This expectation is not reflected in the NHRA, or in the Act with respect to requirements for substantiating services in compliance audits. Practitioners would benefit from education about their need to make records of services they initiate or provide to private patients in public hospitals.

**Recommendation 6**  That the department develop on-line education for hospital practitioners about the requirements for them to make adequate and contemporaneous records of services they initiate or render to private patients in public hospitals.

Stakeholders prefer to receive data electronically rather than in hard copy. Stakeholders advised that having an electronic copy of data provided them with a more efficient and effective way of cross-referencing with their own electronic records. This is particularly the case for audits of hospital services, where the number of services and line by line data is significantly greater than compared to what would be required in the audit of services rendered by a single general practitioner in their own practice. Data for the self-assessment was transferred using a secure external email capability known as PGP. The PGP system was available for use when the project team was part of the Department of Human Services, but the Department of Health has yet to develop a capability to send personal information via email in a protected environment. A secure email system is required if the department’s compliance activities are to be efficient, effective with reduced impost on stakeholders.

**Recommendation 7**  That the department develops a secure email capability for the purpose of communicating with external stakeholders when conducting compliance interventions.

The department has an obligation under the *Public Governance, Performance and Accountability Act 2013* to recover debts owed to the Commonwealth, including any debts incurred as a result of benefits being paid for services that are incorrectly claimed. A Medicare benefit can only be assigned by a patient to a medical practitioner in accordance with the Act; a Medicare benefit cannot be assigned to a hospital. Although a practitioner may not have control of the hospital claiming processes or have received the Medicare benefit, the practitioner would still be accountable under section 129AC of the Act for the debt that arises from an adverse finding at audit.

Given the high servicing volumes at public hospitals, a hospital that routinely makes incorrect claims to Medicare by double billing may generate hundreds of incorrect claims.
against a single provider number. In the event of an audit, this may lead to immense red tape for a practitioner having to find documents to substantiate each claim. In addition, the debt raised may be so large that only a hospital would have the financial capacity to repay the debt.

In circumstances where the hospital had a significant role in the double billing of services to Medicare, it would be fairer and preferable if the audit and debt recovery was directed through the hospital administration in the first instance, rather than through the practitioner who rendered the service. Where out-sourced services have been double billed, it may similarly be preferable to seek recovery of a debt from the business entity that holds the nominated bank account into which benefits have been paid. This would be particularly advantageous where services have been figurehead billed, such as for out-sourced pathology.

**Recommendation 8** That the department provides advice to the Minister to enhance powers to audit and/or recover incorrectly paid Medicare benefits directly from the entity (other than the rendering practitioner) holding the nominated bank account into which Medicare benefits have been paid.

6  Conclusion

Over the four years of the Budget measure a greater understanding has been gained of the public hospital environment, billing practices and challenges for on-going Medicare compliance. The risk of double billing in public hospitals will continue into the immediate future. However the Budget measure has demonstrated that practitioners and hospitals are keen to comply and will do so if provided with clear, consistent and unambiguous directions. Comprehensive support will require ongoing education, stakeholder engagement and feedback on the outcomes of audits and other compliance interventions. Practitioners need to be more aware of their legal obligations when billing under Medicare for services rendered in public hospitals, and hospitals need to be more accountable for non-compliant billing, both within their institution and by out-sourced providers whom they have engaged. Double billing has the potential to adversely impact the sustainability of the Medicare programme. Managing double billing behaviour will require a multi-pronged approach over many years. This will principally require enhancements to education, the regulatory framework and to compliance interventions.
## 7 Glossary and Acronyms

