Consultation Paper on Improving Medicare Compliance

AAPM Submission – October 2017

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The Australian Association of Practice Management (AAPM) is pleased to make this submission to the Australian Government Department of Health Consultation Paper Consultation Paper on Improving Medicare Compliance.

As a past member of the Medicare Compliance Working Group, AAPM has advocated that the Medicare Compliance program has not kept up with the changing business structures of healthcare.

AAPM agrees with bringing the three Acts into alignment. AAPM supports the Medicare Compliance program being applicable to all providers, including those in the Dentistry and Pharmacy sectors.
AAPM is concerned that some of the recommended changes may place a greater onus on already heavily burdened healthcare practice administration.
In regard to recovering debt, AAPM's view is that there is no "one size fits all'' arrangement for apportioning debt and ultimately the debt must sit with the provider unless definitively proven otherwise.

AAPM offers the following comments against specific questions and themes set out in the Consultation Paper.

A. Organisation Billing

The current legislation places all of the liability for Medicare claiming against a Medicare provider number on the individual provider. However, the Department's experience over recent years is that practices, hospitals and corporations are either claiming directly on behalf of the individual provider or significantly influencing their claiming behaviour. In a number of compliance cases considered by the Department, the practice or other employing or contracting organisation has claimed benefits on behalf of health providers without provider knowledge.

AAPM Response:
AAPM has reservations about linking the liability of the individual with the Organisation which does the billing. It is still important that the individual provider is required to take responsibility for their billings as the patient assigns their rights to the individual practitioner, not to the Organisation. The liability should remain with the doctor as they determine the charge. No other staff should determine the doctors charge. We are concerned that the liability will automatically shift to the Organisation if the debt cannot be claimed from the individual.

The proposed changes would amend the HIA, the NHA and the DBA to:

A1 allow the Department to directly collect information from employing organisations, corporations and hospital authorities such as practice records, details of business structures and details of employed or contracted health providers to support compliance action;

AAPM Response:
If the proposed approach means Medicare would want to collect business information and provider contractual information from all practices not just those who offend, this would be an

unnecessary burden on the vast majority of practices who are compliant.
AAPM's view is that the Department should only be able to collect information as part of a compliance activity relevant to the suspected breach and that particular provider.

A2 require health providers as part of a compliance activity to advise the Department of their working practice locations, relevant bank accounts and the employment or contractual arrangements they have with organisations, corporations and hospital authorities (information about whether or not the provider is employed or contracting with an organisation may be included in provider registration processes in the future);

AAPM Response:

The proposed requirement that as part of a compliance activity, health providers advise the Department of their working practice locations, relevant bank accounts and the employment or contractual arrangements appears unnecessary. All the information should be available to the Department, except for the contractual arrangements which should only be requested if part of a compliance activity. The Provider Number including their HPI-I and HPI-O will supply identify the provider and location. Bank account details are already provided when a provider receives a payment from Medicare. The provider's contractual status has no relevance for provider registration.

A3 share the liability for debts between the provider and the practice or employing/contracting organisation, corporation or hospital where the practice or employing/contracting organisation, corporation or hospital has claimed incorrectly on the provider's behalf.

- depending on the circumstances, a debt might be raised against the practice or employing/contracting organisation, corporation or hospital only or might be split equally or in some agreed proportion (*the Department would particularly appreciate input on administratively simple approaches to identifying when it may be appropriate to attribute some liability for debts to an organisation rather than the provider and the arrangements for determining the split of any liability between the organisation and the provider*); and

AAPM Response:

AAPM has concerns about this proposal.

In the instance where a provider is engaged via a medical service agreement (or similar), operating under their own ABN and paying a service fee to the Practice for use of services and infrastructure (a very common model in non-corporatised businesses) each practitioner is autonomous and engages with the MBS and Medicare on an individual basis. It would be unjust for the Practice to wear any liability for incorrect billing or over servicing activity. AAPM questions whether a practice can be legally liable for the Medicare billing errors of an independent contractor. Practice staff have no way of knowing if MBS criteria are met during a confidential consult and follow the billing instruction given to them by each individual provider.

Ultimately the GP should be the one determining the item to be billed and they should have a good knowledge of the system and the rules. This should not be delegated to the practice administration staff.

While the responsibility for compliance ultimately lies with the service providers there are some

exceptions to this. These include:

- Hospitals - it would be hard to determine the billings on a daily basis and this is more likely to be done completely by the hospital's admin team
- Residential Aged Care Facilities - GPs are paid an hourly rate to attend to patients and may not be aware of what is being billed in their name by the organisation.
- Salaried health service providers working for NFP health services or Aboriginal Community Controlled Health Organisations.

A4 clarify the powers of the Director of the Professional Services Review to cover not only organisations and corporations that employ providers but corporates and organisations who engage providers otherwise than as employees.

AAPM Response:
AAPM agrees that this should be clarified and the review should be able to cover corporates and organisations which engage providers otherwise than as employees. Organisations such as Community Health Services engage service providers who may rent rooms and often these organisations bill on behalf of the tenant service provider as part of the service/rental agreement.

B. Compulsory offsetting

In 2014-15, the Department of Human Services was able to recover Medicare debts that were only 20 per cent of the amount of debts raised that year arising from incorrect claiming, inappropriate practice or fraud.