<table>
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<th>Term</th>
<th>Definition</th>
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<tr>
<td>Administered savings</td>
<td>Savings of Medicare benefits expenditure. Note: the Department of Human Services administers Medicare and the payment of Medicare benefits on behalf of the Department of Health</td>
</tr>
<tr>
<td>Budget measure</td>
<td>The ‘<em>Fraud prevention and compliance – Improve billing practices within public hospitals</em>’ Budget measure (known as the Inappropriate Billing Project)</td>
</tr>
<tr>
<td>Business Entity</td>
<td>Any hospital, Local Hospital Network (LHN) or out-sourced public or private organisation</td>
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<tr>
<td>Compliance interventions – audit/Compliance Audit</td>
<td>Compliance audits are designed to verify the details of services where the department has identified a risk that the payments made may have been made incorrectly.</td>
</tr>
<tr>
<td>Compliance interventions - education</td>
<td>Letters sent to remind the entity of their Medicare claiming requirements</td>
</tr>
<tr>
<td>Direct savings</td>
<td>Savings achieved through, repayment of incorrectly claimed Medicare benefits and debts raised</td>
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<tr>
<td>Geocoding</td>
<td>Process of finding associated geographical coordinates</td>
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<tr>
<td>HPG</td>
<td>Health Professional Guideline. A HPG provides guidelines to help medical practitioners understand what documents can be used to substantiate services if they are asked to participate in a Medicare compliance audit or review.</td>
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<tr>
<td>Inappropriate Billing Project</td>
<td>Inappropriate Billing Project, also known as <em>The Fraud prevention and compliance – Improve billing practices within public hospital 2012-13 Budget measure</em></td>
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<tr>
<td>Indirect savings</td>
<td>Savings from measuring the change of claiming behaviour of the medical practitioners as a result of the compliance interventions</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LHN</td>
<td>Local Hospital Network: an organisation that provides public hospital services in accordance with the National Health Reform</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Agreement</td>
<td>Agreement. A local hospital network can contain one or more hospitals, and is usually defined as a business group, geographical area or community.</td>
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<tr>
<td>MBS</td>
<td><strong>Medical Benefits Schedule</strong>; a listing of the Medicare services subsidised by the Australian government.</td>
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<tr>
<td>MBS Item</td>
<td>A unique number assigned to each professional serviced contained in the MBS.</td>
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<tr>
<td>National Health Data Dictionary</td>
<td>The National Health Data Dictionary contains the Australian National Standard of Data Definitions recommended for use in Australian health data collections; and the National Minimum Data Sets agreed for mandatory collection and reporting at a national level.</td>
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<tr>
<td>NHFP</td>
<td>National Health Funding Pool</td>
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<td>NHA</td>
<td>National Healthcare Agreement</td>
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<td>NHRA</td>
<td>National Health Reform Agreement</td>
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<tr>
<td>Patient level claim data</td>
<td>data generated by billing for all Medicare patients</td>
</tr>
<tr>
<td>SRO</td>
<td>Senior Responsible Official, the officer accountable for the success of the project</td>
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<tr>
<td>the Act</td>
<td>Health Insurance Act 1973</td>
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<tr>
<td>The Board</td>
<td>The Health Compliance Project Board</td>
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<tr>
<td>Total savings</td>
<td>The summation of direct and indirect savings</td>
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<td>Voluntary Acknowledgment (VA)</td>
<td>Acknowledgements made to the department by medical practitioners regarding overpayments they may have received because of an incorrect claim under Medicare.</td>
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<tr>
<td>Working Group</td>
<td>The Inappropriate Billing Project Working Group</td>
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</tbody>
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Appendices

Appendix 1: Relevant regulatory framework

The Health Insurance Act 1973

The Act regulates the payment of Medicare benefits for eligible services rendered to eligible patients by eligible practitioners. When considering the legislative requirements imposed under the Act, it is important to:

- note that the provisions of the legislation are applied at the practitioner level, not at a business entity level. This means that a medical practitioner is legally responsible for any claim made under their Medicare provider number or in their name, even if the billing was done on their behalf by a third party (for example, hospital administration); and
- recognise that billing of Medicare in public hospitals are eligible only when they satisfy certain requirements, for example when a medical practitioner appropriately exercises their rights to private practice in public hospital settings.

Section 17 Medicare benefits not payable in respect of certain medical expenses

(1) A Medicare benefit is not payable in respect of a professional service if:
   (a) the medical expenses in respect of that service have been paid, or are payable, to a recognized hospital;

In 1976 the Act was amended to include a qualification that would ensure that the Commonwealth was not funding the provision of professional services by the payment of Medicare benefits where those services were government funded by some other mechanism.

This was included under the provision stated in subsection 19(2), which was added to help prevent so called ‘double dipping’:

Section 19 Medicare benefit not payable in respect of certain professional services

(2) Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with;

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(a) the Commonwealth;
(b) a State;
(c) a local governing body; or
(d) an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.

Section 129AC provides a statutory basis for the recovery of Medicare benefits. Subsection 129AC (1) applies where benefits are paid as a result of the making of a false or misleading statement (this includes administrative or other unintentional errors). Payments made as a result of a false or misleading statement are recoverable from the person (or estate of the person) by or on behalf of whom the false or misleading statement was made.