To help improve debt recovery rates:

B1 strengthened powers to compulsorily offset MBS debts from future MBS payments are needed under the HIA to match the existing powers in the NHA and the DBA. To avoid hardship for providers, compulsory offsetting would only be applied if agreement could not be reached on a voluntary repayment plan within 30 days. Only up to 20 per cent of each future payment would be withdrawn to pay down the debt.

B2 further, in line with practice at the Australian Taxation Office, the legislation will provide for payments to be sought from third parties through a garnishee notice scheme.

AAPM Response:
AAPM agrees with this in principle.
One practical issue may be that reconciling payments may be very difficult in the practice management software system if the MBS payment was withheld. Medicare needs to consult with AAPM and Software vendors to ensure there is a practical approach to managing the reconciliation of payments.

C. Administrative changes and strengthened recovery provisions

Additional changes to harmonise administrative arrangements across the three Acts so that the same standards and administrative penalties apply to all health providers, including pharmacists and dentists**.**

AAPM Response:

AAPM agrees that bringing all health care professionals under the same set of regulations is also very reasonable.

It is proposed the legislation will:

C1 introduce provisions under the NHA to allow for a PBS debt to be recovered when a pharmacist claims a benefit but does not supply the prescribed medicine;

AAPM Response:

AAPM agrees with this proposal.

C2 apply the same two-year record keeping period for all health providers, including pharmacists and dentists;

AAPM Response:

AAPM agrees with this proposal.

C3 make it faster and easier for providers to repay MBS debts where they self-report that they have claimed incorrectly. This will be achieved by amending the HIA and the DBA by removing the requirement to offer a review of decision where a provider voluntarily acknowledges incorrect payments.

AAPM Response:

Paragraph C3 is a particularly important amendment. Currently the offer of a review and the requirement to wait 30 days before amending claims makes it difficult for patients if an error has been made and they need a Mental Health Item number to be claimed by their GP before they are able to claim a Medicare rebate for psychology services. Currently when a Mental Health Care Plan item is incorrectly input such as 2517 (Diabetes Cycle of Care) is input on a Bulk Bill Claim instead of a 2715 (Mental Health Treatment Plan) it takes more than a month to amend the claim as Medicare waits 30 days after they receive a notification to allow for a request for a review even though the GP has initiated to notification. This causes a further delay in the patient seeking treatment or being able to claim their rebate from Medicare. Removing the need to offer a review when a GP acknowledges the incorrect payment would mean this error could be corrected much more quickly and also acknowledge that the GP has reviewed the error before they notify Medicare.

C4 apply compulsory administrative penalty provisions to dentists and pharmacists, consistent with the conditions that apply to other health providers for incorrect billing under the MBS. The administrative penalty will follow the same principles as the current HIA provisions and can go up or down from a base rate of 20 per cent depending on the conduct of the provider. Providers can ensure they pay no penalties by voluntarily acknowledging any incorrect billing before being contacted by the Department for an audit. No penalty applies to debts of $2,500 or less.

C5 seek a change to the NHA to provide a notice to produce power requiring pharmacists who do not voluntarily provide documents to substantiate claims, consistent with provisions applying to health providers in the HIA and DBA; and

C6 introduce a debt raising power in the NHA that applies to pharmacists where they have made false or misleading statements, consistent with provisions applying to dentists and other health providers in the other two Acts.

C7 clarify the documentation required to substantiate that subsidised services were provided to a patient (currently described in the Health Professional Guidelines), by allowing the Minister to prescribe the records that must be kept – including the records needed to substantiate that a patient is an admitted public or private patient at the time that professional services are rendered.

AAPM Response:
AAPM agrees with proposals C1- 7.

OTHER COMMENTS

While Medicare is looking at making changes to keep up to date with changes in the way practices operate, it would make sense to consider the following recommendations as well:

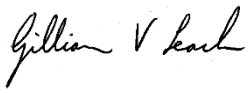
- Simplifying the 'gap' system, so a patient could pay only the gap to the doctor and the Medicare rebate could be assigned directly to the service provider's account. Currently the doctor must wait weeks for a cheque via the patient, or months for a direct deposit if the patient does not bring the cheque in. It is also not uncommon for patients to bank the cheque in their own account and the practice never receives the money.

- The requirement to print the Medicare voucher for the patient to sign should be removed. This is very outdated and inefficient with the technology now in place in most practices. There is a sizable cost to the Practice in consumables and time as well as being an environmentally wasteful exercise.

- Currently, doctors are unable to charge bulk-billed patients for the cost of dressings for wound-care. AAPM has provided the Department with a paper on this matter - Private Billing of Dressings and Consumables
  A national subsidy scheme is needed to enable general practices to provide modern wound care dressings at no cost for disadvantaged patients.
  While this scheme is being developed, as an interim measure practices should be able to charge bulk-billed patients at wholesale rates for the cost of dressings provided at the time of the consultation.
  These measures would bring huge benefits including better health outcomes and quality of life for patients, and reduced costs to the health and aged care systems due to fewer unnecessary hospitalisations and the ability for patients to live successfully in their own homes for longer.

About AAPM

The Australian Association of Practice Management (AAPM) is the professional association for business managers of all healthcare practices including general practice, specialists, dentists and allied health as well as multi-disciplinary clinics. AAPM provides education, support, advice and advocacy for healthcare practice managers. Our aim is to ensure that they are able to effectively manage healthcare practices, that they are able to have the infrastructure and systems in place to provide a high quality health services to the Australian community for better patient outcomes. Consequently, AAPM is ideally placed to assist in implementing the government's primary healthcare reforms.



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