Section 129AC Recovery of amounts overpaid etc. and administrative penalties

False or misleading statements

(1) Where, as a result of the making of a false or misleading statement, an amount paid, purportedly by way of benefit or payment under this Act, exceeds the amount (if any) that should have been paid, the amount of the excess is recoverable as a debt due to the Commonwealth from the person by or on behalf of whom the statement was made, or from the estate of that person, whether or not the amount was paid to that person, and whether or not any person has been convicted of an offence in relation to the making of the statement.

Public Governance, Performance and Accountability Act 2013

Section 11 requires the department to pursue the recovery of debts owing to the Commonwealth. Any incorrectly claimed payments can constitute a debt to the Commonwealth.

Section 11 Recovery of debts

Guide to this section

The purpose of this section is to require accountable authorities of non-corporate Commonwealth entities to pursue the recovery of debts owing to the Commonwealth.

This section is made for paragraph 103(c) of the Act.

The accountable authority of a non-corporate Commonwealth entity must pursue recovery of each debt for which the accountable authority is responsible unless:

(a) the accountable authority considers that it is not economical to pursue recovery of the debt or
(b) the accountable authority is satisfied that the debt is not legally recoverable or
(c) the debt has been written off as authorised by an Act
The National Health Reform Agreement

As subsections 17(1) and 19(2) of the Act refer to an arrangement between the Commonwealth and the States and Territories, it is important to also consider the content and principles of the NHRA.

In August 2011 the NHRA was signed by the Commonwealth, States and Territories with the intended purpose of delivering major reforms to the organisation, funding and delivery of health and aged care. It sets out the agreement between the Commonwealth, State and Territory governments to work in partnership to improve the health outcomes for all Australians.

The reform superseded the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform. The NHRA is intended to support the relevant provisions of the Act in preventing instances of ‘double dipping’. Clause A6 of the NHRA states:

‘...Subject to any exceptions specifically made in this Agreement or through variation to this Agreement, the Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program’.

The NHRA includes financial and governance arrangements for Australian public hospital services. Implementation has allowed the Commonwealth and the States to work in partnership to improve patient access to services and public hospital efficiencies.

Clause 4 of the Agreement specifically states the principles regarding the provision of services through the public hospital system as follows:

‘States will provide health and emergency services through the public hospital system, based on the following Medicare principles:

- a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;
- b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
- c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.’

The Agreement is supported by a number of Schedules designed to provide further detail on individual health services. The Business Rules for the Agreement, as stipulated in Schedule G, are of particular relevance to billing arrangements for public patient charges (clause G1), patient arrangements in public hospitals (clauses 14-23) and public hospital admitted patient election forms (clause G24).

At the Councils of Australian Governments (COAG) meeting of 1 April 2016, leaders agreed to a Heads of Agreement that preserved activity base funding and the use of the national efficient price from 1 July 2017 to 30 June 2020\(^\text{11}\).

In preparation for the next national health reform agenda, the department has an opportunity to provide evidence based recommendations and proposals which would provide practitioners and hospital administrators with clarity on claiming Medicare in public hospitals.

\(^{11}\) http://www.coag.gov.au/node/537
Appendix 2: Public hospital billing survey provided to specialists and consultant physicians at St George public hospital

Public hospital billing survey

Overview

The Department of Health (the department) continues to develop education resources to assist both new and experienced health professionals to understand and correctly use the MBS. This survey will help us to understand who may benefit from the education resources and what topics may be useful.

This survey should take no longer than 10 minutes to complete.

We would encourage you to answer the questions based on your experiences of billing Medicare in public hospitals. There are no right or wrong answers to these questions.

You can respond to this survey anonymously - the questions relating to your name and email address are optional. If you enter your email address you will be able to return to edit your survey at any time until you submit it. You will also receive an acknowledgement email when you complete the survey.

Any personal information obtained throughout the completion of this survey will be managed in accordance with the Commonwealth Privacy Act 1988 which includes the Australian Privacy Principles. More information can be found on the Privacy and personal information [http://www.health.gov.au/internet/main/publishing.nsf/Content/privacy_security.htm] page on the department’s website.

Thank you for taking time to complete this survey.

Introduction

1. What is your name?
   The response to this question is optional.

2. What is your email address?
   The response to this question is optional.

   If you enter your email address then you will be able to return to edit your survey at any time until you submit it. You will also receive an acknowledgement email when you complete the survey.

Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.
3 What is your medical speciality?
(Required)

Please select only one item

- Surgeon
- Consultant physician
- Anaesthetist
- Other (please go to Question 4)

4 If 'Other' was selected in Question 3, please specify your medical speciality

Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.

5 Where do you receive information about billing Medicare Benefit Schedule (MBS) item numbers in a public hospital? Please select all that apply
(Required)

Please select all that apply

- Other colleagues
- Medicare
- Medicare's online resources
- Hospital policy / operation documents
- Practice manager / Administrative Support / Receptionist
- Professional organisation
- I have not received information from anyone
- Other (please go to Question 6)

6 If 'Other' was selected in Question 5, please indicate the areas where you receive information about billing MBS item numbers in a public hospital?

Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.

7 Medicare Benefits Schedule (MBS) item numbers billed to Medicare for the service you provide are mostly decided by?
(Required)

Please select only one item

- Myself
- Hospital (please go to Question 9)
- Practice manager / Administrative Support / Receptionist
- Other (please go to Question 8)
8. If 'Other' was selected in Question 7, please specify who decides on the Medicare Benefits Schedule (MBS) item number billed to Medicare for the service you provided?

9. If 'Hospital' was selected in Question 7, who or what determines the Medicare Benefits Schedule (MBS) item number billed? (select all that apply)

   Please select all that apply
   - Hospital clerks
   - Accounts staff
   - Policies
   - Other (please go to Question 10)

10. If 'Other' was selected in Question 9, please describe who or what determines the item number billed?

Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.

11. My provider number can currently be used to bill Medicare by: (Select all that apply) (Required)

   Please select all that apply
   - Myself
   - Registrar / other junior hospital staff
   - Another specialist / consultant physician
   - Other (please go to Question 12)

12. If 'Other' was selected in Question 11, please identify who can currently use your provider number to bill Medicare?
Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.

13. If someone else manages the administration of your billing, do you check that the Medicare Benefits Schedule (MBS) item numbers billed to Medicare are correct?

(Required)
Please select only one item

☐ Yes  ☐ No

Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.

14. When do you review your Medicare billing data to ensure the Medicare Billing Schedule (MBS) item number has been correctly billed for the service you provided?

(Required)
Please select only one item

☐ Never  ☐ Yearly  ☐ Monthly  ☐ Weekly  ☐ Daily  ☐ Other (please go to Question 15)

15. If ‘Other’ was selected in Question 14, please specify when you review your Medicare Billing data to ensure the Medicare Billing Schedule (MBS) item number has been correctly billed for the service you provided?

Billing Medicare in a public hospital

The following questions are based on your experiences of billing Medicare in a public hospital setting.

16. How do you review the claims for your Medicare services to ensure that they have been correctly billed?

(Required)
Please select all that apply

☐ I can review the claims for my services at any time from the hospital computer system
☐ I am able to request information from hospital administration / accounts area
☐ I ask for information directly from Medicare  ☐ I review account records that are managed by my private practice
☐ Other (please go to Question 17)
17 If ‘Other’ was selected in Question 16, please describe how you review the claims for your Medicare services to ensure that they have been correctly billed?

Billing Medicare in a public hospital

18 I would like more education resources on? (select all that apply)

Please select all that apply

- Medicare and rights to private practice
- Provider or patient eligibility (other than rights to private practice)
- Provider numbers
- Specific MBS item numbers
- Other (please go to Question 10)

19 If ‘Other’ was selected in Question 18, please list the type of education resources you would like.

Billing Medicare in a public hospital

20 Is there anything else that you would like to add about your public hospital billing experiences?
Appendix 3: Public Hospital Compliance Web Activity

Graph 1: Web Activity for ‘Claiming of referred consultation services under Medicare in public hospitals’

- During the first half of October 2015 education letters were sent to 10 Local Hospital Networks (representing 47 public hospitals across Australia). This letter provided information about Medicare billing requirements for consultation services by specialists and consultant physicians in public hospitals and included a reference to ‘resources available on the ‘Billing Public Hospitals’ webpage’ (human.services.gov.au/billingpublichospitals).

- Additionally, a communique was provided to the hospital administrator at St George during December 2015. The communique, which was distributed to specialists and consultant physicians, included advice regarding the availability of online educational material and provided a reference to the ‘Claiming of referred consultation services’ website.

- Graph 1 shows an increase in web activity on the ‘Claiming of referred consultation services under Medicare in public hospitals’ webpage during October 2015. There were 145 unique views in October 2015; 115 more views that the previous month; with a steady increase in web activity continuing into November and December 2015.

- Web activity for this page continued to grow, recording 500 views in June 2016.
On 7 May 2014 an article was published in ‘Forum’ - ‘Pathology and diagnostic imaging services in public hospital emergency departments’.

Graph 2 shows a significant spike in the number of unique views of the ‘Pathology and Diagnostic Imaging’ web page with a total of 605 unique views of this page in May 2014.

This was 502 more views than the previous month (103 views in April 2014).
On 9 July 2015, an article was published in ‘News for Health Professionals’ on the Department of Human Services website. The article was designed to promote a new hospital compliance landing page - ‘Billing Medicare in Public Hospitals’.

Graph 3 shows there were 466 unique views of this page in that month; 118 more views than the previous month.
On 30 June 2016 an article was published in ‘News for Health Professionals’ on the Department of Human Services website. The article focused on ‘New online resources to help with billing Medicare in public hospitals’ and included links to each of the pages containing online educational material (via the Department of Health web page).

Graph 4 shows the number of unique views of the ‘Billing Medicare in Public Hospitals’ web page where the page was accessed via the Department of Health website (as opposed to the Department of Human Services). The graph shows a substantial increase in web activity during July 2016 with views up by 207 to 237 views.
Appendix 4: Public hospital billing survey – Summary report provided to St George administrators

Public hospital billing survey - Summary report

The aim of the survey was to understand who benefits from the publication of education resources and what topics may be useful as part of the department’s continued approach to developing education resources. At closure of the survey there were 37 responses received.

Key findings recorded from the survey:

- Respondents\(^\text{12}\) indicated that they mainly get information about billing Medicare from other colleagues (17), Medicare online resources (21) and practice/administrative staff (14). Eighteen per cent (18\%) indicated they referred to hospital policy/operation documents.

- Twenty-one per cent (21\%) indicated that that decision on what MBS item number was billed to Medicare for the services rendered was made by the hospital.

- Twenty-one per cent (21\%) of respondents indicated that their provider number can be used to bill Medicare by registrars and other junior hospital staff.

- Sixty-two per cent (62\%) of respondents did not check that the MBS items numbers billed to Medicare are correct, with a large majority never reviewing their billing history.

- Respondents asked for more education about:
  - Medicare and rights to private practice and
  - Specific MBS Item numbers

- Respondents are uncertain about the actual requirements for billing personal attendance items, including:
  - whether they needed to personally write the clinical notes and letters to referring practitioners and
  - whether services rendered by registrars are eligible for Medicare

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\(^{12}\) For some questions, respondents may have selected more than one response as they were asked to select all options that applied.
• Respondents identified difficulty in establishing whether a patient was a public or private patient, especially if their status changes during the hospital episode.

• Respondents identified that they felt a pressure to meet revenue targets built into the hospital’s budget.

**Areas for consideration:**

• Hospital staff including senior and junior medical staff, policy makers and administrative staff would benefit from education relating to requirements for rendering or initiating services under Medicare.

• Medical practitioners should be aware that if they bill Medicare under their Medicare provider number or in their name, they are legally responsible for that claim, including repayment of benefits for incorrect claims, even if the billing was done by hospital administration.

• Medical practitioners should decide which item numbers are charged to Medicare for services they provide.

• Provider numbers can only be used by the medical practitioner to whom it has been assigned.

• Registrars cannot bill Medicare in Public Hospitals. Medical practitioners rendering services in a public hospital cannot bill Medicare for services provided by Registrars/junior medical staff.

• Medical practitioners need to be given the opportunity to check their Medicare billing and should be encouraged to do so on a regular basis. If benefits have been claimed incorrectly, medical practitioners can complete and send the department a Voluntary acknowledgement of incorrect payments form.

• When billing under Medicare in a public hospital, medical practitioners are required to maintain adequate and contemporaneous notes – just as they would a private patient in any other setting. They must also be able to substantiate that the requirements of the MBS item have been met.

• Medical practitioners may benefit from education about the hospital’s policies on the classification of patient election status.

• Services can only be billed under Medicare in a public hospital when medical practitioners meet the requirements of the MBS, including:
  - that the patient elected to be treated as a private patient
  - that the patient is eligible for a Medicare benefit
  - that the service is eligible and not already funded by other means
  - that any necessary referral is valid for Medicare purposes and
  - that the MBS item number is correctly billed for the service provided
For more information:

- More information to assist staff to understand the department’s health compliance audit process is available at [health.gov.au](http://health.gov.au) then go to the For Health Professionals tab and select Health Provider Compliance.

- The department is developing education to help assist those who bill Medicare in public hospitals. These resources can be found on the Public Hospital Compliance page.

- If medical practitioners think that a Medicare benefit may have been claimed incorrectly, they can tell the department by completing a Voluntary acknowledgement of incorrect payments form which can be found on the Voluntary acknowledgement page.

- If staff have concerns relating to a health provider they can submit the details to the Department online by Submitting a health provider related tip-off. Alternatively, staff can call 1800 314 808 between the hours of 9am to 5pm AEST to provide the details to the Health Provider Compliance Tip-off Line.
Appendix 5: Savings

The project aimed to achieve savings of $24.7 million.

As at 31 March 2017, the department achieved $22.52 million in savings.

Table 1.1 – Inappropriate Billing Project Savings – as at 31 March 2017

<table>
<thead>
<tr>
<th>Inappropriate Billing Project</th>
<th>Total ($) millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings achieved</td>
<td></td>
</tr>
<tr>
<td>• Direct savings</td>
<td></td>
</tr>
<tr>
<td>1. Money received from self-assessment – Pathology and diagnostic imaging services in public hospital emergency departments self-assessment</td>
<td>$0.53</td>
</tr>
<tr>
<td>2. Debts raised – Personal attendance items audit</td>
<td>$0.01</td>
</tr>
<tr>
<td>3. Debts raised – Rights of private practice tip-offs</td>
<td>$0.00</td>
</tr>
<tr>
<td>Total direct savings:</td>
<td>$0.54</td>
</tr>
<tr>
<td>• Indirect savings</td>
<td></td>
</tr>
<tr>
<td>4. Behaviour change – Pathology and Diagnostic Imaging in emergency departments of public hospitals compliance activity</td>
<td>$18.97</td>
</tr>
<tr>
<td>5. Behavioural change – Single hospital compliance audit</td>
<td>$0.31</td>
</tr>
<tr>
<td>6. Behavioural change – Provision of education to 10 Local Hospital Networks (46 public hospitals)</td>
<td>$2.70</td>
</tr>
<tr>
<td>Total indirect savings:</td>
<td>$21.98</td>
</tr>
<tr>
<td>Total savings achieved as at 31 March 2017:</td>
<td>$22.52</td>
</tr>
<tr>
<td>Variance from $24.7 million target:</td>
<td>-$2.18</td>
</tr>
</tbody>
</table>
Appendix 6: Documentation used to substantiate a Medicare claim for private patients in a public hospital

A successful compliance audit is reliant on access to and the provision of appropriate documentation to substantiate that a Medicare benefit was correctly claimed. When billing Medicare in a public hospital, documents used to substantiate a Medicare claim would be expected to include:

- the patient’s name and the date on which the service was provided
- sufficient information to explain the type of service provided
- for admitted patients, a signed election form or patient record to confirm that the patient was admitted as a private patient, including the time when the election was made and the time when the service was rendered
- for non-admitted patients, evidence that the patient chose to be treated as a private patient for that service
- sufficient evidence to clearly demonstrate that a claim is eligible
- sufficient information to confirm that the service is not already funded by some other means
- sufficient information to confirm that the patient is eligible for a Medicare benefit
- sufficient information to confirm that the requirements of any valid referrals required for that service have been clearly met
- evidence that a formal agreement exists that allows the medical practitioner to exercise a right of private practice at the public hospital
- evidence that when the service was being rendered that the medical practitioner was exercising their right of private practice and
- in respect to services provided in emergency departments, evidence of the time of day for the following:
  - when the clinical decision to admit was made
  - when the service was provided
  - when the patient made an election to be treated as a private patient

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13 For example, diagnostic imaging services must be in written form (including electronic) and include the description of the diagnostic imaging service, the date of the request, the requesting practitioner’s details including signature, surname, initial or given names, practice address, provider number, and the patient’s name and address.